Commonwealth of Virginia
Department of Behavioral Health and Developmental Services
FFY 2016 PATH Application

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PROJECT NARRATIVE AND SUPPORTING INFORMATION

SECTION A: Executive Summary

The Commonwealth of Virginia Department of Behavioral Health and Developmental Services (DBHDS), Office of Mental Health Services, Community Support Services (CSS) has provided homeless services under PATH since 1991. With its allocation of $1,463,397 in Federal Fiscal Year (FFY) 2016 PATH funds, the Commonwealth will continue to provide PATH-allowable services in the communities within our state with a high prevalence of homeless persons with Serious Mental Illness (SMI) and/or co-occurring SMI and Substance Use Disorders (SMI/SUD). Since FFY 2010, has utilized federal PATH funds to support contracted training and coordination services for its SSI/SSDI Outreach, Access and Recovery (SOAR) initiative, and these services will continue for the coming program year.

Organizations to receive funds: The table included in Item 4 below provides detail on Virginia's PATH sites that will operate during the 2016-2017 PATH program year.

PATH funds allocated to providers: See table below for information on each provider. PATH matching funds are provided by the individual program and include a mix of local and state general fund dollars as well as in-kind services.

Service Areas: See table below for information on the catchment area of each provider.

Services to be Supported by PATH Funds: Virginia's PATH sub-grantees will provide a range of allowable PATH services, including outreach, screening and diagnostic treatment services, habilitation and rehabilitation services, community mental health services, access to alcohol and drug treatment for persons with severe mental illness, staff training, case management, supportive and supervisory services in residential settings, referrals for primary health care, job training, educational services, and relevant housing services.

Numbers of Persons to be Contacted and Enrolled: During State Fiscal Year 2015 (July 1, 2014 through June 30, 2015), Virginia's PATH programs provided services to 2,040 enrolled consumers. Additionally, 8,109 homeless persons received outreach services in these programs during the year. As indicated in the table below, Virginia PATH providers expect to contact an estimated 5,178 individuals and enroll 1,780 individuals during SFY 2017 Approximately 78% of these individuals are anticipated to be literally homeless.

PATH Provider Organization (All CMHCs)	Service Area (City/County)	Base Funding	Outcome Incentive	Total Federal PATH Budget	Local Match	Persons to be Contacted	Persons to be Enrolled	Percentage Literally Homeless
Alexandria CSB	Alexandria	$90,256	$15,927	$106,183	$43,772	100	50	80%
Arlington DBHS	Arlington County	$57,253	$10,103	$67,356	$19,463	917	180	40%
Blue Ridge CSB	Roanoke and Salem; Craig, Botetourt and Roanoke Counties	$64,032	$11,300	$75,332	$24,860	145	100	89%
Fairfax-Falls Church CSB	Fairfax and Falls Church; Fairfax County	$139,861	$24,681	$164,542	$127,731	1,000	230	98%
Hampton/Newport News CSB	Hampton and Newport News	$86,552	$15,274	$101,826	$43,240	325	180	90%
Loudoun County CSB	Loudoun County	$42,655	$7,527	$50,182	$94,072	100	65	50%
Norfolk CSB	Norfolk	$90,597	$15,988	$106,585	$60,454	230	120	86%
Portsmouth DBHS	Portsmouth	$45,658	$8,057	$53,715	$18,000	110	80	70%
Prince William Co. CSB	Manassas and Manassas Park; Prince William County.	$74,857	$13,210	$88,067	$30,914	170	50	98%
Rappahannock Area CSB	Fredericksburg; Spotsylvania, Stafford, Caroline and King George Counties.	$83,422	$14,722	$98,144	$32,715	270	130	85%

PATH Provider Organization (All CMHCs)	Service Area (City/County)	Base Funding	Outcome Incentive	Total Federal PATH Budget	Local Match	Persons to be Contacted	Persons to be Enrolled	Percentage Literally Homeless
Region Ten CSB	City of Charlottesville; Albemarle, Green, Nelson, Fluvanna and Louisa Counties	$55,209	$9,743	$64,862	$52,301	220	175	95%
Richmond Behavioral Health Authority	Richmond (for veterans outreach, includes Henrico, Chesterfield and Hanover Counties and the City of Petersburg)	$158,524	$27,205	$186,499	$75,210	575	200	50%
Valley CSB	Staunton and Waynesboro; Augusta and Highland Counties	$34,975	$6,172	$41,147	$20,640	125	70	80%
Virginia Beach CSB	Virginia Beach	$107,907	$19,042	$126,949	$92,434	891	150	95%
Subtotal		**$1,131,758**	**$199,721**	**$1,331,390**	**$736,750**	**5,178**	**1,780**	**78%**
SOAR Coordination Contract	Contracted with Richmond Behavioral Health Authority; services provided statewide			$73,472				
DBHDS Administrative Set-Aside				$58,536				
TOTAL				**$1,463,397**				

SECTION B: State-Level Information

1. State's Operational Definitions

a. Homeless Individual

The operational definition for determining who is homeless is derived from the McKinney legislation. The term **"homeless"** includes persons who lack a fixed regular and adequate nighttime residence. It also includes persons whose primary night-time residence is either a supervised public or private shelter designed to provide temporary living accommodations; an institution that provides temporary residence for individuals intended to be institutionalized; or a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings.

b. Imminent risk of becoming homeless

The term "imminent risk of becoming homeless" includes one or more of the following criteria: doubled-up living arrangement where the individual's name is not on the lease, living in a condemned building without a place to move, arrears in rent/utility payments, having received an eviction notice without a place to move, living in temporary or transitional housing that carries time limits, being discharged from a health care or criminal justice institution without a place to live. In addition to the criteria above, persons who live in substandard conditions are by definition *at risk* of homelessness, due to local code enforcement, police action, voluntary action by the person, or inducements by service providers to go to alternatives like short-term shelters whose residents are considered to be homeless. There is not a recommended time-frame for imminence as individual eviction processes vary.

c. Serious Mental Illness

PATH providers may determine individuals as meeting the Serious Mental Illness criteria if there is an informed presumption that:

- The individual is experiencing or displaying symptoms of mental illness and is experiencing difficulty in functioning as a result of these symptoms that indicates severity, and
- The individual has shared or has a known history of engagement with mental health services OR has symptoms and functioning that indicates there is a history of or expected tenure of significant mental health concerns, and is of appropriate age to be diagnosed with a Serious Mental Illness. (Transition age youth may also be eligible for PATH, when they are independent of parents or guardians.) This determination should reflect and be consistent with the state's definition of Serious Mental Illness.

The operational definition for serious mental illness found in Virginia State Board Policy #1029, (effective June, 1990), is as follows: "Serious mental illness (SMI) means a severe and persistent mental or emotional disorder that seriously impairs the functioning of an adult, 18 years of age or older, in such primary aspects of daily living as personal relationships, self-care skills, living arrangements, and employment, as defined along three dimensions: diagnosis, level of disability, and duration of illness."

Diagnosis: There is a major mental disorder, diagnosable under DSM-IV-TR, which is a schizophrenic, major affective, delusional, organic or other psychotic disorder, or a disorder that may lead to a chronic disability, such as a personality disorder. Individuals who are seriously mentally ill and who have also been diagnosed as having a substance abuse disorder or mental retardation are included.

Severe Disability Resulting from Mental Illness: The disability results in functional limitations in major life activities. Individuals typically meet at least two of the following criteria, on a continuing or intermittent basis for at least two years:

- Is unemployed, is employed in a sheltered setting or supportive work situation, or has markedly limited or reduced employment skills or has a poor work history.
- Requires public financial assistance for out-of-hospital maintenance and may be unable to procure such assistance without help.
- Has difficulty in establishing or maintaining a personal social support system.
- Requires help in basic living skills such as hygiene, food preparation, or money management.
- Exhibits inappropriate social behavior, which results in demand for intervention by the mental health and/or judicial system.

Duration of Mental Illness: Must meet at least one of the following criteria:

- Is expected to require services of an extended duration.
- Has undergone psychiatric treatment more intensive than outpatient care more than once in a lifetime (e.g. crisis response services, alternative home care, partial hospitalization or inpatient hospitalization).
- Has experienced an episode of continuous, supportive residential care, other than hospitalization, for a period long enough to have significantly disrupted the normal living situation.

d. Co-occurring serious mental illness and substance use disorders

Persons who meet both the Serious Mental Illness and one of the below definitions of substance use are considered "co-occurring". There are two levels of substance use disorders: substance addiction (dependence) or substance abuse.

Substance addiction (dependence), as defined by ICD-9, means uncontrollable substance-seeking behavior involving compulsive use of high doses of one or more substances resulting in substantial impairment of functioning and health. Tolerance and withdrawal are characteristics associated with dependence. Dependence is a maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following occurring at any time in the same 12-month period.

- Needing markedly increased amounts of the substance to achieve intoxification or a desired effect or having a markedly diminished effect with continued use of the same
- Having the characteristic withdrawal syndrome for the substance or the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms;
- Taking larger amounts of the substance or over a longer period than was intended;
- Having a persistent desire or unsuccessful efforts to cut down or control substance use;

- Spending a great deal of time on activities necessary to obtain the substance, use the substance, or recover from its effects;
- Giving up or reducing important social, occupational, or recreational activities because of substance use; and
- Continuing substance use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

Substance abuse as defined by ICD-9 means a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances. It leads to clinically significant impairment or distress, as manifested by one (or more) of the following occurring within a 12-month period:

- Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household);
- Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);
- Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct); and
- Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights).

PATH Services for Veterans

PATH sites in Virginia are appropriate service sites to address the needs of veterans in two ways: (1) veteran population for the areas, and (2) coordination of services for homeless veterans.

Population

The U.S. Census Bureau's 2012 American Community Survey reports on veteran populations (the most recent population-specific data available) indicate that 728,143 veterans are living in the Commonwealth of Virginia, which is approximately 12% of Virginia's total population. Areas in which PATH services are provided include a number of Virginia jurisdictions with significant veteran populations:

Tidewater/Southeastern Virginia Area: This area includes several large military installations, and as such, veterans comprise a significant percentage of area residents. The population of veterans as a percentage of the entire adult population in the PATH site areas of the Tidewater region are Portsmouth 15.7%; Newport News 17.3%; Norfolk 16.5%; Hampton 19.6%, and Virginia Beach 20.0%, These areas have high percentages of Gulf War veterans and those who served in Iraq and Afghanistan, and PATH sites report seeing an increasing number of young veterans from Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF).

Northern Virginia Area: PATH sites in this area serve several communities with a high veteran population. Rappahannock Area CSB covers counties with 9.0% to 20.0% veteran population. Prince William County covers an area with a 13.9% veteran population.

Central Virginia Area: PATH service areas in the central Virginia area include Richmond, and Region Ten CSB, cover cities/counties with 15.5%-17% veteran population.

Western Area: Blue Ridge CSB covers city/county areas with veteran populations ranging from 10% to 14%, and Valley CSB's catchment area has a similar population of veterans.

Coordination of Services for Veterans

PATH sites are expected to approach services for veterans in the way that is the most effective for their area. In some cases it works best to coordinate services with the local U.S. Department of Veterans Affairs (VA) outreach representative, who can provide them with quicker access to care, flexible service delivery, assistance with VA and SSI benefits, and can provide additional housing and supportive recovery options. Many times PATH workers assist the person in making a good connection with the VA representative and tracking the progress that the person is making. If the connection is not successful, the PATH worker can pick the client back up on their caseload and assist them in moving into mainstream services on the civilian side. PATH providers also continue to watch for changes in the services available to veterans and adjust their outreach strategies accordingly.

PATH sites are encouraged to have a working relationship with either their closest VA Medical Center or the VA Outreach worker for their area. As a result, PATH has noticed a solidifying of relationships with the veteran's service organizations. The increased presence of VA representatives on local HUD Continuum of Care committees and state level homeless coordination teams is also expected to have a positive impact.

Virginia Veteran and Family Support Program

In addition to services provided to homeless veterans by our PATH programs, the Virginia Department of Veterans Services (VDVS), in collaboration with DBHDS and other state human service agencies, operates the Virginia Veteran and Family Support Program (VVFS), formerly known as the Virginia Wounded Warrior Program. Supported by State general funds since 2009, VVFS provides behavioral health and rehabilitative services to military personnel, including active duty military and members of the National Guard and Reserve services returning from combat in Iraq and Afghanistan and their families. The program is operated on a regional basis, and one CSB in the five VVFS geographical service regions is contracted to be as the regional coordination site and fiscal agent for program funds. PATH services are available in some part of all five VVFS regions, as follows:

VVFS Region	**PATH Communities**	**PATH Providers**
Central Virginia	City of Richmond and surrounding jurisdictions	Richmond Behavioral Health Authority
	Charlottesville and surrounding jurisdictions	Region Ten CSB
Northern Virginia	City of Alexandria	Alexandria CSB

VVFS Region	PATH Communities	PATH Providers
	Arlington County	Arlington CSB
	Fairfax County	Fairfax-Falls Church CSB
	Loudoun County	Loudoun County CSB
	Prince William County	Prince William CSB
Northwestern	City of Fredericksburg and surrounding jurisdictions	Rappahannock Area CSB
Southwestern	City of Roanoke and surrounding jurisdictions	Blue Ridge Behavioral Health
Tidewater	Cities of Hampton and Newport News	Hampton-Newport News CSB
	City of Norfolk	Norfolk CSB
	City of Portsmouth	Portsmouth Department of Behavioral Health
	Virginia Beach	Virginia Beach CSB

The needs of homeless veterans meeting the program's eligibility requirements will be addressed by VVFS, and Virginia's PATH programs work collaboratively with VVFS in their areas of service. VVFS staff includes two state-level Homeless Veterans Coordinators who are working with communities across the state to help build local coalitions and care continuums to improve veterans' access to available resources, including housing vouchers, employment support, and social services. Virginia's PATH programs work with these coordinators to improve veterans' services in their local communities. Additional collaboration around the needs of service members and their families is accomplished through the Virginia Service Members and Veterans Coordinating Council, a state-level steering committee that is comprised of representatives of state agencies, military-specific entities such as the three Veterans Affairs Veterans Integrated Service Networks (VISNs) operating in Virginia; the Virginia National Guard; specific military branches such as the Army and Navy; veterans service organizations operating in Virginia, and other similar groups. Virginia's SPC represents DBHDS on this Council.

To further efforts at addressing veteran homelessness, in September 2014 Virginia PATH began a pilot project which is focusing on outreach to veterans who are homeless or at risk of homelessness through by funding a veteran-focused PATH outreach position at Richmond Behavioral Health Authority (RBHA). This effort, which is detailed in RBHA's Local Intended Use Plan, is operated in collaboration with VVFS.

PATH Efforts to Assist Veterans

The table below summarizes each of our current sites' veteran services plans as proposed for FFY 2016.

PATH Site	Description of Services Provided to Veterans
Alexandria CSB	The Homeless Outreach/PATH Coordinator (HOPC) works closely with the shelters, drop in center, meal programs, detoxification and CSB mental health centralized intake at identifying homeless veterans. The HOPC has developed connections with the VA's Homeless Outreach Social Worker and collaborated to link veterans to health care, food and personal identification. HOPC has developed relationships with members of the VA's PACT Team and is familiar in navigating the VA hospital system in support of meeting the needs of Veterans with SMI. Alexandria Department of Community and Human Services (DCHS) Center for Economic Support's Office of Community Services took the lead in coordinating the efforts to end veteran homelessness. It is a city-wide collaboration between local homeless service providers, veteran service providers, the Office of Veteran Affairs and DCHS's PATH program. The group also included members familiar with veterans and their experiences, including a retired Air Force colonel and an administrative assistant in the Community Services Program whose husband is active duty Army. The City of Alexandria was able to attain homeless veteran "Functional Zero" status in December 2015.
Arlington CSB	Arlington County is in close proximity to several Veterans Affairs facilities. Because of its location, the outreach workers of the Veterans Affairs Medical Center (VAMC) in Washington, DC come to the Arlington Department of Human Services, the Arlington Street People's Network drop-in center and the Residential Program Center once per week. They also schedule appointments with vets at the Arlington Detention Center. Staff from the V.A. has provided trainings regarding V.A. benefits and how to access them to DHS personnel and we have everyone's direct contact line. Arlington County has successfully accomplished the goal of housing all veterans with SMI. PATH continuously works in conjunction with nonprofit agencies to continue to maintain this goal and work towards the housing of all homeless consumers in the county.
Blue Ridge Behavioral Health	Homeless veterans who have a mental illness or a substance abuse problem who are enrolled by the PATH staff have access to the same array of BRBH-provided case management and treatment services as other identified individuals. As veterans, they also have access to services available to homeless veterans at the VAMC in Salem, VA, and/or through the Virginia Wounded Warrior Program. These veterans are provided a choice of primary provider. The PATH worker has a contact at the VAMC and will initiate collaboration and referral if needed. If the homeless individual chooses to receive services from the VA, the PATH worker will assist in the transition to VA services. Identified homeless veterans who do not have a mental illness or a substance abuse problem are referred to staff of the VAMC Program for Homeless Veterans. The Blue Ridge Continuum of Care actively participated in the Veteran's Initiative and was successful in bringing veteran's homelessness to a functional zero.
Fairfax Falls Church	Major services for area veterans are provided in the District of Columbia, Martinsburg ,WV, and Perryville, MD. Both vets and the PATH Team greatly benefit from our relation with the VA's satellite office on in southern Fairfax County. Satellite staff is regularly consulted about benefits and eligibility, and has been instrumental in arranging contact with more distant but most applicable VA services. We are utilizing the Wounded Warrior program as a resource for both training and direct client services. Having such active and available veteran's services have decreased the number of PATH contacts with this special population.
Hampton Newport News	The HNNCSB PATH team interfaces and treats homeless veterans with SMI the same as all other PATH clients. Most veterans are already connected to services so they are ineligible for PATH services but the PATH team will still assist them in resource location. For those who are eligible the team works to connect them to

PATH Site	Description of Services Provided to Veterans
	required and requested services including but not limited to the VA, Wounded Warrior, HNNCSB, and other community programs. The HNNCSB staff works extensively with the veteran service continuum in the area through the Continuum of Care, the regional VA, and the local Military Affairs Committee. The HNNCSB also is working with the VA on the new Ending Veteran Homelessness Campaign that began at the end of 2014. The resource development specialist attended and participated in the planning process and the Director of Property and Resource management is on the state leadership team. One of the homeless services providers and the resource development specialist are currently participating in the campaign, connecting veterans to services and performing assessments. During the 100 day challenge the region housed 136 homeless veterans, some of them located and referred by the PATH team. The HNNCSB PATH team and homeless services department intends to continue its effort to outreach and identify homeless veterans with SMI.
Loudoun	PATH Clinicians screen every outreached individual for possible veteran status. If the veteran does not have possession of his or her DD214 then they receive assistance in getting this vital document. Depending on the needs and desires of the person, referrals are made to the VA Medical Center in Martinsburg, WVA, and Friendship Place (DC). PATH has established a good rapport with the VA Medical Center outreach worker and as a result they will perform assessments in the field within a week. During this fiscal year Loudoun County Department of Family Services, Loudoun PATH's parent agency, added a Veterans Services Coordinator position which significantly contributes to the veterans' service continuum. PATH refers veterans to that program for assistance.
Norfolk	Norfolk CSB collaborates with the local Hampton VAMC staff on the needs of PATH consumers who are veterans. Medical and substance abuse counseling services through the VA are made available to veterans enrolled in the program and 80% of the Veterans in the program have made the VA their medical home. VA Homeless Outreach staff is consulted in identifying eligible candidates and releases of information are routinely executed to coordinate care more effectively. PATH staff works in collaboration with the Virginia Veteran and Family Support as well as the VA outreach workers. Once a homeless veteran is identified by PATH the linkage is immediately made for VA services. If the client is not eligible for VA services then PATH continues to assess the individual for PATH eligibility. If the individual is not PATH eligible then linkage to other outreach services happens. PATH staff will be working the new 100 day challenge to end veteran homelessness as well.
Portsmouth	Homeless veterans in Portsmouth are outreached and assessed for needs and services, and appropriate referrals are made on their behalf. Depending on their needs, homeless veterans are referred to the Hampton VAMC Veterans Outreach Case Manager, the Wounded Warrior Program and other services. Portsmouth is one of three designated communities in the Commonwealth of Virginia working with the Zero:2016 campaign to end homelessness in the veteran population. The Portsmouth CoC is working with the VA and other organizations working to find homes for veterans. The PATH case manager works with, and receives referrals from, all of these agencies. The PATH case manager is finding that she is working more with the vets who do not met criteria for some of the established programs due to receiving less than honorable discharges. These are very difficult to place as they are not eligible to receive benefits but often cannot hold a job.
Prince William	PATH staff provides direct active outreach services to veterans in the local homeless drop-in-center and local church congregate meal sites, on the street, at campsites, and in the woods. PATH therapists receive referrals from other homeless service providers or veterans volunteering their time in the community, often not part of an organization but simply as a way to help a peer. Assessment of veteran status is normally completed at the first or second contact during the outreach phase of

PATH Site	Description of Services Provided to Veterans
	engagement. As the veteran becomes an enrolled PATH client, an assessment is completed identifying needs, such as untreated mental illness, health issues, lack of income and housing. PATH therapists link clients directly with mainstream services for issues exposed in the needs assessment. Services available to veterans include mental health, substance abuse, primary health, case management, employment, education and housing as identified in Section four of this application. PATH therapists directly link clients with services available to only veterans, such as the US Department of Veterans Affairs (VA) Medical Center in Washington, DC; the VA Healthcare for Homeless Veterans; and the VA case manager responsible for HUD VASH vouchers. Within the last 18 months, Friendship Place and Operation Renewed Hope Foundation have begun working with the PWC COC to identify veterans for housing opportunities. As the VA is designed to provide housing for honorably discharged veterans only, Friendship Place and Operation Renewed Hope Foundation can house veterans under any discharge status that is not dishonorable, thus opening the door for more overall veteran eligibility. In keeping with the emphasis to house all veterans by the end of 2015, PWC placed great emphasis on outreaching to the unsheltered homeless population to identify veterans to begin the process of securing housing. PWC PATH was represented on the veterans workgroup subcommittee under the PWC COC, formed to identify all known campsites, coordinated with the "leadership" of each site and establish a process of not only identify the veterans of that area for targeted services but also the needs and preferences of the group at large. A total of 44 formerly homeless veterans in PWC have been housed through this collaborative effort during the first three quarters of FY 2016.
Rappahannock Area	Through outreach and in-reach during community breakfast and dinner hosted by the Veterans of Foreign Wars and their veteran Stand Down Events, the PATH Outreach Worker has multiple referral and outreach opportunities. The CoC has for the last year maintained a by-name list of all veterans who are currently homeless. Individuals are then fed into the list via homeless service providers such as Micah and PATH. Discussions at these meetings set in place action plans which include housing and other veteran related support services. Additionally the PATH Outreach Worker is in regular contact with the staff and leadership of Virginia Veteran and Family Support Program staff based at RACSB, and through Quinn Rivers and the Micah Hospitality Center, the PATH Outreach Worker meets weekly with the VA Representative.
Region Ten	Region Ten CSB is partnered with the Virginia Veteran and Family Support Program and a VVFS Veteran Peer Specialist is embedded within the CSB to further ensure coverage of the homeless veteran population. The PATH coordinator/case manager works with the VVFS Peer Specialist to assure that referrals. In addition, the Veterans Administration is represented on the Thomas Jefferson Area Coalition for the Homeless Continuum of Care committee.
Richmond	The RBHA PATH program currently has a PATH-Vet case manager who identifies homeless veterans with SMI through multiple sources, all of which participate in the Richmond Continuum of Care (CoC). CoC partners include the local Veterans Administration Medical Center Homeless Services Team, Virginia Department of Veterans Services, Virginia Veteran and Family Support Program, Virginia Supportive Housing, Homeless Point of Entry, Daily Planet, Department of Social Services, Richmond Behavioral Health Mental Health Services Division, and HOMEWARD. In addition to referrals from within the CoC, the PATH-Vet CM does independent outreach with the VVFS Homeless Resource Specialist, and the RBHA Homeless Services Team. This involves outreach in the field, at feeding sites, and any locale where homeless veterans are known to frequent. The PATH-Vet CM follows up with veterans with SMI and ensures that they receive services such as clinical assessments and linkage to other community services as needed.

PATH Site	Description of Services Provided to Veterans
	The PATH-Vet CM provides short-term case management, culminating in a warm handover to the agency or organization best suited to work long term with the individual. Short term case management means connecting homeless veterans with SMI to the appropriate health care system – either through the Veterans Health Administration, or for those veterans ineligible for VHA services, to a local health care system that provides the continuity of health care services required for that individual. Short term case management includes ancillary services offered through the Virginia Wounded Warrior Program (VVFS), primarily, peer support, assistance with employment, assistance with disability income, and assistance with documents required for permanent housing. Given the regional scope of VVFS (22 counties, and 5 independent cities), the PATH-Vet CM works collaboratively with VVFS case managers outside of the Greater Richmond area. Periodically, the PATH-Vet CM may have to travel to any point within the Region IV catchment area, to assist with cases involving homeless veterans with SMI. More generally, however, the PATH-Vet CM provides technical support to the VVFS case managers throughout Region IV.
Valley CSB	Potential PATH clients are asked about their veteran status upon initial intake in order to identify homeless veterans with SMI. PATH also coordinates with local shelter programs who also gather initial information on residents' veteran status. PATH staff will work to coordinate housing resources to homeless veterans as needed. PATH staff have worked with the Supportive Services for Veteran Families via the Total Action for Progress (TAP) located in Roanoke, VA, whereby the program can provide rapid rehousing assistance for homeless veterans in the Augusta County catchment area. PATH staff also works to connect homeless veterans to the local Staunton CBOC so veterans can access medical and psychiatric care. PATH staff has also collaborated with the local veteran-specific staff at the Virginia Employment Commission in Fishersville, VA to provide employment-based and other case management-based services to local homeless veterans.
Virginia Beach	Virginia Beach PATH has helped organize a homeless veterans' support group. The group meets weekly and provides access to veterans that are in need of services. The group is working to have various veterans organizations such as VA, Disabled American Veterans (DAV), the American Legion, AMVets, and Veterans of Foreign Wars attend the meeting as least once a month to provide education and an opportunity to obtain services from the organizations. PATH outreaches to veterans in the community, assisting them with acquiring DD214's to access VA services including VA benefits. PATH assists in accessing homeless housing services such as Vets House and the VA voucher program in Hampton, VA. The Hampton Veterans Administration Medical Center, Hampton, VA provides medical and psychiatric care for veterans. The Virginia Beach Community-Based Outpatient Clinic provides medical and psychiatric care to enrolled consumers of the Hampton medical center. PATH links with the Veterans' Outreach Liaison to enhance the outreach services for veterans. In addition, PATH collaborates with Virginia Beach Community Development Corporation by referring homeless veterans to its subsidized apartments for veterans.

4. Alignment with PATH Goals

Adults with SMI who are literally homeless are the priority population served by Virginia's PATH providers. Of the estimated 1,780 individuals to be served by Virginia PATH during FFY 2016, approximately 78% are estimated to be literally homeless. Along with housing placement and connection to mental health services, street/shelter outreach and case management have been

among the highest service priorities of Virginia's PATH program since its inception. Over the years, these expectations have been communicated consistently to our PATH sites. The majority of Virginia's PATH providers operate in urban or urban/suburban areas and spend a significant proportion of staff time conducting street and shelter outreach in order to identify and engage individuals who are literally homeless. In those PATH coverage areas that are more suburban or rural, staff seek out unsheltered individuals who are living in wooded areas or encampments and shelters (where they exist in rural areas) to offer services. Literally homeless individuals with serious mental illness often need high levels of case management services in order to access services and supports, and it is for this reason that case management is such a high priority in Virginia's PATH program. For SFY 2015, Virginia PATH programs reported providing case management services to 81% of individuals enrolled, and our expectation that street outreach and case management are priority services for PATH consumers will not change in SFY 2017.

5. Alignment with the State Comprehensive Mental Health Services Plan

Virginia's SPC is also the administrator of the Commonwealth's Mental Health Block Grant, and in this dual role, has the ability to foster connections between PATH services and the state's overall mental health plan. PATH services, state-level outcomes, progress in service delivery, and relationship with other state agencies and providers to improve access to housing are included in the Comprehensive State Plan for Virginia DBHDS (2014-2020). In addition, PATH services complement many of the goals and vision statements described in the Comprehensive State Plan for Behavioral Health and Developmental Services (previously-referenced current edition 2014-2020). A few of these are outlined below.

- *Promote implementation of integrated care primary care and behavioral health care delivery models across the Commonwealth. (p. 30)*

  Four of the CSBs operating PATH services currently participate in Virginia's "*A New Lease on Life"* (ANLOL) integrated primary care and behavioral health care initiative. ANLOL began as a collaborative effort of the Virginia Health Care Foundation, Virginia Association of Community Services Boards (VACSB), Virginia Association of Free Clinics (VAFC), and the Virginia Community Healthcare Association (VCHA) to improve care integration for physical and behavioral heath services In addition, four PATH providers – Alexandria, Arlington, Norfolk and Richmond - are also grantees under SAMHSA's Primary and Behavioral Health Care Integration (PBHCI) Program. Homeless individuals are able to access primary health care service through all these efforts.

- *Address housing needs for individuals with mental health and substance use disorders and those with developmental disabilities. (p. 39)*

  Several Virginia PATH sites, through their agencies or partner organizations, have embarked on opportunities to expand housing options for their consumers through Safe Havens, Housing First projects, Shelter +Care, and SRO housing. DBHDS promotes Fair Housing training and advocacy as a tool for both acquisition and retention improvement in the competitive markets and in specialized programs. As usual practice, PATH sites

provide housing acquisition services for their consumers and have some capacity to provide follow-up supportive services to help stabilize them in this housing for a short period of time. In addition, in the spring of 2015, DBHDS and two of its PATH sites, Norfolk Community Services Board and Hampton-Newport News Community Services Board, applied for and were subsequently awarded a three-year grant from SAMHSA under the Cooperative Agreements to Benefit Homeless Individuals for States (CABHI-States) program. With grant funds, DBHDS and the two CSB partners have created a program titled **Virginia Road2Home** which has created two interdisciplinary teams of trained and experienced staff to seek out and engage up to 400 chronically homeless individuals with severe behavioral health problems each year. The teams, which include clinicians, case managers, a benefit specialist trained in the SOAR model, a housing specialist, an employment specialist and a peer support specialist, provide access to behavioral and primary health care services and assistance with finding and retaining permanent housing for approximately 350 individuals over the life of the project. Included in the program's housing resources is State General Funds allocated to DBHDS to fund permanent supportive housing for the program's enrollees.

- *Expand the capability of Virginia's behavioral health services system to recognize and address the growing services and supports needs among veterans. (p. 50)*

  As described in Section 2 above, in FFY 2014, Virginia PATH developed a partnership with the Virginia Veteran and Family Support Program (VVFS) and Richmond Behavioral Health Authority to provide targeted outreach and engagement services to homeless veterans who meet PATH eligibility criteria. More information about this collaboration can be found in Richmond Behavioral Health Authority's Local Intended Use Plan. In addition, Virginia's State PATH Coordinator is a member of the state-level Virginia Military and Veterans Coordinating Council, a staff-level advisory board for VVFS. The SPC's participation on this Council enables DBHDS to maintain a close collaborative relationship with VVFS, a collaboration which provided the impetus for the homeless veterans outreach initiative mentioned above.

6. Alignment with State Plan to End Homelessness

The Governor's Coordinating Council on Homelessness (GCCH, previously known as the Homeless Outcomes Coordinating Council) was created in 2010 to address the housing and service needs of homeless Virginians. The Council is co-chaired by Secretary of Health and Human Resources, William Hazel, M.D., and Secretary of Commerce and Trade, Maurice Jones (former HUD Deputy Secretary). Similar to the U.S. Interagency Council on Homelessness, membership includes a cross section of government agencies as well as local and statewide nonprofit organizations. It meets quarterly and includes four standing committees: Ending Veteran Homelessness Committee, Interagency Partnership to Prevent & End Youth Homelessness, Performance & Impact Committee, and the Solutions Committee..

<u>Accomplishments to Date</u>
The GCCH has proven to be an effective vehicle for helping to achieve meaningful outcomes. Under its leadership and direction, in the past five years, Virginia has reduced homelessness

across several sub-populations. The January 2015 Point in Time count of individuals experiencing homelessness showed reductions from 2010 – 2015 as follows: 23% overall reduction (9,080 individuals to 7,001 individuals); 24.6% reduction in households with adults and children (1,181 to 890); 31% decrease in Veterans (881 to 604); 31% decrease in chronically homeless individuals (1,150 to 1,041); 17% decrease among individuals with serious mental illness (1,291 to 1,074); and a 46% decrease among individuals with substance use disorders (2,047 to 1,101).

The GCCH has endorsed Virginia's new action plan for its Healthcare and Housing (H^2) Initiative. Virginia was one of the first states selected for onsite technical assistance through HUD's H^2 Initiative in 2014 to plan efforts designed to increase homeless services and supportive housing participants' access to healthcare resources. The Virginia H2 Action Plan was produced through the facilitated efforts of key representatives of Continuum of Care (CoC) leads, supportive housing providers, public housing authorities (PHAs), federally qualified health clinics (FQHCs), public behavioral health care providers (CSBs), and other local, regional, and state-level departments and associations of health, behavioral health, social services, Medicaid, managed care, and housing. The Virginia H2 Action Plan also serves as the inter-agency plan for Virginia's new SAMHSA CABHI project, awarded in 2015. H2 activities are overseen by the Coordinating Council's Solutions Committee. The chair of the Solutions Committee is DBHDS Assistant Commissioner for Behavioral Health, Daniel Herr, J.D., and committee members include DBHDS mental health and substance abuse services staff and representatives from the Virginia Departments of Housing and Community Development (DHCD), Aging and Rehabilitative Services (DARS), Corrections (VADOC), Criminal Justice Services (DCJS), Social Services (VDSS), Veterans Services (DVS), the Employment Commission (VEC), the Virginia Housing Development Authority (VHDA), and the Housing Alliance (VHA). The provides leadership, oversight, coordination, and support for statewide implementation of this plan to achieve the following five goals:

1. Housing: Ensure that every person in the Target Population has access to housing and to the support services needed for ongoing residential stability.
2. Health Care: Enhance access to health and behavioral health services needed to maximize health, manage ongoing conditions and facilitate housing retention.

3. Coordination: Improve coordination between the housing and health care systems, at both the systems and service levels.

4. Data: Use data to inform decision-making in order to enhance system efficiency and improve quality of care and outcomes.

5. Alignment with Other Efforts: Support H2 with complementary efforts currently underway in Virginia.

Planned activities include cross-agency efforts that build upon existing Medicaid enrollment assistance resources, including Cover Virginia (a web-based tool for information and online applications for Virginia's Medicaid programs and health insurance options available through the Federal Marketplace), CoC Coordinated Entry, Virginia Poverty Law Center, Governor's Access

Plan (GAP), Commonwealth Coordinated Care (for Medicare/Medicaid dual-eligibles), and the existing capacity of CSBs, FQHCs, HCH programs, and free clinics.

7. Process for Providing Public Notice

Each year, Virginia's annual PATH application is posted on the DBHDS Web site for comment. The site is easy to access, the plan is easy to find, and there is a link next to the plan that sends comments directly to the State PATH Coordinator. Once DBHDS has finalized the application for this year, this plan will replace the one currently on the website and will be available for public comment. Any comments received will be taken into consideration for next year's PATH plan and recommendations for substantive changes will be reported to CMHS for review.

8. Programmatic and Financial Oversight

The PATH Program is administered by Virginia's SPC, whose position is sited in the DBHDS Office of Mental Health Services. Financial oversight is provided by the Department's Fiscal Office through a standard Performance Contract with CSBs. Until March 2016, the SPC operated the PATH program in collaboration with the former Director of Mental Health Community Support Services in the Office of Mental Health. However, the individual in that position retired from state service as of March 24, 2016, and DBHDS leadership are in discussion about restructuring that position. As a result of reorganization in the Office of Mental Health, the SPC now reports to the Office's Operations Manager.

The SPC reviews program applications and annual reports; monitors the quarterly incentive program (described below); orients new PATH workers, supervisors and/or PATH sites to state and federal PATH policies and procedures; assists PATH sites with program development and transition; provides technical assistance by telephone, written correspondence, and on-site monitoring and technical assistance visits. The SPC also assists in inter-agency communications and network building; promote program development that would benefit PATH consumers; assist in accessing housing development and supports funding; represents DBHDS on homeless services coordinating bodies, and works with the Virginia Behavioral Health Advisory Committee (BHAC, formerly the Mental Health Planning Council). The SPC holds one of three agency voting seats on the BHAC.

Two tools used by the SPC for programmatic oversight are on-site visits and quarterly performance monitoring. All sites receive periodic on-site reviews and are rated on their compliance with expectations. In past years, Virginia's SPC conducted annual site visits with each program; however, due to state budget cuts and downsizing in the DBHDS Central Office over the last several years, DBHDS no longer has the staff capacity to conduct annual on-site reviews. At this time, reviews are being conducted as needed, when issues are identified, when a major change in program staff necessitates an on-site training and orientation session, or as part of regular monitoring and oversight activities which DBHDS undertakes annually with selected CSBs. Sites with significant performance issues are placed under a corrective action process as needed and their continuance in the program is contingent on successful completion of corrective actions. Sites with less significant issues are provided with correspondence which includes recommendations for improvement and a request for evidence that these areas of improvement

have been addressed. In the past, one site was removed from the program as a result of this process.

PATH Program Quarterly Performance Reporting

DBHDS uses quarterly PATH reporting to monitor progress, determine technical assistance and training needs, and also to determine the allocation of performance awards via the Virginia PATH Performance Incentive Program. This program sets aside 15% of the federal PATH allocation for each site as a "Performance Incentive Fund" which is awarded based on the quarterly performance of the site as measured by its performance at achieving important PATH objectives. Virginia PATH utilizes the "progress reporting" feature in the PATH Data Exchange for its providers to submit required quarterly reports, and performance is evaluated using that data on a calendar-year basis; annual performance is assessed using data from Quarters 3 and 4 of the prior fiscal year and Quarters 1 and 2 from the current fiscal year. The measures assessed and the methodology used is described as follows:

PATH Performance and Outcome Measures	**Target**
Individuals enrolled from outreach as a percentage of the CoC's Point in Time Count	200%
Percent of Consumers Served who are Literally Homeless	80%
Number of PATH Consumers Served as a Percentage Expected by Budget	100%
Mental Health Services Attained	50%
Housing Attained	20%
Income Assistance Attained	15%
Average Other Services Attained	15%

Methodology:

Outreach Enrolled as a Percentage of PIT = Total number of persons who were outreached/contacted who became enrolled divided by the most recently published HUD Point In Time (PIT) count of homeless individuals with SMI in the PATH program's Continuum of Care. It is estimated that the annual number of homeless individuals with SMI is about three times the number counted in a given PIT count, but to account for differences in capacity of PATH programs, the target percentage for this effort is 200%.

Percent Literally Homeless = Total number of persons who were outreached/contacted with a "literally homeless" housing status divided by the total number of persons who were outreached/contacted.

Number of Clients as a Percentage Expected by PATH Budget =
Step 1. Divide the PATH program budget by number of persons enrolled in PATH to find the average cost per client for each PATH program.
Step 2. Make the median (midpoint) of all the results from Step 1 plus 10% equal to the expected cost per client.
Step 3. Divide the total PATH budget by the results of Step 2 (expected cost per client) to identify the number of clients expected to be served.

Step 4. Divide the number of persons enrolled in PATH by the results of Step 3.

MH Service Attained = Number of persons that attained the Community Mental Health type of referral divided by the number of persons enrolled in PATH.

Housing Attained = Number of persons that attained the Housing Placement Assistance type of referral divided by the number of persons enrolled in PATH.

Income Assistance Attained = Number of persons that attained the Income Assistance type of referral divided by the number of persons enrolled in PATH.

Average Other Services Attained =
The percent of PATH clients that attained Substance Use Treatment plus
The percent of PATH clients that attained Primary Health Services plus
The percent of PATH clients that attained Job Training plus
The percent of PATH clients that attained Educational Services plus
The percent of PATH clients that attained Relevant Housing Services plus
The percent of PATH clients that attained Employment Assistance plus
The percent of PATH clients that attained Medical Assistance
Divided by 7 (categories of referrals)

Process for Assessing Performance Incentive Awards

For the purpose of calculating awards, one point is assigned to each of the seven measures, and incentives are be awarded based on the PATH program's score on an annual assessment of performance. For example, if a PATH program achieves 100% performance on all seven measures, its score for the year will be seven (7) total points, and for that year, 100% of Performance Incentive Funds will be awarded. Similarly, if the annual score is 3.5, the program will be awarded 50% of its incentive funds for the year. Virginia's SPC uses the results of the annual performance incentive assessment to identify the need for training and technical assistance to providers who fail to meet outcome expectations.

Defining Service Delivery

Current PATH sites were provided copy of the definitions of PATH services previously developed by the PATH State Contact Administrative Workgroup (AWG) when those definitions were adopted and all Virginia PATH sites have been using these definitions since September 2005. These definitions, including "homeless", "at risk of homelessness", and the Commonwealth's definitions of Serious Mental Illness, Substance Use Disorder and co-occurring disorder, are provided to PATH sites as guidance for developing their Local Intended Use Plans. DBHDS understands that SAMHSA has approved new service definitions for FFY 2016 and Virginia PATH will adopt the new definitions when they are released publicly.

Promoting Innovative Practices

Just as there are many ways to provide efficient and creative PATH services, no one PATH site can do everything. Instead of continuing to try to promote these good ideas to each site, for some years now, Virginia PATH sites have been given the opportunity to declare their specialty and then report on their progress and outcomes related to that specialty (in addition to the statewide incentive program reporting). The specific services are then more reflective of the needs and capacities of the target area. The initiatives are called Virginia PATH Innovative Practices and are outlined below. These practices are included in the PATH RFA for the coming program year and the applications of respondents who propose to implement any or all of these services are given additional consideration in the scoring process.

SOAR: Providing SSI Outreach Services to PATH Clients

Any program that identifies SSI application services as a targeted service of the program. In order for this to be considered an innovative practice, the program must meet the following criteria:

- PATH program provides full assistance with the application process.
- PATH program maintains a relationship with local DDS and SSA.
- PATH program develops relationships with practitioner(s) who perform or are Willing to perform DDS consultative examinations and will be easy for clients to access.
- PATH program provides data to state contact on SSI activities as an attachment to their quarterly reports.

Developing Outreach Partnerships with Downtown Organizations/Associations

Any program that has or is willing to develop a relationship with downtown or commercial neighborhood organizations or businesses with the intent of increasing outreach and partnerships in serving PATH eligible persons in the identified communities. Typical activities include: attending organization/association meetings, assisting the area in identifying issues of homelessness, working towards mutually agreeable solutions, accepting referrals from the group or individual members, providing training to organizations and associations on PATH services, homelessness, and mental illness, serving as liaison between the Continuum of Care and the community, and participating in joint outreach activities. PATH programs participating in this practice provide an update on these partnerships with their quarterly reports.

Focusing Services on Targeted Street Outreach.

PATH programs that have staff who spend a significant part of their time looking for, identifying, and engaging persons on the streets, in woods or camps, and other places where other services are not being provided may identify themselves under this practice. PATH programs identifying themselves as providing this service provide information on their quarterly reports as to the numbers of persons outreached and number of contacts made to them separately in their quarterly reports.

Partnering with Emergency Rooms and/or hospitals to serve PATH Consumers

PATH programs that have or will develop relationships with their local hospitals to identify PATH eligible clients who frequent emergency rooms in an effort to assist them in accessing mainstream services to resolve issues identified in their needs assessment. Providers identifying this service will indicate the number of persons served through this and a brief narrative of the relationship with their quarterly reports.

Partnering with medical clinics to jointly address medical and psychiatric needs

PATH programs who wish to identify this practice must have federally qualified health care clinics, Health Care for the Homeless programs, or other indigent care clinics or mobile health outreach services in their communities and have or will develop relationships with these services to jointly address medical and psychiatric needs to PATH eligible persons. Numbers of persons served through this partnership and a brief narrative of the relationship will be reported with their quarterly reports.

9. Selection of Local-Area Providers

Virginia's PATH funds historically have been allocated to sites using a formula that creates a need score for each of the PATH sites. That score combined the HUD Homeless Assistance Pro-rata for each community and the PATH-targeted disabled homeless subpopulations. The population estimations identified in the previous section also provide guidance for the targeting of need areas.

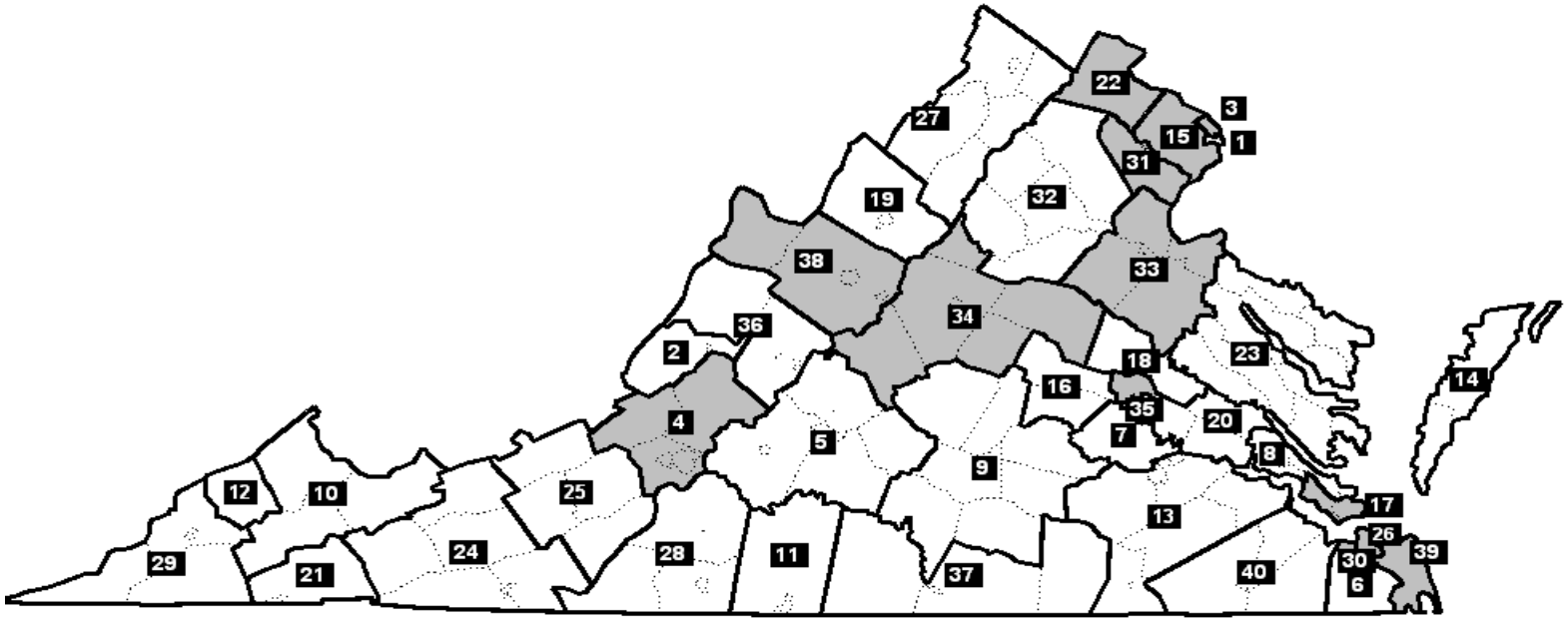
Currently, all Virginia PATH programs are sited in community mental health centers that receive their base funding through electronic warrants from DBHDS twice monthly from September through August. Current PATH sites include all major metropolitan areas, covering at least 57% of the estimated eligible population. There are four CSB service areas that have significant estimates of a homeless SMI population but are not current PATH sites (see chart, next page).

- Chesterfield and Henrico counties are suburbs of the City of Richmond, which reports serving persons from the suburbs as they come to Richmond to seek shelter and services. For FFY 2016, these jurisdictions will receive limited PATH services designed to identify homeless veterans as part of the PATH-Virginia Veteran and Family Support (VVFS) collaboration which is being implemented by jointly by Richmond Behavioral Health Authority and VVFS. Non-veteran homeless individuals with SMI identified during outreach efforts in those jurisdictions will be referred to appropriate services.

- The City of Chesapeake is adjacent to Norfolk, Portsmouth, and Virginia Beach. The Norfolk site serves a high portion of Chesapeake residents as limited shelter is available in Chesapeake and individuals often cross jurisdictional lines to seek shelter in Norfolk, which has a much larger number of shelter beds. In the winter, these three PATH site areas have winter shelter that accommodates persons from across the region.

- The New River Valley CSB catchment area is adjacent to the Blue Ridge/Roanoke and the Piedmont areas. Roanoke serves as the hub for homeless services in the western area of the state.

Virginia's FFY 2016 PATH Covered Service Regions



Community Service Board Service Area Identifications – Shaded Areas Indicate Current PATH Coverage Areas

1 Alexandria
2 Alleghany Highlands
3 Arlington
4 Blue Ridge
5 Central Virginia
6 Chesapeake
7 Chesterfield
8 Colonial
9 Crossroads
10 Cumberland Mountain
11 Danville-Pittsylvania
12 Dickenson
13 District 19
14 Eastern Shore
15 Fairfax-Falls Church
16 Goochland-Powhatan
17 Hampton-Newport News
18 Hanover
19 Harrisonburg-Rockingham
20 Henrico Area
21 Highlands
22 Loudoun
23 Mid Peninsula-Northern Neck
24 Mount Rogers
25 New River Valley
26 Norfolk
27 Northwestern
28 Piedmont
29 Planning District 1
30 Portsmouth
31 Prince William
32 Rappahannock-Rapidan
33 Rappahannock Area
34 Region Ten
35 Richmond
36 Rockbridge Area
37 Southside
38 Valley
39 Virginia Beach
40 Western Tidewater

10. Location of Individuals with SMI who are Experiencing Homelessness

Current numbers of homeless persons with serious mental illness in Virginia is estimated to be 17,269 (method described below). Geographic regions for this report are identified by Community Service Board (CSB) service regions. There are 40 CSBs that cover the entire state. The estimate for each CSB service region is indicated on the table below; the geographic location and area is demonstrated on the map on the following page. In both the table and the map, 14 current PATH service areas are indicated with shading. Note that one service area, that of the Charlottesville/Albemarle County area, also includes a sub-contracted consumer-run organization.

DBHDS compiles population estimates for each CSB service area and determines the estimated number of adults with SMI based in each area for the Comprehensive Plan. The estimate of the number of adults age 18 and over with serious mental illnesses was developed using the methodology published by the U.S. Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA) in the Federal Register, Volume 64, No. 121, dated June 24, 1999. This methodology, which estimates that 5.4% of the state's resident population has a serious mental illness, was applied to Virginia 2014 Estimated Population data released by the University of Virginia's Weldon Cooper Center for Public Service to estimate that 348,687 adults in Virginia had a serious mental illness in 2014. The homeless/at-risk prevalence estimates are derived by calculating 5% percent of the SMI population (Task Force on Homelessness, 1992 and Blueprint for Change, 2003). The following table represents the current estimates based on this methodology.

Estimates of Homeless or At Risk persons with Serious Mental Illness

(Shaded Rows are PATH Communities)

CSB Name	2013 Population Estimates, 18+	SMI Adult Population Estimate (5.4%)	Homeless/At-risk and SMI estimate (5% of SMI)	January 2015 PITC SMI Adults*
Total Sub-Populations	6,457,174	348,687	17,434	1,079
Fairfax-Falls Church	895,007	48,330	2,417	153
Prince William	363,095	19,607	980	44
Virginia Beach	347,990	18,791	940	100
Henrico	268,286	14,487	724	
Rappahannock Area	262,658	14,184	709	50
Chesterfield	176,301	9,520	476	
Hampton-Newport News	247,102	13,344	667	95
Loudoun County	256,448	13,848	692	35
Horizon	205,657	11,105	555	
Blue Ridge Behavioral Healthcare	202,872	10,955	548	84
Norfolk	195,533	10,559	528	62
Region Ten	195,201	10,541	527	32
Arlington	187,973	10,151	508	27

CSB Name	2013 Population Estimates, 18+	SMI Adult Population Estimate (5.4%)	Homeless/At-risk and SMI estimate (5% of SMI)	January 2015 PITC SMI Adults*
Northwestern	178,623	9,646	482	
Richmond	177,675	9,594	480	101
Chesapeake	176,301	9,520	476	
New River Valley	150,704	8,138	407	
District 19	136,580	7,375	369	
Rappahannock Rapidan	132,389	7,149	357	
Colonial	130,283	7,035	352	
Alexandria	123,834	6,687	334	72
Middle Peninsula-Northern Neck	114,311	6,173	309	
WesternTidewater	114,488	6,182	309	
Piedmont	112,476	6,074	304	
Harrisonburg-Rockingham	104,632	5,650	283	
Valley	97,445	5,262	263	35
Mt Rogers	95,630	5,164	258	
Danville-Pittsylviania	82,990	4,481	224	
Crossroads	83,039	4,484	224	
Hanover	78,738	4,252	213	
Cumberland Mountain	76,477	4,130	206	
Planning District 1	73,343	3,961	198	
Portsmouth	73,506	3,969	198	47
Southside	66,703	3,602	180	
Highlands	58,037	3,134	157	
Goochland-Powhatan	40,720	2,199	110	
Eastern Shore	35,812	1,934	97	
Rockbridge	33,856	1,828	91	
Alleghany-Highlands	17,302	934	47	
Dickenson County	12,158	657	33	

* PIT (Point in Time) Count = total for larger Continuum of Care area, which may include jurisdictions not in the CSB catchment area.

1) Based on 2014 Population Estimates from the Weldon Cooper Center for Public Service at the University of Virginia.
2) The SMI prevalence rate formula above is as described in the Virginia 2014-2020 Comprehensive State Plan.
3) Homeless/At Risk SMI numbers = 5% prevalence estimates (Blueprint for Change, 2003)

11. Matching Funds

Virginia's PATH programs are sited within Community Mental Health Centers, which are a component of our local-area CSBs. Their CMHC status provides a range of funding, including state general funds, local funds, Medicaid and other reimbursements, federal and state grants, fees paid by recipients, and other sources. Each provider is required to match its federal PATH award with a minimum of 33% of local resources, which include state general funds, local revenue sources, and in-kind contributions. All CSBs who are allocated PATH funds have provided assurance that required match funds will be available as of the start of the PATH program year on September 1, 2016. As is evident in our detailed program budget on Page 4, a number of Virginia's PATH sites match at a higher percentage than the minimum; as a result, the Commonwealth's total match far exceeds the required 33%. Virginia's PATH match for FFY 2016 is 50.3% of our federal award total.

12. Other Designated Funding for PATH-Eligible Persons

State general revenues are used, but not specifically designated, to support services to persons who are homeless and have SMI. State funding can be used to provide direct services, housing supports, local match for HUD Continuum of Care projects, and other services for homeless consumers with serious mental illness. Community Service Boards use State general funds to match PATH program services in those areas that have PATH sites and they do support services to consumers who are identified and referred through PATH. In addition, approximately 75% of Virginia's annual Community Mental Health Services Block Grant (MHBG) award is allocated to CSBs to support services for adults with SMI. However, like State general funds, CSBs' MHBG allocations are not specifically designated for individuals with SMI who are homeless.

Substance Abuse Prevention and Treatment Block Grant (SAPTBG) funds are not generally used to fund PATH services. However, during SFY 2011, DHBDS began an innovative partnership with the City of Virginia Beach to address the needs of adults with substance use disorders who experience chronic homelessness. Due to the nature of the Virginia Beach community, which is a popular East Coast vacation spot with mild weather and a well-coordinated homeless service system, Virginia Beach has a large number of chronically homeless individuals with serious substance use disorders who are ineligible for PATH services because they do not have serious mental illness. In order to address the needs of this population, in March 2011, DBHDS began providing SAPTBG funds to the City of Virginia Beach to fund a "Substance Abuse PATH" project to operate in conjunction with the Virginia Beach PATH Program. Virginia Beach is using this SAPTBG award to fund an additional half-time "SA PATH" outreach worker who concentrates specifically on providing PATH-type services such as outreach, engagement and case management services to this population, and also to support the cost of substance abuse treatment, housing assistance and other needed services. Most of these individuals are originally identified by the Virginia Beach PATH Program during outreach activities, so PATH Program staff are able to make immediate referrals to the SA PATH worker when they determine that an individual is ineligible for formal PATH enrollment. In addition, the SA PATH worker is benefiting from the collaboration with Virginia Beach PATH staff in identifying services and resources for these consumers.

13. Data and HMIS Plan

At present, DBHDS is not involved in funding, utilizing or operating HMIS at the state or local level. The Virginia Department of Housing and Community Development (DHCD), the state agency which oversees state and federal Emergency Shelter Grant, State Shelter Grant, and Homelessness Prevention and Rapid Re-housing funds, is the only state agency with HMIS involvement. Communities receiving funds from those programs are required to utilize HMIS to report data, and DHCD contracts with Homeward, a Richmond-area organization that manages HMIS data collection and reporting for the Richmond and Fredericksburg Continuua of Care as well as the "Balance of State," which is comprised of those Virginia communities that do not have their own Public Housing Authority. Three PATH communities are represented in that HMIS data system, but Virginia has no consolidated statewide HMIS system which encompasses all areas served by PATH.

In order to meet SAMHSA's requirement that PATH annual report data be submitted through HMIS by the end of State Fiscal Year 2017, DBHDS will be working to implement the plan detailed in the table below. An important component of this effort is a joint technical assistance effort in which DBHDS is currently engaged with staff of the Center for Social Innovations/SAMHSA Housing and Homelessness Resource Network and ICF International, the HUD HMIS technical assistance contractor. In July 2014, DBHDS applied and was approved for joint technical assistance by HUD and SAMHSA in order to identify successful strategies to accomplish our PATH HMIS data transition. This effort officially began in October 2014 with individual conference calls with each PATH site and their local HMIS administrators to provide background information for the technical assistance team about the PATH CoCs and the challenges and barriers they might face in implementing the PATH HMIS requirement. Because all of Virginia's PATH programs are sited within community services boards (CSBs), which are community mental health providers, the most challenging and potentially expensive barrier identified to date is the need for PATH staff to enter consumer data into both HMIS and the CSB's electronic health record (EHR). The technical assistance team, which includes the SAMHSA and HUD representatives mentioned above as well as Virginia's SPC and the DBHDS Director of Mental Health Community Support Services, has developed a plan for working with DBHDS and each PATH site and the HMIS administrators to investigate the possibility of developing a transfer of data from the EHR to the local HMIS, or vice versa, to avoid the need for double entry. This technical assistance plan will continue throughout calendar year 2015.

Goal: To ensure all Virginia PATH providers are entering data regularly into their community HMIS system and have the ability to report PATH data annually to SAMHSA via HMIS by no later than the end of State Fiscal Year 2016, which in Virginia will be June 30, 2016.

Activity	Responsible Party	Deadline
Evaluate the current status of HMIS data entry capability among Virginia PATH programs to determine training and technical assistance needs and identify barriers and challenges to implementation.	State PATH Coordinator	Ongoing

Activity	Responsible Party	Deadline
Participate in SAMHSA PATH HMIS Learning Community.	State PATH Coordinator and one PATH provider	Ongoing
In collaboration with Virginia PATH Programs, communicate with local HMIS administrators to determine capability to accept PATH data, understanding of PATH services, and technical assistance needs around PATH.	State PATH Coordinator, local HMIS and PATH Program staff, SAMHSA/HUD technical assistance team	Spring 2016 and ongoing
Work with Community Services Boards' Information Technology and Quality Improvement staff, PATH Program staff, and local HMIS administrators to determine cost of modifying HMIS systems to accept and report PATH data.	State PATH Coordinator, PATH Program Staff, Community Support Services Director, CSB IT/QA staff, SAMHSA/HUD technical assistance team	Spring (ongoing effort)
As appropriate, schedule meetings with PATH Program staff, HMIS administrators and HMIS vendors to discuss plan implementation.	State PATH Coordinator, PATH Program Staff, SAMHSA/HUD technical assistance team	Ongoing throughout SFY 2017
Conduct PATH HMIS statewide meeting to address HMIS requirements	State PATH Coordinator, PATH Program Staff, Community Support Services Director, CSB IT/QA staff, SAMHSA/HUD technical assistance team	SFY 2017, as needed
Provide training to PATH Program staff on new HMIS standards and data entry policies/procedures as needed.	HMIS administrators, State PATH Coordinator	SFY 2017, as needed
Implement and test new PATH/HMIS data standards.	PATH Program Staff, CSB IT/QA staff, HMIS administrators	SFY 2017, when new PATH annual report announced
Implement annual reporting through HMIS.	PATH Program Staff, with oversight by State PATH Coordinator and CSB IT/QA staff and HMIS administrators	July 1, 2016

14. PATH Program Staff Training

Both DBHDS and our PATH programs provide ongoing training opportunities for PATH staff. The State PATH Coordinator plans trainings or otherwise coordinates availability for PATH providers to attend. Some training opportunities are supported financially by DBHDS, varying from full cost coverage to a registration fee to cover some of the costs. The State PATH Coordinator keeps PATH sites updated on training availability through e-mail notices of training and conferences through local, state, and national training resources. Over the past few years, several sites have been able to send staff to conferences held by the National Alliance to End Homelessness (NAEH) and the National Health Care for the Homeless Council (NHCHC).

When funding is available, DBHDS provides a Virginia PATH Training Conference for PATH providers, the attendance costs of which are typically covered in full for all Virginia PATH

program staff with funds remaining after the performance incentive awards are distributed. The most recent statewide PATH meeting was held in November 2015 and focused on the transition to HMIS data reporting. The joint SAMHSA/HHRN and HUD technical assistance team working with Virginia on our PATH HMIS data transition provided onsite training and technical assistance to all our PATH sites as a group and all found the two-day meeting very helpful to their transition process

15. SSI/SSDI Outreach, Access and Recovery (SOAR) Initiative

Virginia's SOAR efforts began in 2005, when three PATH sites began implementing the SOAR model through the Virginia PATH SSI Outreach Initiative. Currently, there are fourteen active SOAR communities here with more than 150 SOAR-trained workers. Seven of our active SOAR sites are PATH programs and approximately 12 current PATH workers are SOAR-trained. In order to strengthen Virginia's SOAR program, in 2011, DBHDS began contracting with one of Virginia's PATH providers, Richmond Behavioral Health Authority, for a State SOAR Coordinator (SCC) who is a former PATH/SOAR worker. The SCC position is designed to coordinate and strengthen the relationships and communication between the partners involved in the Virginia SOAR Network with the goal of continually expanding Virginia's SOAR efforts. The SCC's responsibilities include providing SOAR-related training and technical assistance to existing and new SOAR sites, overseeing collection and reporting of SOAR outcome data to state and federal partners, and working with other state and community agencies to strengthen and expand SOAR services in Virginia.

Since DBHDS created the SCC position in September 2011, the SOAR project in Virginia has continued to thrive and expand. Virginia's SCC has worked with the SOAR sites in existence at that time (all of which were PATH programs) to strengthen their data collection and reporting effort and improve collaboration with the Social Security Administration and Disability Determination Services (DDS). In addition, she has been working to expand SOAR to numerous other areas of the state where PATH services are not offered, and has been collaborating with several local Continua of Care to provide technical assistance on developing a SOAR initiative.

In Virginia SOAR efforts continue to be an active aspect of service delivery for both PATH and other community-based providers that serve adults experiencing homelessness. Although not universally applied across the state, in several communities SOAR activities are planned and integrated through the local Continuum of Care (CoC) bodies, in collaboration with the SCC as well as in partnership with SSA and DDS. For communities that seek to engage in SOAR efforts separately from the local CoC body, the SCC serves as lead facilitator and coordinator of these activities to ensure SOAR efforts remain vibrant. To help expand SOAR efforts to new communities, the SCC will often provide a visual presentation to providers outlining the benefits of using the SOAR model. Expansion of SOAR efforts is an ongoing activity and new SOAR communities are currently being developed. Overall our state SOAR efforts have been fruitful as Virginia continues to hold a 70% cumulative approval rate for initial SOAR applications in 2015. In addition, Virginia was recognized as a "SOAR Superstar State" for reducing the time to decision by an average of 39 days, meaning individuals' disability applications were approved on average within 102 days. The Commonwealth was also recognized for maintaining a consistent capacity of over 100 SOAR applications for the past three years.

16. Coordinated Entry

In this section, SAMHSA has requested a description of "the state's coordinated entry system and the role of key partners." In Virginia, coordinated entry of homeless individuals and families into Virginia's homeless service systems is managed at the local level by each individual Continuum of Care. The Commonwealth has no statewide coordinated entry system. Information on individual PATH sites' participation in their local Continuum of Care coordinated entry can be found in their respective Local Intended Use Plans as Item #3.

17. State Efforts to Assist Justice-Involved Persons

While the Commonwealth of Virginia does not have criminal justice initiatives to benefit PATH-eligible individuals specifically, in recent years, the state has supported a variety of behavioral health and criminal justice reform efforts designed to decrease the rate of incarceration among individuals with serious mental illness (SMI). Because homeless individuals often interface with the criminal justice system, these initiatives do end up benefitting some PATH consumers. Examples of such initiatives include Crisis Intervention Teams (CIT), jail diversion, and re-entry services for persons being released from the custody of the Virginia Department of Corrections.

Virginia's jail diversion and CIT efforts began in 2007 and 2008 with the creation of the Commonwealth Consortium for Mental Health/Criminal Justice Transformation. Jail diversion efforts implemented over the last eight years have used the "Sequential Intercept Model," a conceptual framework for communities to develop targeted strategies for justice-involved individuals with SMI. The model envisions the criminal justice system as a series of points of "interception" at which an intervention can be made to prevent individuals with SMI from entering or penetrating deeper into the criminal justice system. The interception points are (1) law enforcement and emergency services; (2) initial detention and initial hearings; (3) jail, courts, forensic evaluations, and forensic commitments; (4) reentry from jails, state prisons, and forensic hospitalization; and (5) community corrections and community support. Using the model, a community can develop targeted strategies at each intercept point that evolve over time to increase diversion of people with mental illness from the criminal justice system and to link them with community treatment. DBHDS provides funding to a number of CSBs, some of which have PATH programs, to support the development of local diversion initiatives, and each CSB PATH provider has provided information in its Local Intended Use Plan which addresses local efforts to assist PATH consumers with criminal justice involvement.

Virginia's criminal justice and behavioral health transformation efforts were expanded in March 2015 when Governor Terence McAuliffe signed Executive Order 4 establishing the Center for Behavioral Health and Justice, an interagency collaborative that is working to better coordinate behavioral health and justice services. The mission of the Center is to achieve greater behavioral health and justice coordination across public and private sectors through a collaborative, multi-systems approach to data collection and analytics; evidence based programs and practices; education, outreach and training; and technical assistance and resource development. Jail diversion, CIT and re-entry services will continue to be part of this effort.

In addition to state efforts, each Virginia PATH program provides assistance to individuals with criminal justice involvement. Information on these efforts can be found in the each site's Local Intended Use Plan as Item #11.

Section C: Local Provider Intended Use Plans

The following is a copy of the outline for Virginia's PATH Local Intended Use Plans (LIUP). Each provider's individual LIUP and budget are included on the pages that follow.

Virginia PATH Local Intended Use Plan, FFY 2016/SFY 2017
PATH Program Year 2016-2017

1. Description of Provider Organization:
a. Name:
b. Organization Type:
c. Description of Services Provided:
d. Region Served:
e. Provider's experience in providing services to homeless/at-risk individuals and those with SMI and/or co-occurring SUDs:
f. Description of housing or services that are specifically targeted to PATH-eligible consumers:
2. Program Budget and Federal Funds Requested: (Attach detailed budget using Excel file provided by DBHDS):
a. Amount of federal PATH funds requested:
b. Source and amount of Provider's minimum required 33% match funds:
c. A brief narrative describing the items in the attached budget:
3. Collaboration with Local HUD Continuum of Care (CoC): Describe the organization's participation in the HUD Continuum of Care program, other local planning activities and program coordination initiatives, such as coordinated entry and coordinated assessment activities. If you are not currently working with the CoC, briefly explain the approaches to be taken by the agency to collaborate with the local CoC.
4. Collaboration with Local Community Organizations: Provide a brief description of partnerships and activities with local community organizations that provide key services (i.e., outreach teams, primary health, mental health, substance abuse, housing,

employment, etc.) to PATH eligible clients, and describe coordination of activities and policies with those organizations. Provide specific information about how coordination with other outreach teams is achieved.
5. Service Provision: Describe the plan to provide coordinated and comprehensive services to eligible PATH consumers. Please address the following information.
a. Projected number of adult consumers to be contacted with PATH funds:
b. Projected number of adult consumers to be enrolled using PATH funds:
c. Percentage of adult consumers projected to be "Literally Homeless", and activities to maximize the use of PATH funds to serve adults who are literally homeless as a priority population:
d. Strategies that will be used to target PATH funds for street outreach and case management as priority services.
e. Indicate whether your organization provides, pays for, or otherwise supports evidence-based practices and other training for local PATH-funded staff, including training and activities to support migration of PATH data into HMIS.
f. Describe gaps in the current service system and how PATH will assist consumers in addressing those gaps.
g. Describe services available for consumers who have both serious mental illness and substance use disorder.
h. Describe strategies for making suitable housing available to PATH consumers (e.g., indicate the type of housing usually provide and the name of the agency that provides such housing).
i. If you plan to implement one or more Virginia PATH Innovative Practices, indicate which one(s) and describe the implementation plan:
j. Briefly describe your plan for providing the following PATH-allowable services:

Outreach:
Screening and Diagnostic Treatment:
Habilitation and Rehabilitation:
Community Mental Health Services:
Alcohol or Drug Treatment Services:
Staff Training:
Case Management:

Supportive and Supervisory Services in Residential Settings:
Minor Renovation:
Planning of Housing:
Technical Assistance in Applying for Housing:
Improving the Coordination of Housing Services:
Security Deposits:
Costs Associated with Matching Eligible Homeless Individuals with Appropriate Housing Situations:
One-time Rental Payments to Prevent Eviction:
Referrals for Primary Health Services, Job Training, Education Services and Relevant Housing Services:

6. HMIS Data Integration: Describe your HMIS transition plan, with accompanying timeline, to begin using HMIS to collect and report PATH data in HMIS by July 1, 2016. If you are fully utilizing HMIS for PATH services, please describe plans for continued training and how you will support new staff. Indicate any technical assistance needs you may have in meeting the HMIS data requirements.
7. SSI/SSDI Outreach, Access, Recovery (SOAR): Describe your plan to train PATH staff on SOAR. Indicate the number of PATH staff trained in SOAR and the number of PATH-enrolled consumers assisted through SOAR during State Fiscal Year 2013, and the approximate number of staff to be trained in SOAR for State Fiscal Year 2015.
8. Program demographics and cultural competency: Describe the following.
a. The demographics of the target population.
b. The demographics of the staff serving PATH consumers.
c. How staff providing services to the target population will be sensitive to age, gender and racial/ethnic differences of consumers.
d. The extent to which PATH staff receive training in cultural competence.

e. The extent to which the organization adheres to the Culturally and Linguistically Competent (CLAS) Standards. The CLAS standards can be accessed at http://www.ThinkCulturalHealth.hhs.gov.

9. Consumer and Family Involvement: Describe how individuals who are homeless and have serious mental illnesses, and family members will be involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards. (See attached Appendix I – Guidelines for Consumer and Family Participation.)

10. Outreach to Homeless Veterans: Describe how your PATH program identifies and outreaches to homeless veterans with SMI, and the services available to them in your catchment area. How does PATH interface with your veterans' service continuum?

11. Describe your PATH program's efforts to minimize the challenges and foster support for PATH clients with a criminal history, such as collaboration with local jail diversion and/or other programs. If you can, estimate the percent of PATH clients with a criminal history.

PATH Site Name					
Budget FFY 2016/SFY 2017 (2016-2017 PATH Year)					
Staff Title	***Annualized*** Salary	FTE	PATH Funded	Match	Match Source (Cash or In-kind)
Example Outreach Staff	*$39,266*	*0.75*	*$14,725*	*$14,724*	*Cash*
Total Staff Salary					
Fringe					
Total Personnel					

** Always list positions separately & separate salary from benefits ("fringe")*

Travel (Outreach travel, travel for training, state meetings, etc.)			
Use of Agency Vehicle			
Training Travel			
Training Conference Costs			
Total Travel Costs			

Equipment (Personal property/equipment having useful life of more than one year)			
Laptop (new)			
Cell Phone (replacement)			
Total Equipment Costs			

Supplies (Office Supplies, Outreach Supplies, Computer Software)			
Office Supplies			
Outreach Supplies			
Supplies			
Total Supplies Costs			

Contractual			
Cell phone service fee			
Total Contractual Costs			

Other (List and Describe Each)			
Medication Assistance			
Identification related purchase costs (incl. Birth certificates)			
Rental Assistance			
Bus Tokens			
Staff Training (non-travel registration and costs)			
Administrative Costs			
Total Other Costs			
Total Proposed Budget			Is match > or = to 1/3 of federal allocation?

VIRGINIA PATH PROGRAM

Local Provider Intended Use Plans

Virginia PATH Local Intended Use Plan, FFY 2016/SFY 2017
PATH Program Year 2016-2017

1. Description of Provider Organization:
a. Name: Alexandria Department of Community and Human Services
b. Organization Type: Community Mental Health Center
c. Description of Services Provided: Alexandria Department of Community and Human Services referred to as (DCHS) throughout the remainder of the application provides services to the residents of the City of Alexandria. DCHS provides services to those experiencing homelessness, mental illness, substance abuse and/or intellectual disabilities. In addition, DCHS assists individuals and families in accessing needed entitlements to increase overall self-sufficiency and independence. DCHS also collaborates with other community partners and supports to provide consumers with assistance in gaining shelter, permanent housing, meals, medical needs and other services as deemed appropriate.
d. Region Served: Alexandria, Virginia
e. Provider's experience in providing services to homeless/at-risk individuals and those with SMI and/or co-occurring disorders. The current Homeless Outreach/PATH Coordinator position referred to as (HOPC) throughout the remainder of the application has worked for DCHS providing case management to individual's with serious mental illness, co-occurring substance misuse disorders, and experiencing homelessness since 2002. Prior to working for DCHS he worked at a local homeless shelter for over three years. HOPC is a subject matter expert on homelessness with lived experience and having served on the Commonwealth of Virginia's Policy Academy Team in 2003 and was part of the Governors Policy Council until 2007. In 2004, he was a presenter at the Virginia PATH Training Conference where he provided a presentation titled, "MH/SA Hard to Reach. HOPC also was a presenter at the 2007 state housing conference where he presented, "CSB's & Supportive Housing". HOPC was a technical reviewer of the SAMSHA manual, "Supporting Outreach: A Manual for PATH Program Administrators & Outreach Supervisors", and in 2012 HOPC participated in developing the technical review questions for the national PATH survey. HOPC is a member of the Homelessness Resource Center Advisory Board (SAMHSA), was a board member of The National Coalition for the Homeless from 2003-2007 and has been a member of the National Coalition's Faces of Homelessness Speakers Bureau since 2003, where he speaks to thousands of people each year on issues of homelessness and poverty. HOPC has held the position of PATH Outreach Coordinator since 2014.
f. Description of housing or services that are specifically targeted to PATH-eligible consumers: DCHS offers various housing programs and services of which PATH clients are eligible. DCHS currently offers assistance with emergency shelter for immediate assistance with getting off of the street in two shelters within the City of Alexandria. Those two facilities have a total of 124 emergency shelter beds (76 of which are for single adults). In addition, DCHS operates a Safe Haven housing program with 12 beds. DCHS also has access to a total of 97 transitional housing bed units (35 of which are for single adults), along with 57 supervised apartment units. . The DCSH supervised apartment program is currently being transitioned to a permanent supported

housing model. All shelter and housing programs provide case management services and seek to be recovery-oriented and client centered.

2. Program Budget and Federal Funds Requested: (Attach detailed budget using Excel file provided by DBHDS):

a. Amount of federal PATH funds requested: $106,183

b. Source and amount of Provider's minimum require
d 33% match funds: $43,772 is the total of match funding that will be provided from the City of Alexandria general funds

c. A brief narrative describing the items in the attached budget:
The majority of the budget is used for personnel salary's with the remainder being spent on administrative costs, client food, client transportation, clothing and lodging.

3. Collaboration with Local HUD Continuum of Care (CoC): Describe the organization's participation in the HUD Continuum of Care program, other local planning activities and program coordination initiatives, such as coordinated entry and coordinated assessment activities. If you are not currently working with the CoC, briefly explain the approaches to be taken by the agency to collaborate with the local CoC. Describe your organization's participation in the local CoC and any other local planning, coordinating or assessment activities. If the PATH program does not collaborate directly with the CoC, please describe other staff or programs within the organization that do. Also, describe your CoC's efforts at implementing the Coordinated Assessment process as described by HUD.
The City of Alexandria DCHS is an integral member the CoC, known locally as the Partnership to Prevent and End Homelessness or simply the Partnership. The Partnership seeks to manage the on-going community-wide planning and coordinating efforts to identify and address the needs of those persons experiencing homelessness within The City of Alexandria. The Partnership also identifies current gaps in services for PATH-eligible and homeless clients, housing needs and other resources to reduce the amount of homelessness within the city. In addition, The Partnership collaborates to identify additional housing resources needed within the city for PATH-eligible clients.
The HOPC serves as a member of the Partnership's Housing Permanency and Planning Committee, Shelter Appeal Committee, Winter Shelter Committee, veterans Committee and Housing Crisis Response Workgroup. In this capacity, the HOPC provides advocacy for those with serious mental illness and co-occurring substance misuse at risk of becoming homeless and/or those who are homeless and seeking to regain housing and/or housing resources. The HOPC also serves as a member of the Residential Treatment Team and advocates for PATH clients to have priority placement in DCHS operated housing programs. The HOPC coordinates with the Partnership and is the lead in the unsheltered portion of the annual HUD Point-in-Time count. The current HOPC has been involved in the COC since 2000.

The Director of Community Support Services (PATH program manager) is a member of the Partnership's governing board as well as an active member on several subcommittees.

The Comprehensive Recovery Team Leader (direct supervisor of the PATH position) regularly consults with members of the Partnership and participates in the Partnership's PIT subcommittee.

The Partnership fully implemented the HUD Coordinated Assessment in September 2012 by creating the Homeless Services Assessment Center (centralized intake for persons seeking emergency shelter). The HOPC was actively involved in planning of the center and continues to have input in center's operation. HOPC has been trained to use shelter assessment in the field when necessary.
The Homeless Services Assessment Center has an active diversion component and seeks to divert persons from entering emergency shelter when possible.

4. Collaboration with Local Community Organizations: Provide a brief description of partnerships and activities with local community organizations that provide key services (i.e., outreach teams, primary health, mental health, substance abuse, housing, employment, etc.) to PATH eligible clients, and describe coordination of activities and policies with those organizations. Provide specific information about how coordination with other outreach teams is achieved.

DCHS provides comprehensive fully integrated outpatient mental health and substance abuse treatment. In addition to outpatient treatment DCHS has a substance misuse detoxification program, a 30 day substance misuse residential program, a psychosocial rehabilitation program, as well as an array of housing programs for individuals with serious mental illness and occurring substance misuse disorders. PATH clients are a priority population for these programs.
SHELTERS/DROP-IN CENTER: DCHS currently collaborates with Carpenter's Shelter and Alexandria Community Shelter to provide emergency shelter for street homeless individuals. The HOPC works collaboratively with the staff from both shelters, attends shelter meetings, engages/outreaches clients at both shelters in an effort to get them appropriately linked with services to address their overall needs. The HOPC works closely with staff at both shelters in an effort to identify PATH-eligible clients and to provide needed referral linkages. The HOPC also conducts regular outreach efforts at David's Place drop-in center in an effort to engage homeless PATH-eligible individuals. The HOPC maintains regular contact with staff and meets with clients who are referred and/or identified by staff. David's Place provides PATH-eligible and non-PATH eligible homeless individuals with a place to shower, complete laundry and receive mail.
MEAL PROGRAMS: The HOPC works closely with staff at local faith-based food programs to engage individuals that are PATH-eligible. The HOPC makes frequent visits; in the form of outreach to the various meal programs during lunch and dinner hours. The HOPC also follows-up with staff at the various programs when there are presented concerns about PATH-eligible clients. The HOPC also provides educational support to staff in the various meal programs with regard to the role of the HOPC and outreach/engagement efforts. In addition, the HOPC also provides community partners at the various sites with information about community services. Meal programs are currently operated by local churches, Salvation Army, Christ House, Old Presbyterian Meeting House, Downtown Baptist Church and other concerned community members.
PUBLIC LIBRARIES: The HOPC works closely with staff at local libraries at identifying and engaging PATH eligible person and engaging them in PATH services, providing education and referral to other services. The HOPC has partnered with one library to start a pilot where the HOPC is scheduled to provide regular hours for engagement and consultation for two hours once a week. HOPC also participated in homelessness training for library staff and provides updates

to staff on Winter Shelter opening and closing.
EMERGENCY ASSISTANCE: There are several organizations such as: Christ House, Christ Church, Old Presbyterian Meeting House, ALIVE House and other faith-based and community organizations within the City of Alexandria that assist with emergency needs such as clothing, food baskets and emergency financial assistance for both PATH-eligible and non-PATH-eligible individuals. In addition, consumers are able to access various components of DCHS for emergency assistance as well (both PATH-eligible and non-PATH-eligible) consumers.

MEDICAL: PATH-eligible individuals are also able to access primary medical care via Neighborhood Health, Inc. (formerly ANHSI) and/or the City of Alexandria Department of Public Health. The HOPC assist PATH-eligible consumers in making the needed linkages for their service needs. DCHS a grant recipient of A New Lease on Life (ANLOL) funds has partnered with Neighborhood Health (formerly ANHSI) to provide integrated primary medical and behavioral health care on site at the mental health center. The ANLOL grant expires in October 2016, however DCHS intends on continuing this service with local support.
COLLABORATION W/PARTNERS: The HOPC collaborates with City of Alexandria Police Department to conduct outreach efforts at local camp sites and to engage consumers in the community. In addition, the HOPC has established a relationship with Veterans Administration (VA) Hospital through the Community Resource and Referral Center (CRRC). HOPC has become adept at navigating services at the VA National Medical Center and Community VA Service Center. The HOPC also maintains relationships with local business owners within the City to address issues related to street homeless individuals and getting them linked with appropriate services. The HOPC also partners with the City of Alexandria Police Department to facilitate a quarterly presentation on PATH and homeless services during the Crisis Intervention Team (CIT) training for police officers, sheriff deputies and other first responders. This presentation is offered to provide them with additional education on the homeless population within the City; as well as the services that PATH offers.
EMPLOYMENT: PATH-eligible clients and non-PATH-eligible individuals are able to receive assistance with employment search, resume writing and other needed assistance to increase employability via the DCHS Work Force Development Program and also via the employment specialist staff at the local community shelters. The HOPC collaborates with these programs and refers individuals as appropriate to obtain assistance from their programs.

5. Service Provision: Describe the plan to provide coordinated and comprehensive services to eligible PATH consumers. Please address the following information.

a. Projected number of adult consumers to be contacted with PATH funds: Projected number of adult consumers to be contacted with PATH funds: The Alexandria Department of Community and Human Services PATH program projects contacting 100 consumers during the FY2017 year using PATH funds.

b. Projected number of adult consumers to be enrolled using PATH funds: Projected number of adult consumers to be enrolled using PATH funds: The Alexandria Department of Community and Human services projects the enrollment of 50 consumers during the FY2017 using PATH funds.

c. Percentage of adult consumers projected to be “Literally Homeless”, and activities to maximize the use of PATH funds to serve adults who are literally homeless as a priority population: The Alexandria Department of Community and Human services projects that 40 of the 50 consumers will be “Literally Homeless” in the FY2017 using PATH funds.

d. Strategies that will be used to target PATH funds for street outreach and case management as priority services. . The HOPC will engage in street outreach, targeted location outreach, follow-up on community requests for outreach, conducting assessments for enrollment into the PATH program and providing needed case management services until the individuals are successfully linked to DCHS services and/or other appropriate long term services to address their needs.

e. Indicate whether your organization provides, pays for, or otherwise supports evidence-based practices and other training for local PATH-funded staff, including training and activities to support migration of PATH data into HMIS.

MEDICATION MANAGEMENT: The DCHS Mental Health Clinic provides psychiatrists who are skilled in working with individuals who have a mental illness and/or a co-occurring substance abuse diagnoses. Consumers are able to receive psychiatric services which include psychiatric and diagnostic assessments and regular follow-up appointments for medication monitoring. Nursing staff are available to provide education to clients and their families, and to monitor and administer medications as directed. Support staff provides assistance to clients requiring additional assistance with prescription coverage.

PEER SUPPORT: The West End Wellness Center (WEWC), a DCHS-funded psychosocial program for individuals who have a mental illness and/or a co-occurring substance abuse diagnosis, provide Peer Support which includes individualized coaching activities, therapeutic support and group interactions.

SUPPORTED-EMPLOYMENT: The WEWC also has a Vocational Unit which provides Supported Employment opportunities to individuals with mental illness and/or co-occurring substance abuse diagnoses. Vocational staff members assist clients with skills assessments, opportunity review, resume development, applications, interview skills and professional comportment. They collaborate with supervisors on their job site and provide continued supports to clients after they are hired in an effort to ensure success in the workplace.

FAMILY PSYCHO-EDUCATION: The DCHS Mental Health Center provides a scheduled group, co-facilitated by the supervisor of the Comprehensive Recovery Team (intensive case management) and a Peer Support Specialist. This group provides both education and support to the loved ones and families of individuals with mental illness and/or a co-occurring substance abuse diagnosis.

CULTURAL COMPETENCE and SENSITIVITY: Every staff member and clinician at DCHS, including the HOPC, is required to attend an annual training in Cultural Competence. DCHS provides services to a multi-linguistic population and retains the services of multi-linguistic staff. Multi-lingual staff members are available for evaluation and assessment services, case management, therapy and residential services. Staff may also utilize the City of Alexandria's Language Line, a telephonic language interpretation service. Printed products are provided in multiple languages made to be consistent with the population served by DCHS.

MOTIVATIONAL-INTERVIEWING: DCHS supports the utilization of Motivational Interviewing techniques. DCHS provides Motivational Treatment groups and the HOPC has been trained in this technique and utilizes it regularly when engaging consumers.

STAGES OF CHANGE: DCHS clinicians, including the HOPC, take the stages of change into consideration continuously throughout the engagement and treatment process. In an effort to provide client centered service delivery when engaging individuals. The HOPC uses the stages of change/stages of treatment when assessing individuals and utilizes this knowledge in clinical discussion, while developing and implementing and individualized service plan, and while making recommendations and referrals to community resources of the client's preference.

HMIS: The HOPC is currently collaborating with the HMIS Administrator within the City to begin migrating data from the existing system into HMIS.

f. Describe gaps in the current service system and how PATH will assist consumers in addressing those gaps. The 2015 Point in Time count (PIT) identified 124 beds in the City of Alexandria Emergency Shelter programs. The count also identified 159 single homeless individuals, 23 of which were unsheltered adults. Significant difficulties arise in sheltering the homeless, many of which are due to the wide variety of unique and urgent needs experienced by this population. This problem is exacerbated by the difficulties often experienced by shelter staff when attempting to manage individuals who do not take medication as prescribed for psychiatric and/or medical conditions or those individuals who exhibit bizarre or odd behaviors. An emergency shelter is needed that would specialize in providing shelter to those individuals that, by virtue of their illness (such as schizophrenia with paranoid features) cannot or will not utilize the existing shelter systems. previously-existing barriers in access to emergency shelter for PATH clients however, ongoing training is needed for shelter staff to be prepared and skilled to work with PATH clients. DCHS currently offers Mental Health First Aid (MHFA) training to non-licensed staff that currently work with consumers with severe mental illness. This training is offered to provide additional education on the signs and symptoms of mental illness. In addition, attendees of the training are provided with strategies to engage effectively with this population. In addition, the HOPC attends meetings with shelter staff either weekly and/or bi-weekly. During those meetings; the HOPC also offers education around mental illness, how to effectively engage consumers and warning signs that may require further clinical intervention. The HOPC is also available to shelter staff to consult regarding various PATH-eligible clients that may be in the shelter(s) and also meets with consumers as needed to assist shelter staff. The HOPC currently serves on the Centralized Intake Committee; and is able to advocate for needed policy changes and re-evaluation of practices that may impact PATH-eligible clients with shelter admittance.

Overall, there is a lack of affordable housing in the City of Alexandria for PATH and non-PATH consumers. The PATH client is in competition with the general population for safe and affordable housing. However, the PATH client is at a great disadvantage, falling into the extremely low or low-income level. The waiting lists for subsidized housing opportunities often average three to six years or more in length. The HOPC currently collaborates with the housing locator staff at both shelters in an effort to locate private landlords that are more willing to accept PATH-eligible clients that may have difficulty obtaining housing in the traditional housing market. In addition, the HOPC also serves as a member of the Housing Permanency Committee which offers homeless prevention assistance and also access to rapid re-housing funds where applicable. Lastly, as a member of The Partnership the HOPC also has a voice to advocate for more affordable housing options that would be of benefit to PATH-eligible and non-PATH eligible homeless persons within the City of Alexandria.

A lack of opportunities for health and dental care is a problem encountered by PATH consumers, who frequently lack entitlements such as Medicaid, Medicare or other medical insurance that accompanies Supplemental Security Income, Social Security Disability Insurance or full-time employment. There are few providers in the city who are able to accommodate PATH consumers. Due to the severity of their illness; many PATH-eligible clients lack insight into their need for medical care as well. Casey Clinic provides medical care to low-income Alexandria

residents but the client must present with a chronic ailment, such as diabetes, severe and persistent hypertension, or HIV/AIDS in order to qualify for services. Neighborhood Health, Inc., provides low-cost, basic medical services to PATH and non-PATH residents of Alexandria. The HOPC works with administrative staff to refer PATH clients for services and to coordinate appointments as well as follow-up care. DCHS and Neighborhood Health, Inc. have a partnership to provide integrated primary medical and behavioral health care to consumers regardless of their income and/or insurance status.
The Alexandria Health Department Dental Clinic assists low-income Alexandria residents by providing extraction services. The Northern Virginia Dental Clinic, Donated Dental Services Project and the Virginia Dental Association work in conjunction to provide a variety of dental services to both PATH and non-PATH consumers. The waiting period for an appointment is an average of seven months by which time the consumer has often opted for or required an extraction or has become consumed with other acute needs. There is a definitive need in the city for an improvement in the variety and timeliness of provision of dental services to low-income Alexandria residents. The HOPC is able to access PATH funds to provide for immediate dental needs such as extractions during the waiting period. However, one barrier that remains is the lack of mobile dental and/or medical care for PATH-eligible consumers. This would be increase the likelihood of follow-up on medical care; as consumers often don't keep their scheduled appointments.

A major barrier the homeless population encounters is obtaining a valid identification card. The Virginia DMV requires two identification documents; one "proof of legal presence," meaning the person has a legal right to be in the United States and one "proof of Virginia residency," such as a utility bill. Possession of a valid identification is essential for PATH and non-PATH consumers in order to apply for benefits, many housing programs, employment and often in order to gain access to mainstream services.

Having access to services is a priority for the Seriously Mentally Ill (SMI), chronically homeless population. Previously, clients who agreed to engage in traditional mainstream mental health services may wait weeks for a mental health intake appointment. An increase in collaborative efforts among staff members has resulted in a significant decrease in wait time. Clients can be accommodated with an intake appointment in a matter of days and/or they can come in for a "first come/first served" appointment by arriving within the 8am hour. The "first come/first served" slot is available Monday-Friday. In the interim, the HOPC continues to provide any necessary services, referrals or therapeutic assistance that is required. However, appointments can be difficult to schedule, especially for chronically homeless, SMI individuals who may also have a co-occurring substance abuse diagnosis and are sometimes ineffective at managing their time and appointments as well as medications. To that end, the HOPC has the capacity to assist with "mobile intake" appointments at the shelter sites for those PATH-eligible consumers who are unable to tolerate a traditional office appointment. However, one barrier that remains is the ability to provide mobile psychiatry appointments in the community at sites such as: the shelter and/or drop-in centers. This would be beneficial to reduce the number of missed and/or forgotten appointments by consumers.

There are significant benefits to be had with continued efforts in collaboration. The HOPC will continue to attend committee meetings and trainings, build effective and positive relationships

with community service providers and provide strong, consistent, client-centered advocacy for PATH consumers to appropriate committees and groups in an effort to continue progressive movement toward providing much-needed services.

g. Describe services available for consumers who have both serious mental illness and substance use disorder. DCHS is committed to providing comprehensive services to individuals with a co-occurring mental health and substance abuse problem(s). Services are integrated and follow best practice guidelines. The HOPC staff has been cross-trained and is knowledgeable on diagnoses, treatment and services in the areas of both mental illness and substance abuse. In addition, the HOPC conducts assessments for both disorders and makes the appropriate recommendations. Assessments include mental status, risk to self and others, urine screens for drugs and an overall behavioral assessment based upon contact with the individual as well as any information that might be acquired through collateral sources. The HOPC works closely with clinicians at both the Mental Health Center and Substance Abuse Services locations to provide a multi-disciplinary team approach to address the varying needs of consumers with a mental illness and co-occurring substance abuse disorder. The City of Alexandria Detox program provides short-term detoxification and also a 30 day residential treatment program. The HOPC partners with detox staff to provide community outreach and education. In addition, substance abuse outpatient (SAOP) provides drop in groups, individual therapy and also the Matrix program.

h. Describe strategies for making suitable housing available to PATH consumers (e.g., indicate the type of housing usually provide and the name of the agency that provides such housing). The HOPC works closely with PATH-eligible clients to assist with applying for appropriate housing options such as group homes, supervised apartments and independent living units operated by DCHS. In addition, the HOPC works closely with staff at both shelters to make referrals to programs such as: Christ House Transitional Housing, Community Lodgings, Pathway Homes Permanent Supported Housing, New Hope Housing Permanent Supportive Housing. In addition, the HOPC advocates for PATH-eligible clients that may be eligible for homeless prevention resources and/or resources to assist in getting them re-housed after losing housing. The HOPC also assists consumers in making needed linkages to housing resources available through The Alexandria Redevelopment and Housing Authority (ARHA) to obtain subsidized housing. In addition, the HOPC works collaboratively with housing locator staff at both local shelters to find non-traditional housing resources from private landlords for those PATH-eligible clients with housing barriers such as: criminal background records, eviction history and/or limited funds. However, the most frequent barrier continues to be limited and/or no funds. The HOPC also serves as an advocate on the Residential Treatment Team to advocate for PATH-eligible clients for DCHS operated housing programs. PATH-eligible clients are given priority for DCHS operated housing programs; secondary to their housing and other barriers. In addition, the HOPC works closely with staff in the Office of Community Services to access additional resources for PATH-eligible and non-PATH-eligible homeless clients.

i. If you plan to implement one or more Virginia PATH Innovative Practices, indicate which one(s) and describe the implementation plan:

None

j. Briefly describe your plan for providing the following PATH-allowable services:

Outreach:
The HOPC conducts regular street outreach and targeted outreach in the community in an effort to engage PATH-eligible homeless individuals. The HOPC makes regular visits to local meal sites, shelters, the drop-in center, libraries, parks, camp sites and other areas in the city in which the homeless population frequents. The HOPC uses motivational interviewing in an effort to engage and develop a rapport with PATH-eligible and other homeless individuals. The HOPC also responds to various requests by community partners and members with concerns related to homeless persons seen in the community. The HOPC provides educational support to the individuals encountered during outreach in an effort to educate them on available services and to build a rapport to assist with their needs.

Screening and Diagnostic Treatment:
The HOPC completes needed screenings and gathers needed psychosocial and social history on all PATH-eligible clients. In addition, the HOPC completes diagnostic assessments on clients as needed in an effort to facilitate appropriate linkage to services. The information gathered is used to develop a service plan and identify immediate and short-term needs and goals. The HOPC uses a client centered, trauma informed and recovery-oriented approach when engaging all PATH-eligible clients.
Habilitation and Rehabilitation: Upon successful engagement the HOPC and client work together to examine available services and opportunities within the community. After identifying the client's preferences, the HOPC assists the client with linkage to the identified services. These efforts may include referrals to the West End Wellness Center (WEWC), a DCHS psychosocial rehabilitation program and or/supported employment opportunities. Referrals may also be made to the Department of Aging and Rehabilitative Services (DARS), which has staff with regularly scheduled hours at the DCHS mental health center. Psychosocial rehabilitation and supported employment services are not PATH funded. The concept of recovery has become an integral component of community-based services for PATH and non-PATH consumers alike. Wellness Recovery Action Plan (WRAP) has been initiated with targeted PATH consumers.

Habilitation and Rehabilitation: N/A

Community Mental Health Services:
PATH-funded services include crisis intervention, assistance with acquiring emergency financial resources for medication and referrals for appropriate medical care. The HOPC works closely with other DCHS staff, Emergency Services, Police and other community partners to complete initial screenings for possible psychiatric hospital admissions, crisis stabilization programs, psychiatric evaluations and/or medication evaluations. These services are funded through the DCHS. Community Mental Health services are also afforded to PATH consumers who have not fully engaged in traditional mental health services. The HOPC maintains a consistent outreach effort that includes meeting consumers where they live and spending time in the community, while at the same time providing what could be considered to be traditional mental health services such as crisis intervention, mental status evaluations and counseling.
Alcohol or Drug Treatment Services: The HOPC completes diagnostic assessments to determine alcohol or substance use, abuse or dependence. The HOPC utilizes motivational interviewing techniques, knowledge of stages of change and co-occurring disorders best

practices to engage PATH consumers in treatment. Based upon the assessment, the HOPC will work with the client to identify the client's preferences, develop recommendations and provide referrals for substance abuse treatment services.
Alcohol or Drug Treatment Services: In addition to outpatient treatment DCHS has a substance misuse detoxification program, a 30 day substance misuse residential program, a psychosocial rehabilitation program, as well as an array of housing programs for individuals with serious mental illness and occurring substance misuse disorders. PATH clients are a priority population for these programs.
Staff Training: Training is provided to local emergency shelter staff members, DCHS case managers, Emergency Services staff, volunteers at local faith-based outreach programs and other individuals who have frequent interaction with PATH consumers. A general training on homelessness was provided to the city's Library staff. Consultations and in-service trainings are also provided to local law enforcement agencies. The focus of training is to provide general education and to address issues specifically related to providing quality services to homeless individuals with a mental illness and/or substance use disorder. The HOPC strives to assist providers and the community in achieving and more comprehensive understanding of both the challenges faces by the homeless population and the services that are available within the community. During weekly and/or bi-weekly shelter meetings; the HOPC provides needed education related to psychiatric issues and strategies to work more effectively with identified PATH-eligible clients.
Case Management: The HOPC provides all PATH consumers with case management services until each client is linked with the ongoing traditional or mainstream services. In accordance with a recovery-oriented approach, needs are identified and goals are developed collaboratively with the client and carefully consider their needs and preferences. PATH-funded case management services include ongoing assessment of individual needs and preferences; referrals and other assistance with linking individuals to agency and community-based services; assisting in applying for SSI/SSDI, Medicaid, SNAP and other entitlements; ongoing monitoring of service provision and the efficacy of such services. Case management services are funded and provided by the DCHS through a variety of programs. Supportive and Supervisory Services in Residential Settings: The HOPC routinely refers PATH clients to DCHS Mental Health and/or Substance Abuse residential programs. DCHS-funded residential services not only provide a safe living situation but also offer the necessary individualized support and structure within the home to ensure a successful placement and lessen homelessness recidivism. New residents receive intensive screening and support during the admission process. Clients and staff collaborate to determine placement which will most effectively meet the consumer's needs and preferences. Residential staff members orient the new resident to the home, review expectations, revise the ISP and assist the client with learning and practicing independent living skills.
Supportive and Supervisory Services in Residential Settings: DCHS has both full and part-time direct service and supervisory staff in its residential programs. HOPC is available to residential staff to consult on any challenges related to maintaining housing. HOPC is also available to assist staff at other housing programs within the CoC.
Minor Renovation: N/A

Planning of Housing: The HOPC is an active member of the Residential Treatment Team; which is comprised of DCHS staff. To that end, this staff plays and instrumental role in identifying PATH-eligible clients that are appropriate for DCHS operated housing programs. In addition, the HOPC serves as an advocate to expedite the placement of PATH-eligible clients in DCHS operated housing programs where most appropriate.

The HOPC also works with staff at both shelters and attends their meetings either weekly and/or bi-weekly to identify PATH-eligible clients that may be able to apply for community residential programs and/or be eligible for housing in the community. The HOPC also serves as an active member of the Housing Permanency Committee. In this capacity, the HOPC serves as a clinical advocate for those who are PATH-eligible and non-PATH-eligible to gain needed housing funding assistance for a short term period.

The HOPC is a member of The Partnership; the CoC within the City of Alexandria that comes together to discuss needed resources for the PATH-eligible and non-PATH-eligible homeless population. The HOPC also serves on the Washington Area Council of Governments (COG) with other jurisdictions within the region to address issues related to homelessness, housing and other needed resources.
Technical Assistance in Applying for Housing:
The HOPC makes direct referrals to local housing providers, including DCHS-sponsored facilities, and assists PATH-eligible consumers with the completion of applications. In addition, the HOPC follows up with clients throughout the process. The HOPC contacts local housing authorities on behalf of PATH consumers to inquire about status on waiting lists. The HOPC also assesses the likelihood of obtaining or retaining Section 8 vouchers (or other subsidized housing) for consumers with problematic housing history. The HOPC also serves as an advocate in matters where the PATH-eligible client may have barriers and/or need additional advocacy.
Improving the Coordination of Housing Services:
The HOPC serves on various committees and workgroups within the city to advocate for PATH-eligible clients housing needs. The HOPC also assists shelter case management staff with referrals for PATH-eligible clients to various housing programs and also offers assistance with follow-up. The participation of the HOPC on the various committees and workgroups allows for additional advocacy for PATH-eligible clients in regard to their housing needs. In addition, the HOPC maintains working relationships with housing locators, staff at ARHA and other housing resources in an effort to facilitate housing options for PATH-eligible clients.
Security Deposits: PATH consumers can receive full or partial security deposits to secure rental housing if the individual does not have the assets to cover the initial cost of moving into a unit. In addition, the HOPC can access additional resources with DCHS as needed to support PATH-eligible clients with security deposit needs.

Costs Associated with Matching Eligible Homeless Individuals with Appropriate Housing Situations:
DCHS may pay for a PATH consumer's housing application fee.
One-time Rental Payments to Prevent Eviction:
PATH funds are available for a one-time rental payment to prevent eviction for the SMI

individual who is at-risk for homelessness.
Technical Assistance in Applying for Housing: The HOPC makes direct referrals to local housing providers, including DCHS-sponsored facilities, and assists PATH-eligible consumers with the completion of applications. In addition, the HOPC follows up with clients throughout the process. The HOPC contacts local housing authorities on behalf of PATH consumers to inquire about status on waiting lists. The HOPC also assesses the likelihood of obtaining or retaining Section 8 vouchers (or other subsidized housing) for consumers with problematic housing history. The HOPC also serves as an advocate in matters where the PATH-eligible client may have barriers and/or need additional advocacy. Improving the Coordination of Housing Services: The HOPC serves on various committees and workgroups within the city to advocate for PATH-eligible clients housing needs. The HOPC also assists shelter case management staff with referrals for PATH-eligible clients to various housing programs and also offers assistance with follow-up. The participation of the HOPC on the various committees and workgroups allows for additional advocacy for PATH-eligible clients in regard to their housing needs. In addition, the HOPC maintains working relationships with housing locators, staff at ARHA and other housing resources in an effort to facilitate housing options for PATH-eligible clients. Security Deposits: PATH consumers can receive full or partial security deposits to secure rental housing if the individual does not have the assets to cover the initial cost of moving into a unit. In addition, the HOPC can access additional resources with DCHS as needed to support PATH-eligible clients with security deposit needs.
Improving the Coordination of Housing Services: HOPC is an active member of the CoC and works with various committees to identify and implement best practices for the coordination of housing services.
Security Deposits: Both PATH eligible and Non PATH eligible persons can receive assistance with security deposits thru DCHS/OCS TAP program. PATH fund may also be used for PATH eligible persons.
Costs Associated with Matching Eligible Homeless Individuals with Appropriate Housing Situations: Eligible homeless individuals may be referred to the HSAC diversion worker who seeks to place persons seeking shelter in appropriate housing when available. HOPC also makes referrals to DCHS housing programs as indicated. There is no additional cost associated with these services.
One-time Rental Payments to Prevent Eviction: PATH funds may be used to prevent eviction. DCHS has funds available thru OCS to assist persons facing eviction.
Referrals for Primary Health Services, Job Training, Education Services and Relevant Housing Services: Primary Health Services: The HOPC assist with referral of PATH clients to primary healthcare providers. Consumers with adequate healthcare insurance are referred to private physicians as appropriate, while consumers with no insurance and/or little income are referred to Casey Clinic or Neighborhood Health Services. The DCHS Mental Health Center hosts Alexandria Neighborhood Health Services, Inc. (ANHSI), a community healthcare organization, which has office hours located in the center specifically to assist consumers with no insurance and/or little income who have general medical needs. All consumers are encouraged to have

regular HIV and TB testing and are encouraged to take precautions against seasonal viruses. Job Training and Education Services are available for all PATH and non-PATH consumers through DCHS's Job-Link program.

6. HMIS Data Integration: Describe your HMIS transition plan, with accompanying timeline, to begin using HMIS to collect and report PATH data in HMIS by July 1, 2016. If you are fully utilizing HMIS for PATH services, please describe plans for continued training and how you will support new staff. Indicate any technical assistance needs you may have in meeting the HMIS data requirements. The City of Alexandria Office of Community Services employs a full time HMIS Administrator. HOPC is working with the HMIS Administrator to become fully trained and to develop a workflow to integrate PATH data into the HMIS system. Technical assistance may be required to transition information from the DCHS EHR to HMIS. Additional assistance may be needed to address and resolve issues pertaining to confidentiality of EHR information that will be available in HMIS. HOPC could benefit from having improved mobile technology in order to access HMIS/Service Point Entry and custom PATH reports, if applicable (outside of generics provided in Service Point). Additional training and data entry support may be required outside of that provided by the City's HMIS Administrator.

7. SSI/SSDI Outreach, Access, and Recovery (SOAR): Describe your plan to train PATH staff on SOAR. Indicate the number of PATH staff trained in SOAR and the number of PATH-enrolled consumers assisted through SOAR during State Fiscal Year 2013, and the approximate number of staff to be trained in SOAR for State Fiscal Year 2015.
HOPC was SOAR trained in 2015 along with one DCHS case manager, two human services workers and four shelter caseworkers.

8. Program demographics and cultural competency: Describe the following.

a. The demographics of the target population.
The data from the 2016 Point-In-Time (PIT) Count conducted on January 28, 2016 yielded the following percentages in terms of the homeless population within the City of Alexandria on that evening:

Persons Experiencing Homelessness
257 people total "literally homeless"
23 unsheltered homeless adults

Single Adults
73% of the homeless population in the City of Alexandria was male
27% of the homeless population in the City of Alexandria was female

Subpopulations (Adults Only)
31% of the population were chronically homeless single adults
<1% of the population were chronically homeless families
5% of the population were veterans
22% of the population were chronic substance abusers
20% of the population suffered from severe mental illness
11% of the population were dually diagnosed (both mental health and substance abuse)
5% of the population had a physical disability
16% of the population suffered from a chronic health condition
3% of the population reported having a diagnosis of HIV/AIDS

b. The demographics of the staff serving PATH consumers.
The HOPC is a black male.
The Comprehensive Recovery Team Supervisor (the immediate supervisor of the HOPC) is a white male.
The Director of Community Support Services (second level supervisor of the HOPC) is a white female.

c. How staff providing services to the target population will be sensitive to age, gender and racial/ethnic differences of consumers.
The City of Alexandria has a culturally diverse population. Accordingly, the homeless population is equally diverse. The HOPC utilizes existing staff and community resources to accommodate the various languages spoken by PATH consumers. Multi-lingual staff members are available for evaluation and assessment services, case management, therapy and residential services. Staff may also utilize the City of Alexandria's Language Line, a telephonic language interpretation service. Printed products are provided in multiple languages made to be consistent with the population served by DCHS. There is funding available for hiring in person interpreters when indicated and time allows.

d. The extent to which PATH staff receive training in cultural competence.
Every staff member and clinician at DCHS, including the HOPC is required to attend an annual training in Cultural Competence. In addition, HOPC has completed a 3cr college course on Cross Cultural Psychology

e. The extent to which the organization adheres to the Culturally and Linguistically Competent (CLAS) Standards. The CLAS standards can be accessed at http://www.ThinkCulturalHealth.hhs.gov.
CULTURALLY COMPETENT CARE :DCHS employs staff of culturally diverse backgrounds as well as staff that are bi-lingual. This practice is done in an effort to accommodate the diversity of the City of Alexandria residents. The agency makes it a practice to recruit, employ and retain staff of diverse ethnicities and cultures; as well as staff that are able to speak multiple and various languages to accommodate the diverse client population. DCHS staff are required to attend cultural diversity training annually. Staff at all levels of the organization ranging from maintenance staff through the medical director are bi-lingual; which seeks to ensure that consumers have a sense of cultural comfort/understanding while at the clinic.
LANGUAGE ACCESS SERVICES: DCHS currently employs staff members that speak several languages ranging from maintenance staff, front desk staff, clinicians, medical director and other support staff throughout the organization. In addition, DCHS makes it a practice to offer signage, client rights handbooks and other written literature in several languages. DCHS also has access to the use of the language line to assist with providing assistance in the service deliver process; as well as the use of interpreters. All of the; aforementioned are used to create a culturally diverse and user friendly environment for the diverse client population served.
ORGANIZATIONAL SUPPORTS: DCHS has regular and ongoing in-service training on cultural diversity. In addition, the organization ensures that its written materials are offered in English and other languages as appropriate. The agency has a Training Coordinator that evaluates the ongoing needs within the agency related to cultural diversity and sensitivity. In addition, the organization has partnerships with community stakeholders of diverse cultural and ethnic backgrounds in an effort to provide best practice to its consumers.

9. Consumer and Family Involvement: Describe how individuals who are homeless and have serious mental illnesses, and family members will be involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards. (See attached Appendix I – Guidelines for Consumer and Family Participation.) DCHS consumers who have previously or are currently experiencing homelessness are consistently encouraged to participate at every level within the department. Family members and significant others of the consumers are also encouraged to be a part of the recovery process, which includes the opportunity to participate in department activities. Although many families are not able to provide housing to the PATH consumer, emotional support and understanding during the recovery process are equally important. The DCHS actively encourages family support in trainings, planning meetings, supportive counseling services and groups, family education groups, therapy for individuals, couples and families, and treatment team meetings to discuss individualized treatment plans (ISPs).

PROGRAM MISSION: The mission of the DCHS is Promoting Respect, Recovery, Hope. In the daily practice of service delivery; consumers are treated with respect, service is recovery-oriented and clinicians seek to instill hope in the consumers.

PROGRAM PLANNING: The Alexandria Community Services Board which has both consumers and community members as a part of the total membership. This affords the perspective of consumers and their needs and is also inclusive of the community as services/plans are developed.

TRAINING & STAFFING: Former DCHS and/or PATH clients have been hired for positions in the Safe Haven program, as Peer Support Specialists and a Clinical Recovery Coach. Past and present PATH consumers also hold positions on a variety of recovery-based committees within the DCHS.

In addition, DCHS offers regular training and staff development opportunities with regard to recovery, client-centered services and family involvement within the treatment and service delivery process.

INFORMED CONSENT: DCHS provides all consumers with client rights and consumer handbook upon entry into services. The aforementioned documents explain service expectations and risks. In addition, clinicians maintain regular dialogue with consumers about their rights in regard to treatment as well as their right to refuse treatment.

RIGHTS PROTECTION: DCHS provides ongoing education to consumers with regard to their rights pertaining to services. In addition, the agency has a compliance officer that is also available to meet with consumers if needed concerning their rights. In addition, the addition practices HIPPA when discussing and/or exchanging any information pertaining to consumers as well as regarding documentation of clinical information.

PROGRAM ADMINISTRATION: DCHS provides opportunities within the organization for consumers and family members to serve as volunteers on the Community Service Board and other workgroups within the City of Alexandria related to services and client needs.

10. Outreach to Homeless Veterans: Describe how your PATH program identifies and outreaches to homeless veterans with SMI, and the services available to them in your catchment area. How does PATH interface with your veterans' service continuum?

HOPC works closely with the shelters drop in center, meal programs, detox and DCHS mental health centralized intake at identifying homeless Veterans. The HOPC developed connections with the VA's Homeless Outreach Social Worker and collaborated to link veterans to health care, food and personal identification. HOPC has developed relationships with members of the VA's PACT Team and is familiar in navigating the VA hospital system in support of meeting the needs of Veterans with SMI.
DCHS Center for Economic Support's Office of Community Services took the lead in coordinating
the efforts to end veteran homelessness. It is a city-wide collaboration between local homeless service providers, veteran service providers, the Office of Veteran Affairs and DCHS's PATH program.
The group also included members familiar with veterans and their experiences, including a retired Air Force colonel and an administrative assistant in the Community Services Program whose husband is active duty Army. The City of Alexandria was able to attain "Functional Zero" status in December 2015

11. Describe your PATH program's efforts to minimize the challenges and foster support for PATH clients with a criminal history, such as collaboration with local jail diversion and/or other programs. If you can, estimate the percent of PATH clients with a criminal history. HOPC works closely with DCHS's Jail Diversion/CORE program and the Alexandria jail forensic discharge planner to ease the transition and coordinate services for PATH clients who are involved with the criminal justice system and are returning to the community. Approximately 40% of PATH clients have had some involvement with the criminal justice system. The HOPC is a member of the CoC Housing Crisis Response subcommittee where he advocates for PATH clients and returning citizens from incarceration.

PATH Site Name: Alexandria Department of Community and Human Services					
Proposed Budget FFY 2017 PATH Year					
Staff Title	***Annualized*** Salary	FTE	PATH Funded	Match	Match Source (Cash or In-kind)
Therapist (PATH Homeless Services Coordinator	$72,001	1.00	48,241	23,760	Cash
Mental Health Team Supervisor	$86,048	0.15	8,648	4,259	Cash
Director of Community Support Services	$127,351	0.05	4,266	2,101	Cash
Total Staff Salary	**$285,400**	**1.2**	**61,155**	**30,121**	
Therapist (PATH Homeless Services Coordinator)	30,240	1	20,261	9,979	Cash
Mental Health Team Supervisor	36,140	0.15	3,632	1,789	Cash
Director of Community Support Services	53,487	0.05	1,792	883	Cash
Total Fringe	**119,867**	**1.2**	**25,685**	**12,651**	
Total Personnel Expenditure			**86,839**	**42,772**	
Travel (Outreach travel, travel for training, state meetings, etc.)					
Use of Agency Vehicle				500	Cash
Training Travel			1,000		
Training Conference Costs			1,500		
Total Travel Costs			**2,500**	500	
Equipment (Personal property/equipment having useful life of more than one year)					
Total Equipment Costs			0	0	
Supplies (Office Supplies, Outreach Supplies, Computer Software)					
Office Supplies			200		
Outreach Supplies			1,000		
Supplies			0		
Total Supplies Costs			1,200	0	
Contractual					
Cell phone service fee			660		
Laptop wireless card			720		
Total Contractual Costs			1,380	0	
Other (List and Describe Each)					
Client Lodging			1,000		
Identification related purchase costs (incl. Birth certificates)			100		
Client Food			0	500	Cash
Public Transportation Fare			1,500		
Staff Training (non-travel registration and costs)			500		
Administrative Costs, City grant regulations require the application for reimbursement of indirect cost; Departmental administrative services			10,586		
Client clothing			578		
Total Other Costs			14,264	500	
Total Proposed Budget			**106,183**	**43,772**	Is match > or = to 1/3 of federal allocation?

Virginia PATH Local Intended Use Plan, FFY 2016/SFY 2017
PATH Program Year 2016-2017

1. Description of Provider Organization:

a. Name: Arlington County Department of Human Services, Behavioral Healthcare Division, Client Service Entry, Treatment on Wheels Program

b. Organization Type: Community Mental Health Center

c. Description of Services Provided:

CSB services are provided through the Department of Human Services. Services are provided to children, adolescents, and adults suffering from intellectual disabilities, substance abuse and mental illness. Services include assessment and evaluation, case management, therapy and counseling, residential services, employment services, day support, emergency services, psychiatric services, juvenile detention and adult jail based services.

d. Region Served: Arlington County, Virginia

e. Provider's experience in providing services to homeless/at-risk individuals and those with SMI and/or co-occurring SUDs:

Arlington Behavioral Healthcare has been providing mental health and substance abuse services to Arlington's homeless SMI consumers for over twenty years. The TOW/PATH program, which exclusively serves homeless SMI consumers and those with co-occurring disorders, has been in operation for ten years. The TOW services provided to the homeless persons of Arlington County are not provided by any other entity. The program truly fills a gap. The mental health and substance abuse assessments and treatment provided by the program supports the homeless persons and the staff of the referring agencies. Since the services are provided at the homeless person's location, barriers of transportation and scheduling are eliminated or minimal. Individual, family, child, and group counseling services are provided. Evening and weekend appointments have also been provided. Linkage with mainstream mental health and substance abuse treatment are facilitated with relative ease since TOW is a county program. Psychiatric time and medication funding is available. The psychiatrist meets with the TOW staff on a weekly basis. Skills and experience represented by the TOW staff include: work with homeless persons and victims of domestic violence; crisis services; case management, including but not limited to advocacy and collaboration; assessment treatment of adults, adolescents, and children in individual, group, and family counseling.

f. Description of housing or services that are specifically targeted to PATH-eligible consumers:

The Treatment on Wheels/Projects for Assistance in the Transition from Homelessness (TOW/PATH) is a program specifically designed to meet the needs of the county's homeless SMI and those with co-occurring disorders. Services provided include outreach, case management, psychiatric services, linking to medical care through the agency's partnership with the Arlandria Neighborhood Health Services Initiatives, and assistance in obtaining housing. The full time PATH worker and those that provide services under the TOW/PATH program, access

housing options through the county's "Permanent Supportive Housing Program" and related housing grants. All TOW/PATH consumers are also eligible for consideration for placement in any three of Arlington's mental health residential group homes and the ICRT (Intensive Community Residential Treatment) group home. Referrals are made when appropriate, to the Arlington Street People's Network (ASPAN), Permanent Supportive Housing program (HPRP); to the Emergency Winter Shelter and Sullivan House (AACH) from November 1st through March 31st and there is a TOW/PATH worker on site two evenings per week to better facilitate the provision of mental health services and identify housing needs. The primary shelter in Arlington is the Residential Program Center (RPC) for adults. There is a designated TOW/PATH worker who serves as liaison to this facility and participates in their staffing regularly, as well as providing case management services to the consumers who are identified as SMI.

2. Program Budget and Federal Funds Requested: (Attach detailed budget using Excel file provided by DBHDS):

a. Amount of federal PATH funds requested: $64,875

b. Source and amount of Provider's minimum required 33% match funds: $19,463

c. A brief narrative describing the items in the attached budget: PATH Funds used to partially fund the duties of a Mental Health Worker on the Homeless Case Management Team.

3. Collaboration with Local HUD Continuum of Care (CoC): Describe the organization's participation in the HUD Continuum of Care program, other local planning activities and program coordination initiatives, such as coordinated entry and coordinated assessment activities. If you are not currently working with the CoC, briefly explain the approaches to be taken by the agency to collaborate with the local CoC.

The TOW/PATH team is a team that is looking to streamline the process for consumers to quickly access services with the County, various community partners and nonprofit organizations. These focus groups meet regularly and will incorporate the HMIS system to provide no wrong door for homeless individuals, and homeless families to obtain assistance. The TOW/PATH team is also onsite at local two local shelters in Arlington for a total of 30+ hours a week to provide services to the homeless population and also provide training to staff at these facilities. The team is actively connected with the Permanent Supportive Housing Program and related housing grants. Consumers are also eligible for consideration for placement in any three of Arlington's mental health residential group homes and the ICRT (Intensive Community Residential Treatment) group home. The TOW/PATH team also has an intake line to better assist with receiving referrals for homeless individuals in the community. The TOW/PATH program has also been involved in yearly Arlington Zero campaigns and meetings to unite forces with other county organizations and work towards accomplishing zero homelessness in the county.

4. Collaboration with Local Community Organizations: Provide a brief description of partnerships and activities with local community organizations that provide key services (i.e., outreach teams, primary health, mental health, substance abuse, housing, employment, etc.) to PATH eligible clients, and describe coordination of activities and policies with those organizations. Provide specific information about how coordination with other outreach teams is achieved.

The Treatment on Wheels/Projects for Assistance in the Transition from Homelessness (TOW/PATH) is a program specifically designed to meet the needs of the county's homeless SMI and those with co-occurring disorders. Services provided include outreach, case management, psychiatric services, linkage to outpatient long term care, linkage to medication and programs which will pay for consumer's medication; linkage to medical and dental care through the agency's partnership with the Arlandria Neighborhood Health Services Initiatives (ANHSI); and assistance in obtaining housing through CCU, ASPAN, RPC, RPC Detox, AACH and Doorways. The TOW/PATH program also helps clients link to substance abuse treatment, including detox facilities, outpatient services and long-term rehabilitation facilities. Other services provided include linking clients to GAP insurance, Social Security Administration services, Department of Motor Vehicle services, nursing facilities; assisted living facilities and Veterans Affairs facilities and services; employment training/vocational trainings/educational services.

5. Service Provision: Describe the plan to provide coordinated and comprehensive services to eligible PATH consumers. Please address the following information.

a. Projected number of adult consumers to be contacted with PATH funds: 917

b. Projected number of adult consumers to be enrolled using PATH funds: 180

c. Percentage of adult consumers projected to be "Literally Homeless", and activities to maximize the use of PATH funds to serve adults who are literally homeless as a priority population:

The percentage of adult consumers projected to be literally homeless is 40%. The TOW/PATH worker is "literally" out on the streets making contact with the priority population. This worker joins community partners to do outreach where the homeless congregate; meal stations, libraries, malls, parks etc., on a daily basis. The PATH program has now been in place for 10 years and is well known by the homeless population in the community. We are finding that more and more of the homeless population are referred by word of mouth.

d. Strategies that will be used to target PATH funds for street outreach and case management as priority services.

Street outreach and case management services for the targeted population served by PATH has always been seen as a priority service in the organization. The full time PATH positions charge the individuals with implementing comprehensive strategies for outreach services and partnering with other community agencies serving the homeless. This is done to ensure maximum opportunities to engage with and serve the seriously mentally ill and those with co-occurring disorders. The agency CFO diligently manages PATH fund distributions and ensures that all

PATH funds are allocated only to PATH development. In the TOW/PATH program all of the clinicians do street outreach when the opportunity presents itself, not just the PATH worker exclusively.

e. Indicate whether your organization provides, pays for, or otherwise supports evidence-based practices and other training for local PATH-funded staff, including training and activities to support migration of PATH data into HMIS.

Arlington County continues to be a strong proponent of evidenced based practices and any and all training opportunities that will enhance service provision to SMI and substance abusing consumers. As part of that endeavor, all of the TOW/PATH workers have been trained in the SOAR (SSI/SSDI Outreach, Access and Recovery) applications for Social Security benefits, Motivational Interviewing, ICD-10, substance abuse/dependence, ethics and risk assessments. Most recently three of the TOW/PATH staff have been successfully trained and certified to be Pre-Screeners. The Pre-Screen certification allows staff to better assist those in crisis within the community. Two of the TOW/PATH staff members have also become Restoration to Competency certified. This certification allows for staff to build relationships within the SMI homeless who are found in jail and could potentially be diverted from jail. The PATH position is a targeted bi-lingual position to better advocate for consumers in the service delivery system. Two of the current PATH worker has been certified as an Interpreters.

f. Describe gaps in the current service system and how PATH will assist consumers in addressing those gaps.

Housing:

There continues to be a need for a low barrier shelter available 12 months a year, which should be addressed in the late spring, early summer with the opening of the new year round shelter. Arlington currently has such a program that operates 5 months a year (The Emergency Winter Shelter). All clinicians in the TOW/PATH program are participating in the 100 Homes initiative where agencies serving the homeless go out in the streets and identify Arlington's most vulnerable homeless consumers for rapid housing opportunities. Several of the TOW/PATH consumers were identified in this survey and are either now housed or very near to being housed. There continues to be a need for a personal living quarters facility in this county, where residents would sign short term leases for very small units that charge a very low rent; as well as medical respite beds for people who are homeless and are experiencing a sub-acute medical episode (post-surgery, flu, hospice care). The members of the team, of which PATH is a part, are vocal advocates for these services and serve on several committees that are working toward this goal.

Transportation:

Transportation for consumers continue to be a challenge. Public transportation has become very expensive and although most consumers are knowledgeable about and willing to use the system, it has become too expensive for them to pay for. The agency is able to provide bus tokens,

Smartrip cards and/or rides in the county vehicle, to only the most important appointments for housing, financial, medical and mental health issues. We try to provide as much assistance with transportation as possible but limited staff resources make this challenging.

Medical Attention:

We are very fortunate to have developed the partnership with ANHSI (Arlington Neighborhood Health Services Initiative) and to have an office on site at the mental health center. Many of the TOW/PATH consumers are able to take advantage of this dependable, convenient health care service on a regular basis. However, we still have too many homeless consumers who regularly show up at the emergency room for sub-acute conditions as there is nowhere else for them to go. Although some of our consumers have access to our local free medical clinic, consumers need more access to primary medical services than the clinic can offer. Whenever possible we collaborate with the ER staff to advocate for consumer care and follow-up.

Brief Counseling:

Many of those who are homeless especially those who are homeless for the first time, do not meet the criteria for serious mental or substance use disorders, yet they are under significant stress and often meet the criteria for an acute stress disorder. These issues do not rise to the level needing Emergency Services intervention. Having short term solution-focused therapy available would benefit these individuals, as well as psycho-educational groups. Currently the PATH clinician and teammates provide this service while on site at various locations around the county. However, time is limited and even brief therapy takes time. In a four hour shift at a particular site a clinician can only effectively provide short-term solution-focused therapy to 3-4 consumers. Efforts are made when appropriate, to refer and connect these individuals with local agencies who offer mental health services on a sliding fee scale; but again, our consumers have limited funding and the local agencies have long waiting lists.

Psycho-Education and Medication Training:

PATH consumers would benefit from education about their disorders, the medications they are taking and strategies for managing the symptoms. Though this information is presented individually to consumers the repeated presentation in a small group setting at shelters and drop-in centers would be beneficial.

g. Describe services available for consumers who have both serious mental illness and substance use disorder.

The Arlington County Behavioral Healthcare Division participates actively in the state-wide initiative, to adopt a “dual-diagnosis” perspective. Staff assumes that a dual-diagnosis is the rule rather than the exception when assessing consumers. In addition to training all staff in the fundamentals of this perspective, one BHD out-patient team is dedicated to serving the consumers who are actively using substances and currently experiencing the symptoms of their mental illnesses. PATH consumers can be directly referred to this specific team.

h. Describe strategies for making suitable housing available to PATH consumers (e.g., indicate the type of housing usually provide and the name of the agency that provides such housing).

Our consumers are eligible for any and all housing opportunities available in the community without discrimination. The TOW/PATH workers make the referrals, provide transportation for consumers to view the programs or interview for admission or leasing, negotiate with landlords for leniency in terms of credit history blemishes and criminal record forgiveness. The housing programs through Arlington County and partnering agencies are listed in 1f.

i. If you plan to implement one or more Virginia PATH Innovative Practices, indicate which one(s) and describe the implementation plan:

Our goal is to establish community relations with the Fire Department and also build alliances with Airport Security. The PATH worker is charged with conducting a weekly walk through at the airport to connect with and engage the homeless population. We would also like to have an expert in forensics to have a new focus on justice involved homeless.

j. Briefly describe your plan for providing the following PATH-allowable services:

Outreach:

All members of the TOW/PATH team will respond to citizen concerns, police requests, other consumer reports and any other source of information about homeless people by going to the location of the report and seeking out the person described. Team members will also provide "in-reach" services at local shelters and the Clinical Coordination Unit on a daily basis. In addition the "Path Outreach Worker" will establish weekly presence at encampments, meal distribution centers, transportation centers, food court of local malls, day labor sites and A-SPAN (Arlington Street People's Assistance Network) Opportunity Place walk-in services for the homeless.

Screening and Diagnostic Treatment:

All Arlington County TOW/PATH team members are Bachelors or Masters prepared Counselors and Social Workers. All have received formal training in screening and diagnosis. The team leader is licensed as a Licensed Professional Counselor (LPC) by the Commonwealth of Virginia and can verify diagnosis. A board-certified Psychiatrist is also available to provide psychiatric assessments when necessary.

Habilitation and Rehabilitation:

The members of our TOW/PATH team all provide mental health counseling and psycho-education to our consumers. Our entire CSB has adopted a Recovery-Oriented vision that encourages the consumer to articulate his or her personal goals, and to achieve the quality of

life that maximizes the consumer's use of natural support systems in pursuit of those goals. Furthermore, TOW/PATH clinicians can refer directly to the Arlington Employment Center, Department of Rehabilitative Services, Job Avenue (a BHD Vocational Program) and the Clarendon Clubhouse.

Community Mental Health Services:

In Arlington, the TOW/PATH team is a part of the Forensic Jail Diversion Team, within Client Services Entry, a Bureau within the Behavioral Healthcare Division. Our team provides the entire range of mental health and substance abuse services literally "where consumers are" rather than only at the main offices. The full range of services includes a variety of case management services and two psychiatrist has been assigned directly to the team who sees all willing consumers enrolled in the TOW/PATH program. As a subunit of BHD, we can make lateral transfers to outpatient teams when appropriate for the consumer in need of a higher level of care and long-term therapy.

Alcohol or Drug Treatment Services:

TOW/PATH clinicians conduct preliminary assessments which include questions relevant to the client's mental health and substance abuse history. During individual sessions, consumers address and explore substance use as it relates to their mental health symptoms. Referrals are made for substance abuse services as needed.

Staff Training:

TOW/PATH clinicians are able to share their knowledge and expertise with other agencies within the county continuum of care. Members of this team provide training to staff of the Emergency Winter Shelter when it opens on November 1. They also provide training to the Clinical Coordination Unit as well as other shelter staff. Local organizations, like the public library, who have frequent interaction with the homeless, often request in-service training on how best to interact in a productive manner. The PATH worker, who is now well known in the community, gets frequent requests to speak and does so with regularity. Training topics include an introduction to mental disorders, how to communicate with a person under the influence of drugs or alcohol, responding to aggressive behavior, multicultural awareness (especially the Hispanic, East African and Southeast Asian communities) and effective communication strategies with persons who do not speak English. Also, during CIT Training we educate law enforcement on how to recognize the symptoms of mental illness when responding to calls involving consumers.

Case Management:

The TOW/PATH program is a part of the Arlington CSB and all clinicians are required to maintain a complete medical record for the consumer including individualized service plans that are co-written with the consumers, reviewed quarterly and rewritten annually. When

writing a service plan clinicians address all domains of the consumer's life and with the consumer, determine how to attain the quality of life the consumer desires. Overarching goals and short term objectives are written and regularly re-evaluated. Examples of case management activities that the TOW/PATH clinicians frequently engage in: negotiations with potential landlords to waive application fees, to give the benefit of the doubt to dubious renters or to reduce the amount of a security deposit; assistance with securing credit reports, developing strategies for cleaning up those reports and purchasing money orders to pay the bills; advocating with physicians to prescribe effective medications available in the $4 programs of the local stores and then teaching consumers how to travel to these stores and purchase their medications. This list is by no means exhaustive.

Supportive and Supervisory Services in Residential Settings:

TOW/PATH clinicians remain a part of the consumer's service team throughout the process of finding, securing and moving into appropriate housing. Once permanent housing has been identified, our team begins the process of termination. We have the ability to remain a part of the service team for 4 months after the consumer moves into housing, in order to transition the client to his or her outpatient team and support staff at a comfortable pace for the consumer.

Minor Renovation: We do not provide this service as all housing within our service area is privately owned and operated.

Planning of Housing:

The manager of the TOW/PATH team participates on the Ten Year Planning Committee and regularly meets with DHS personnel who are responsible for planning housing on both the macro and micro scale here in Arlington. The manager advocates for an increase in units for all types of housing along the continuum from more beds in group homes, to more Housing First model housing units, to more funding of Permanent Supportive Housing apartments and wider criteria for housing grants. The manager is also part of several committees exploring the gaps in housing.

Technical Assistance in Applying for Housing:

The first point in our team's mission is to improve the housing situation for our consumers. We assist with completion of applications, arrangements for application fees, security deposits, first month's rent, etc. We accompany clients on appointments with leasing managers and we can also transport consumers to possible housing opportunities, housing meetings, and other housing related case management needs.

Improving the Coordination of Housing Services:

The team manager participates on the Ten Year Plan Task Force in which issues such as these are directly addressed.

Security Deposits:

We do not pay security deposits. We advocate with several non-profit agencies and churches in the area that are able to provide the funds to the consumers.

Costs Associated with Matching Eligible Homeless Individuals with Appropriate Housing Situations:

This team does not provide direct financial remuneration for housing costs. We advocate with agencies whose mission is to provide these services. We also, in emergency or in times of crisis, temporarily house vulnerable consumers at contracted hotels for temporary shelter. This is due barriers and temporary delays of shelter placements.

One-time Rental Payments to Prevent Eviction:

This team does not provide direct financial remuneration to prevent eviction. We advocate with other agencies to secure these benefits.

Referrals for Primary Health Services, Job Training, Education Services and Relevant Housing Services:

Members of the team refer consumers to this agency's Job Avenue for assistance with employment readiness and placement and Adult Education for ongoing educational pursuits. Consumers are referred to the onsite AHNSI medical services and the local emergency room if necessary. Consumers are also referred to all appropriate housing services.

6. HMIS Data Integration: Describe your HMIS transition plan, with accompanying timeline, to begin using HMIS to collect and report PATH data in HMIS by July 1, 2016. If you are fully utilizing HMIS for PATH services, please describe plans for continued training and how you will support new staff. Indicate any technical assistance needs you may have in meeting the HMIS data requirements.

The local HMIS system in Arlington is ETO. All TOW/PATH clinicians are currently trained to enter data into the system. Demographic data is entered on all consumers who have signed releases and referrals and reports are generated through this system. As of June 2016, the TOW/PATH program and providers have fully migrated to utilizing HMIS/ETO as one of the tracking services for client demographic collection and data gathering. All information asked in PATH application on a quarterly basis, and yearly basis, is found on HMIS/ETO system. At this time ongoing trainings and refreshers courses are periodically required by staff to develop expertise with the system and to ensure complete and accurate data entry/collection.

7. SSI/SSDI Outreach, Access, Recovery (SOAR): Describe your plan to train PATH staff on SOAR. Indicate the number of PATH staff trained in SOAR and the number of PATH-enrolled consumers assisted through SOAR during State Fiscal Year 2016, and the approximate number of staff to be trained in SOAR for State Fiscal Year 2017.

All TOW/PATH workers were certified in SOAR as of February 2015. The goal is to continue to assist consumers with Social Security applications as needed by consumers.

8. Program demographics and cultural competency: Describe the following.

a. The demographics of the target population.

The target population of the TOW/PATH program is adults, 18 and over, who are homeless in Arlington Virginia with serious mental illness. Of the unduplicated consumers served in the first two quarters of FY16; 17% were between the ages of 18-30, 41% were between the ages of 31-50, 36% were between the ages of 51-61 and 6% were 65 or over.

59% were male, 33% were female, and 1% were transgender and 7% were unknown. 44% were African American, 36% were Caucasian, 1% were Asian, 7% were Hispanic and 3% were Multi or Other races and 9% were Unknown.

b. The demographics of the staff serving PATH consumers.

The TOW/PATH team is comprised of 75% Masters prepared Social Workers or Counselors. 25% are licensed and 50% are preparing for licensure. 75% are female and 25% are male. 25% are African American, 50% are Latino or Hispanic, and 25% are Caucasian.

c. How staff providing services to the target population will be sensitive to age, gender and racial/ethnic differences of consumers.

The person currently filling our designated PATH Outreach Worker position is bi-lingual, English-Spanish. All staff members receive regular training in cultural issues. Our county is highly committed to diversity of all kinds and demonstrates and investment in staff receiving the proper training to carry out culturally competent services, regardless of job function.

d. The extent to which PATH staff receive training in cultural competence.

(See attached Appendix 1 – Guidelines for Accessing Cultural Competence.) Arlington County, Virginia which is located just outside of the District of Columbia, is a very diverse community and prides itself on a very inclusive and welcoming culture. This diversity is reflected in the whole of the Human Services Division, and equally in the Behavioral Healthcare Division. The agency employs individuals representing many cultures, races, ages and genders. There are also "peer specialists" amongst the staff with an initiative to hire more in the future. There are a

myriad of languages spoken and information to be shared by clinicians in a variety of programs. There are regular training opportunities available on cultural issues, and the climate of the agency is such that clinicians feel free to ask cultural questions of other staff if a question arises. BHD's board of directors is the Community Services Board (CSB) and on that board is a regular consumer representative. Hiring new staff at BHD is a panel decision and programs are encouraged to have a consumer representative on the hiring panel whenever possible. Staff meetings in the TOW/PATH program regularly includes the addressing of cultural issues and informational articles are copied and distributed. The designated PATH worker in the TOW/PATH program is certified by AHEC in "Interpreting in the Community Setting" and all clinicians in the agency are required to take "Working with an Interpreter" training. Also, all clinicians have access to the "Language Line" where interpreters of any language can be utilized. The PATH workers successfully completed a variety of courses within past year. Courses have consisted of Motivational Interviewing, Violence Interventions, Pre-Screening for emergency crisis intervention; Adult Restoration to Competency, Risk Assessment and REACH trainings.

e. The extent to which the organization adheres to the Culturally and Linguistically Competent (CLAS) Standards. The CLAS standards can be accessed at http://www.ThinkCulturalHealth.hhs.gov.

9. Consumer and Family Involvement: Describe how individuals who are homeless and have serious mental illnesses, and family members will be involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards. (See attached Appendix I – Guidelines for Consumer and Family Participation.)

Arlington County Behavioral Healthcare Division subscribes to the Recovery-Oriented Approach to mental health and substance abuse service provision. This approach emphasizes consumer driven definitions of health and quality of life, participation of the consumer in designing the treatment program and providing consumers with choices when providing services. The Arlington Recovery and Empowerment Center (AREC), a consumer-run drop-in center, opened in the Spring of 2009. The consumers who serve on their Board and work at AREC have been a valuable resource around our efforts to support and encourage a recovery focused agency as well as where we need to improve.

There is also a consumer advisory committee for the Division. Currently there is not a member on this committee who is enrolled in PATH though there are people who have lived the experience of street life in their past. We conduct annual consumer satisfaction surveys. We strongly encourage our clients to allow communication between family members and TOW/PATH personnel. When such communication is authorized, we work together to establish a service plan involving the client, case manager and the family in achieving goals and objectives.

10. Outreach to Homeless Veterans: Describe how your PATH program identifies and outreaches to homeless veterans with SMI, and the services available to them in your catchment area. How does PATH interface with your veterans' service continuum?

As of the year 2016, Arlington County has successfully accomplished the goal of housing all veterans with SMI. TOW/PATH continuously work in conjunction with nonprofit agencies to continue to maintain this goal and work towards the housing of all homeless consumers in the county.

11. Describe your PATH program's efforts to minimize the challenges and foster support for PATH clients with a criminal history, such as collaboration with local jail diversion and/or other programs. If you can, estimate the percent of PATH clients with a criminal history.

The TOW/PATH team serving Arlington County consumers currently has three staff members which are Pre-Screen Certified, four staff members have undergone background checks and have been cleared to enter and work with incarcerated consumers within the jail; and two staff members who have been certified to provide adult outpatient restoration services to consumers found in jail settings and awaiting trial. All certifications mentioned above help the TOW/PATH staff with building relationships and connectivity with those jailed, and facilitates the process of helping consumers connect with services upon their release, in an attempt to reduce recidivism. The TOW/PATH program collaborates on a weekly basis with the Forensics program, the public defender's office, magistrates, airport police and county hospitals in order to effectively help link consumers to community resources and programs.

PATH Site Name: Arlington County Department of Human Services, Behavioral Health Division					
Budget FFY 2016/SFY 2017 (2016-2017 PATH Year)			PATH Funded	Match	Match Source (Cash or In-kind)
Staff Title	***Annualized*** Salary	FTE			
Mental Health Worker	$64,875	1.00	$64,875		Cash
Mental HealthTherapist III	$76,336	1.00		$4,251	Cash
Total Staff Salary	$64,875	1.00	$64,875	$4,251	
Fringe	$19,463		$2,481	$16,982	Cash
Total Personnel			**$67,356**	**$21,233**	Cash
Travel (Outreach travel, travel for training, state meetings, etc.)					
Total Travel Costs			**$0**		

Equipment (Personal property/equipment having useful life of more than one year)			
Total Equipment Costs	0	$0	

Supplies (Office Supplies, Outreach Supplies, Computer Software)			
Office Supplies		$341	
Total Supplies Costs		$341	

Contractual			
Cell phone service fee		$654	
Total Contractual Costs		$654	

Other (List and Describe Each)			
Total Other Costs	0	0	
Total Proposed Budget	**67,356**	**$22,228**	Is match > or = to 1/3 of federal allocation? **YES**

Virginia PATH Local Intended Use Plan, FFY 2016/SFY 2017
PATH Program Year 2016-2017

1. Description of Provider Organization:
a. Name: Blue Ridge Behavioral Healthcare (BRBH)
b. Organization Type: Community Mental Health Center
c. Description of Services Provided: Blue Ridge Behavioral Healthcare (BRBH) is a Community Services Board providing publicly funded Mental Health, Intellectual Disability and Substance Use services. Services include Case Management, crisis intervention and stabilization, psychiatric services, supportive residential services, psychosocial rehabilitation, outpatient substance use treatment and in-home and school-based services for children.
d. Region Served: Roanoke City, Roanoke County, City of Salem, Craig County and Botetourt County
e. Provider's experience in providing services to homeless/at-risk individuals and those with SMI and/or co-occurring SUDs: The mission of BRBH is to "provide quality community-based services that prevent and address mental health disorders, intellectual disabilities and substance disorders." BRBH has received the PATH grant for over 15 years. The current outreach worker has been in the position for nine years. She is certified as a Licensed Practical Nurse and came to the position with fourteen years of clinical experience. Her previous jobs included working as an LPN in a state hospital and here at BRBH. She also served as a case manager for nine years for the seriously mentally ill. She is sensitive to the needs of the homeless population and she is skilled in building rapport and engaging them in services.
f. Description of housing or services that are specifically targeted to PATH-eligible consumers: PATH funds are used to pay for security deposits, emergency housing and one time rental assistance for PATH eligible individuals.
2. Program Budget and Federal Funds Requested: (Attach detailed budget using Excel file provided by DBHDS):
a. Amount of federal PATH funds requested: $75,332
b. Source and amount of Provider's minimum required 33% match funds: $24,860 $24,860 in matching funds will be made available from Virginia General Funds available to Blue Ridge Behavioral Healthcare. BRBH hereby provides assurance that the match required for this

PATH project and detailed in the budget attached will be available on July 1, 2016, the start date for this project.

c. A brief narrative describing the items in the attached budget:

Personnel Costs – BRBH PATH employs an Outreach Worker (1.0 FTE). The outreach worker receives a small amount of clerical support from a secretary (0.10 FTE). Supervision of the outreach worker and the PATH funds is provided by the Director of Mental Health Skill-building Services (0.10 FTE). Fringe benefit costs are calculated at 27.05% of salaries.

Vehicle Operating Costs, Personal Mileage – This is for maintenance costs for the vehicle available for PATH Outreach activities, and for personal mileage reimbursements incurred when the agency vehicle is not available.

Training Travel- Travel related costs for attending workshops and conferences.

Supplies- Represents the costs of office supplies, and outreach supplies such as backpacks, blankets, raingear, clothing, and personal hygiene items that will be made available to consumers.

Contractual Costs: Represents the cost of service fees for the PATH Worker's cell phone.

Co-payments for Primary Health Care: A small fund will be made available to pay $20 co-payments for needed medical care for uninsured PATH eligible consumers.

Medication Purchase Assistance – These funds cover financial assistance with the cost of medications for medical and psychiatric conditions when personal and public resources are not available.

Identification related purchase costs – A small fund will be made available to assist clients with the costs of securing acceptable identification, and will include assistance with the costs of securing birth certificates.

Security Deposits – This category is for PATH-enrolled individuals who are in the process of acquiring rental housing but who do not have the assets to pay the first and last month's rent or other security deposits required to move in.

One-time Rental Payments: These funds are for individuals who cannot afford to make payments themselves and are at risk of eviction without assistance.

Costs Associated with Housing: This is expenditures made on behalf of PATH enrolled individuals who are establishing a household. This may include items such as rental application fees, furniture and furnishings, and moving expenses. This may also include paying for credit checks and outstanding consumer debts that otherwise would keep them

from successfully securing available housing.

Bus Passes – The PATH worker will be provided funds for the purchase of bus passes to provide client access to medical appointments, assessments and treatment programs.

Staff Training – Non-travel related costs of registration and participation in training activities.

Office Rent – Occupancy costs associated with the office space available for the PATH worker.

3. Collaboration with Local HUD Continuum of Care (CoC): Describe the organization's participation in the HUD Continuum of Care program, other local planning activities and program coordination initiatives, such as coordinated entry and coordinated assessment activities. If you are not currently working with the CoC, briefly explain the approaches to be taken by the agency to collaborate with the local CoC.

The PATH manager sits on the Blue Ridge Continuum of Care Committee (COC) as well as the Blue Ridge Interagency Council on Homelessness which is the lead entity for the COC. The PATH manager is actively involved in the activities of both committees. All the homeless providers in the area participate in the COC and meet monthly to collaborate and review progress towards the goals set for our community. The COC uses the VI-SPDAT as its coordinated assessment. The Annual Point in Time Count in January 2016 showed a 15.2 % decrease in homelessness. There has been a steady decrease in the numbers of homeless since 2012. This is due to the hard work and dedication of all the members of these two committees.

4. Collaboration with Local Community Organizations: Provide a brief description of partnerships and activities with local community organizations that provide key services (i.e., outreach teams, primary health, mental health, substance abuse, housing, employment, etc.) to PATH eligible clients, and describe coordination of activities and policies with those organizations. Provide specific information about how coordination with other outreach teams is achieved.

Health and Medical Services:

-Rescue Mission Health Center: provides free medical care with medication assistance. They also make referrals for specialized services.
-New Horizons Medical Center: provides medical care on a sliding fee basis to the poor and uninsured.
-Bradley Free Clinic of the Roanoke Valley: provides free medical services to the working poor.
-Carilion Charity Care: provides charity care for significant medical procedures to eligible individuals.

The PATH worker makes referrals, schedules appointments, and provides bus passes for transportation. When needed the worker will also accompany client to appointments and assist with relating symptoms and encouraging follow through of recommendations.

Mental Health Care:

-Blue Ridge Behavioral Healthcare: provides psychiatric services, medication management services, day treatment and case management services to individuals who meet the Seriously Mentally Ill criteria.
-The Rita J. Gliniecki Recovery Center: is a BRBH program that provides short term crisis stabilization services.
-Family Services of the Roanoke Valley: provides counseling on a slide fee scale.
-Mental Health America Consortium: provides psychiatric services, medication assistance, counseling and education to the uninsured through its Roanoke Valley Mental Health Care Collaborative.
-New Horizons Medical Center: provides limited psychiatric and counseling services on a sliding fee scale.
-Carilion Roanoke Memorial: provides short term in-patient psychiatric services.
-HCA Lewis Gale Pavilion: provides short term in-patient psychiatric services.
-Rescue Mission of the Roanoke Valley: provides psychiatric services to homeless individuals.

The PATH worker makes referrals and schedules appointments for all these services. The worker will also cover bus fair or transport individuals to these facilities for assessment and treatment.

Substance Abuse Services:

-Blue Ridge Behavioral Healthcare: provides medically supervised detoxification from alcohol and other drugs at the Rita J. Gliniecki Recovery Center. Outpatient Counseling Services of BRBH provides intensive outpatient services for adults with serious substance use disorders. This includes group therapy which meets multiple times weekly.
-Rescue Mission of the Roanoke Valley: provides residential substance abuse treatment.
-Lewis Gale Pavilion : provides limited residential and out patient substance abuse services.
-VAMC Salem : provides residential and outpatient substance abuse services to area veterans.

The PATH worker makes and takes referrals, collaborates with providers to secure appropriate services. PATH worker will also monitor services once secured and assist with discharge.

Housing Services:

-Rescue Mission of the Roanoke Valley: provides emergency shelter to individuals and families.
-TRUST House Shelter: provides shelter to individuals and families.
-Salvation Army Red Shield Lodge: provides transitional shelter to men for up to 18 months.
-Salvation Army Turning Point: provides emergency shelter and support to women and their children who have experienced domestic violence..

-Roanoke Redevelopment and Housing Authority: provides permanent low income housing based on income.
-Family Promise: provides emergency shelter to families.
-Community Housing and Resource Center: provides financial assistance to those at risk of becoming homeless who have monthly income.
-Shelter Plus Care: is a funding source through the Blue Ridge Continuum of Care that provides subsidized rent for eligible individuals.
-Private Landlord Network: PATH worker has developed a small network of area landlords that are willing to rent to PATH enrolled clients.
-Subsidized Housing/Private Landlords: There are a handful of private landlords that offer housing based on income for clients that meet their eligibility criteria.

The PATH worker receives referrals from these providers and assesses potential clients on site. The worker makes follows eligible clients and collaborates with shelter staff. The worker makes referrals for permanent housing and assists with application and transition to permanent housing.

Employment Services:
-Department of Aging and Rehabilitation Services: provides assistance to eligible individuals with job training and placement.
-Goodwill Industries: provides job training and employment services
-Virginia Workforce Connection: provides education, training and employment services.

The PATH worker makes referrals, assists with application process, and transports clients for screening. Worker will also monitor services once secured and encourage continuation of services.

5. Service Provision: Describe the plan to provide coordinated and comprehensive services to eligible PATH consumers. Please address the following information.

a. Projected number of adult consumers to be contacted with PATH funds: 145

b. Projected number of adult consumers to be enrolled using PATH funds: 100

c. Percentage of adult consumers projected to be "Literally Homeless", and activities to maximize the use of PATH funds to serve adults who are literally homeless as a priority population:

89% of PATH consumers are projected to be literally homeless. The Outreach Worker visits shelters, residential facilities, hospitals, local jails, parks and other areas frequented by homeless individuals. She also and takes referrals from all public or private facilities along with the local Homeless Assistance Team. The worker assists individuals in the search for permanent or transitional housing. PATH funds are used to pay for security deposits, rent or emergency housing. This is instrumental in getting individuals stabilized and off the streets.

d. Strategies that will be used to target PATH funds for street outreach and case management as priority services.

The Outreach Worker builds rapport with individuals by making frequent visits and building

trust. She uses PATH funds to purchase outreach supplies that she offers to homeless individuals. This includes blankets, raingear, personal hygiene products, backpacks, water bottles, sunscreen, household supplies and other needed items for survival. As she builds trust with the individual and she gathers information that is needed to apply for and obtain resources and benefits. She also makes referrals for medical and psychiatric services. She often accompanies the individuals to these appointments to ensure that symptoms are related and medical follow-up is achieved.

e. Indicate whether your organization provides, pays for, or otherwise supports evidence-based practices and other training for local PATH-funded staff, including training and activities to support migration of PATH data into HMIS.

The PATH Outreach Worker has been trained in Motivational Interviewing, Applied Suicide Intervention Skills (ASIST) and uses these skills when interviewing and meeting with consumers. BRBH offers Assertive Community Treatment (ACT) and Trauma Recovery and Empowerment Model Groups (TREM). The Outreach Worker can and has made referrals to these programs for eligible individuals

The Roanoke area implemented HMIS in 2006 and staff from BRBH PATH have been involved in the process since the beginning. The Blue Ridge Community Assistance Network oversees HMIS in Roanoke. The HMIS vendor has been Pathways but it was decided to change vendors in 2015 to Service Point. There has been a transition to Service Point and HMIS went live with Service Point on 4/1/16. The PATH manager and PATH worker have attended all trainings to be able to transition to Service Point. The PATH manager and PATH worker also attended SAMHSA's PATH Program Participation in HMIS Conference in November of 2015 and BRBH PATH is prepared for full implementation to HMIS by July 1, 2016. Previously the PATH worker entered only demographic information into HMIS but is now prepared to enter projects and services into HMIS. Also the PATH manager is on the HMIS Steering Committee of the COC.

f. Describe gaps in the current service system and how PATH will assist consumers in addressing those gaps.

Gaps in housing services include:

- Very limited access to safe, affordable housing
- An extensive waiting list for Section 8 vouchers
- No Safe Haven program for individuals currently intolerant of program rules regarding participation in treatment
- There is limited housing that is accessible for people with physical limitations.

Other access problems include:

- Problems meeting eligibility criteria for community mental health services due to lack of documentation and no recent hospitalizations.
- Unrealistic expectations by providers that the homeless consumer will follow through with several intake appointments before sending referral to other

support services.

- Delays in eligibility determination for mainstream resources Medicare and Medicaid
- Medicaid eligibility requirements (related to income) that are too restrictive in a system in which Medicaid is the primary source of funds for necessary supportive services
- Past incarcerations limit the ability to secure employment and housing

The PATH worker will advocate for the individual by consulting with service providers and inquiring about additional information needed. The PATH worker will also attempt to gather additional history on the individual. The worker reports services gaps to PATH supervisor and shares input at the HELPS Committee (Homelessness programs Educating and Linking Providers of Service). Often the networking that occurs can produce other community resources that may be available to the client.

g. Describe services available for consumers who have both serious mental illness and substance use disorder.

BRBH routinely offers integrated care to those consumers with co-occurring disorders. Homeless clients with dual disorders can be assessed for appropriate level and intensity of treatment at the Access Center. If appropriate they can be offered crisis stabilization and medically supervised detoxification services. The Veteran's Administration Medical Center also offers detoxification services. A major shelter in the Roanoke area, The Rescue Mission, offers a residential treatment program, and this is always made available to individuals who can abide by the rules and regulations of this faith-based program. In addition, individuals not requiring inpatient care are offered MICA groups available in conjunction with day treatment, case management and psychiatric services through the Department of Adult and Family Services BRBH. The PATH worker assesses the needs of the homeless individual and will make referrals to any of the above listed programs.

h. Describe strategies for making suitable housing available to PATH consumers (e.g., indicate the type of housing usually provide and the name of the agency that provides such housing).

The PATH Worker meets with individuals and assesses housing needs and ability to secure and pay for housing. If the individual is without shelter the worker will encourage the individual to enter a shelter or provide funding for emergency housing. If the individual is residing in a shelter, the worker will meet with the individual and relate temporary and permanent housing options to them (all housing services are listed in above in under question # 4). The worker will assist the individual in applying for and securing the most appropriate housing. The worker can utilize PATH funding for one time rental assistance and security deposits.

The PATH worker also attends the Community Wide Case Conferencing for the Chronically Homeless. This is a bi-weekly meeting to review high scoring VI-SPDAT cases in attempt to collaborate and secure housing for these individuals. This meeting is an offshoot from the Veteran's Initiative which was so successful in our area.

i. If you plan to implement one or more Virginia PATH Innovative Practices, indicate which one(s) and describe the implementation plan:

The PATH worker will continue to provide SOAR services to PATH clients.

j. Briefly describe your plan for providing the following PATH-allowable services:

Outreach:
The BRBH PATH worker employs intensive outreach efforts to identify individuals who are homeless who could benefit from community based services for a problem related to mental illness. Through the establishment of a trusting relationship the worker attempts to encourage the individual to engage in services that will provide the treatment and support that will minimize the effects of the mental illness and increase the likelihood of successfully finding and maintaining housing. PATH worker provides "inreach" outreach by frequenting area shelters and soup kitchens on a daily basis. The PATH worker maintains a close professional relationship with the staff of these establishments to get referrals and collaborate on service needs. The PATH worker meets with the Roanoke City HAT team weekly to coordinate services and also occasionally performs "active"outreach with the Roanoke City HAT team by seeking out homeless individuals who reside in non-traditional settings such as park benches and under bridges.

Screening and Diagnostic Treatment:
The BRBH PATH worker employs screening/diagnostic assessment services related to mental health and substance abuse service needs and attempts to connect the individual with treatment and supports. The PATH worker interviews the homeless client numerous times to gather information without being threatening. While building rapport and trust the PATH worker first assesses the eligibility of the client. As the relationship grows the PATH workers continues to gather needed information to complete a more comprehensive clinical assessment while encouraging engagement in services.

Habilitation and Rehabilitation:
The BRBH PATH worker provides supportive services for eligible PATH consumers. As the PATH worker builds rapport with the homeless individual, treatment options and education services are suggested in attempt to maximize functioning level and build self esteem. The PATH worker makes necessary referrals to vocational or employment programs. The PATH worker also encourages self-advocacy and will promote recovery-oriented programs.

Community Mental Health Services:
The BRBH PATH worker makes referrals to mental health services (e.g. Psychiatric services, medication management, financial assistance to obtain medications, and counseling services). The PATH worker educates the homeless client on service options and encourages engagement. The worker will facilitate an appointment being scheduled. The worker will send assessment information to the referral program to review before the scheduled appointment. The PATH worker will attend the appointment with the client if necessary. The worker will follow-up with the referral program to determine outcome for services or provide any additional information. If the homeless client is opened to services, the PATH worker will continue to provide services to the client as needed throughout the transition.

More recently the PATH worker has been working with the Engagement Specialists at BRBH to locate homeless individuals who are discharged from area hospitals and do not show for their follow-up appointment.
Alcohol or Drug Treatment Services: The BRBH PATH assesses need for substance use treatment and will make referrals to both BRBH programs and community treatment programs. The worker will provide monthly bus passes to individuals so that they can attend treatment programs. The worker will maintain contact with the referral program to ensure client participation and will also maintain contact with the client while receiving services.
Staff Training: The BRBH PATH worker provides consultation with Case Managers and shelter staff on the treatment needs of the homeless and available service providers. The PATH worker will educate Case Managers, intake workers and clinic staff on the unique needs of the homeless population and techniques for engagement. The PATH worker educates the shelter staff on symptoms and treatment of mental illness and service options. The PATH worker also advocates for the rights of the homeless client at the shelter. The PATH worker also provides support to community staff that has completed the on-line SOAR training. She reviews forms and informs them of expectations at our local SSA and DDS offices.
Case Management: The BRBH PATH worker discusses needs with the client and develops treatment goals with the client. Once initial goals are established the PATH worker employs care coordination activities until engaged with community mental health services, medical care, training programs and housing. The worker also assesses eligibility for disability benefits and completes application and follow through with the client. The worker is continually assessing needs and linking the individual with appropriate services and supports, and monitoring the client's status. The PATH worker serves as a liaison to all service providers within the community. The worker makes the referral for service, assists the client with completing the application and scheduling an appointment. The worker will also accompany the client to the appointment to advocate and represent the client. If services are secured the PATH worker with follow-up and monitor the individual's progress.
Supportive and Supervisory Services in Residential Settings: The PATH Outreach Worker meets regularly with individuals that are in residential settings and helps the individuals plan for their transition back to the community. The outreach worker also maintains contact with residential staff to assist with discharge planning. Referrals are made for mainstream resources prior to the discharge when appropriate.
Minor Renovation: N/A
Planning of Housing: The PATH worker participates in the HELPS Group (Homelessness Programs Educating and

Linking Providers of Service) and the Community Wide Case Conferencing for the Chronically Homeless. Both of these meetings are direct care providers gathering to discuss changes and needs with the community. The providers share resources and discuss possible solutions to services needs.

Technical Assistance in Applying for Housing:

The PATH worker provides assistance to homeless individuals in completing housing applications, covering cost of application fees, meeting with prospective landlords and securing and providing needed documentation to the prospective landlord. The PATH worker also assists with obtaining needed identification for housing. This includes birth certificates and picture identification from the DMV. The PATH worker has been certified as a notary in order to aid in this process. The PATH worker will serve as an advocate for the homeless individual and assist with the development of a healthy landlord tenant relationship.

Improving the Coordination of Housing Services:

The PATH manager attends the Blue Ridge Interagency Council on Homelessness and the Blue Ridge Continuum of Care. Both these committees meet monthly and strive to improve interagency relations and housing options for the homeless in the Roanoke Valley.

Security Deposits:

The PATH funds are used to pay for security deposits for PATH eligible individuals. The PATH worker is usually involved in the housing application process and will assess need and offer this support as needed on a one time basis.

Costs Associated with Matching Eligible Homeless Individuals with Appropriate Housing Situations:

The PATH worker uses PATH funds to pay for application fees for housing, assist with moving costs, and purchase household items needed to set up a household.

One-time Rental Payments to Prevent Eviction:

The PATH funds are used to pay for one time rental assistance for PATH eligible individuals. The PATH worker is usually involved in the housing application process and will assess need and offer this support if needed.

Referrals for Primary Health Services, Job Training, Education Services and Relevant Housing Services:
The PATH worker is especially concerned about securing needed medical care for homeless individuals who have often gone many years without proper medical care. The worker makes referrals to the Rescue Mission Health Center, Carilion Healthcare and New Horizons Healthcare. Both provide medical services based on income. The PATH worker will accompany the individual to medical appointments if necessary to relate symptoms and assist with medical follow up. The worker will assist with getting prescribed medications and provide funding for medications if needed. The PATH worker makes referral to the

Department of Aging and Rehabilitative Services for job training and placement. The PATH worker has also made referrals to the local community college for continued education.

6. HMIS Data Integration: Describe your HMIS transition plan, with accompanying timeline, to begin using HMIS to collect and report PATH data in HMIS by July 1, 2016. If you are fully utilizing HMIS for PATH services, please describe plans for continued training and how you will support new staff. Indicate any technical assistance needs you may have in meeting the HMIS data requirements.

Blue Ridge Behavioral Healthcare has participated in HMIS (Blue Ridge Community Assistance Network-BRCAN) since it was implemented in 2006. The current provider is Service Point. The PATH worker has been trained and is prepared to fully utilize HMIS for PATH data. Unfortunately, the PATH worker will still have to enter data into BRBH electronic medical record through Cerner. The PATH manager is working on plans for secretarial support with data into one of these systems. Training and support is offered through the Blue Ridge Community Assistance Network of existing and new staff.

7. SSI/SSDI Outreach, Access, Recovery (SOAR): Describe your plan to train PATH staff on SOAR. Indicate the number of PATH staff trained in SOAR and the number of PATH-enrolled consumers assisted through SOAR during State Fiscal Year 2015, and the approximate number of staff to be trained in SOAR for State Fiscal Year 2016.

The PATH worker is trained in SOAR and has completed 41 SOAR applications for PATH-enrolled consumers in FY 15. Of those 41 applications 35 individuals were approved and are receiving disability. This represents an 85% approval rating.

The PATH worker is also trained as a SOAR trainer and provides technical assistance to those who complete the on-line SOAR training. A limited number of homeless agencies have one staff trained in SOAR. When these staff leaves their agency a new staff person is training when the vacancy is filled. Four community staff has completed the on-line training this year. The PATH worker coordinates quarterly user groups where clarification on forms and best practices are presented to those using the SOAR model.

8. Program demographics and cultural competency: Describe the following.

a. The demographics of the target population.

American Indian or Alaska Native: .5 %
Asian: 0 %
Black or African American: 26 %
Native Hawaiian or Other Pacific Islander: .5 %
White: 61 %
Other: 12 %

b. The demographics of the staff serving PATH consumers.

The PATH worker is a white female.

c. How staff providing services to the target population will be sensitive to age, gender and racial/ethnic differences of consumers.

The PATH worker consults with supporting agencies such as Refugee and Immigration Services and the Hispanic Consortium to seek assistance when the situation requires a change in approach or a change in provider.

d. The extent to which PATH staff receive training in cultural competence.

There is limited training offered. The PATH manager is attending training on 4/29/16.

e. The extent to which the organization adheres to the Culturally and Linguistically Competent (CLAS) Standards. The CLAS standards can be accessed at http://www.ThinkCulturalHealth.hhs.gov.

BRBH strives for all staff to be able to effectively communicate in a respectful manner that is easily understood by diverse populations. BRBH is sensitive to this and several staff has been certified as Qualified Bilingual Staff. The agency is mandated to provide language access services. The AT&T Language Line is available for staff to use for interpretation services. The agency also utilizes Commonwealth Catholic Charities Interpreter Services, and has a contract with a certified interpreter for the deaf.

9. Consumer and Family Involvement: Describe how individuals who are homeless and have serious mental illnesses, and family members will be involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards. (See attached Appendix I – Guidelines for Consumer and Family Participation.)

Blue Ridge Behavioral Healthcare actively seeks input from family and consumers and maintains a family presence in the membership of its Board of Directors, as well as inviting consumer and family participation on various advisory boards and work groups that provide input into program development and design, administration and evaluation. This includes family representation on the Adult and Family Services Advisory Committee of the Board, the group which oversees the work of BRBH PATH. BRBH also employs a number of peer support positions in various programs throughout the agency. Informed consent is assured through agency policy and procedures, and the agency convenes the Local Human Rights Committee, the group that has oversight responsibility for the development and application of the Local Human Rights Plan.

10. Outreach to Homeless Veterans: Describe how your PATH program identifies and outreaches to homeless veterans with SMI, and the services available to them in your catchment area. How does PATH interface with your veterans' service continuum?

The PATH worker visits area overnight shelters, day shelters and the HAT team office on a regular basis. When a homeless veteran is identified the PATH worker educates them on all resources including those specific to veterans such as the VA medical center and Trust House. The PATH worker makes referrals to the VA homeless outreach worker. The homeless veteran

decides where to receive their services. Representatives from the VA Medical Center participate in the Blue Ridge Continuum of Care and the Blue Ridge Interagency Council on Homelessness and service collaboration occurs at these meetings. The Blue Ridge Continuum of Care actively participated in the Veteran's Initiative and was successful in bringing veteran's homelessness to a functional zero.

11. Describe your PATH program's efforts to minimize the challenges and foster support for PATH clients with a criminal history, such as collaboration with local jail diversion and/or other programs. If you can, estimate the percent of PATH clients with a criminal history.

The PATH worker has regular contact with BRBH Alpha Jail Services to assist in coordination of services for homeless inmates in the Roanoke City, Roanoke County/Salem, and Western Regional Jails. She also has quarterly or as needed contact with the Department of Corrections to accept referrals. The PATH worker estimates that 60-70% of PATH clients have a criminal history.

PATH site Name: Blue Ride Behavioral Health					
Budget FFY 2016/SFY 2017 (2016-2017 PATH Year)			PATH		Match Source
Staff Title	***Annualized*** Salary	FTE	Funded	Match	(Cash or In-kind)
PATH Case Manager	$46,152	1.00	$46,152		
Clerical Specialist	$3,394	0.10	$3,394		
PATH Manager	$6,416	0.10		$6,416	Cash
Total Staff Salary	55,962		$49,546		
Fringe	15,138		$13,402	$1,736	Cash
		Total Personnel	**$62,948**	**$8,152**	
Travel (Outreach travel, travel for training, state meetings, etc.)					
Use of Agency Vehicle			$2,500		
Training Travel			$500		
		Total Travel Costs	**$3,000**		

Equipment (Personal property/equipment having useful life of more than one year)			
Total Equipment Costs	0		

Supplies (Office Supplies, Outreach Supplies, Computer Software)			
Office Supplies	800		
Outreach Supplies	2,197		
Total Supplies Costs	**2,997**		

Contractual			
Cell phone service fee		750	Cash
Total Contractual Costs		**750**	

Other (List and Describe Each)				
Medication Assistance	400			
Identification related purchase costs (incl. Birth certificates)	300	300	Cash	
Security Deposits	1,687	2,000	Cash	
One-time rental payments	1,000	4,158	Cash	
Cost associated with housing		3,500	Cash	
Bus Passes	1,000	1,000	Cash	
Staff Training (non-travel registration and costs)	2,000	1,000	Cash	
Co-payments for healthcare		4,000	In-Kind	
Office Rent				
Total Other Costs	**6,387**	**15,958**		
Total Proposed Budget	**75,332**	**24,860**	Is match > or = to 1/3 of federal allocation?	

Virginia PATH Local Intended Use Plan, FFY 2016/SFY 2017
PATH Program Year 2016-2017

1. Description of Provider Organization:
a. Name: Fairfax Falls Church Community Services Board (CSB)
b. Organization Type: : Community Mental Health Center
c. Description of Services Provided: The Fairfax-Falls Church CSB offers a wide range of outreach, outpatient, case management and residential services spanning all of the core services taxonomy areas with an emphasis on providing evidence-based practices that incorporate consumer recovery involvement in the process. The Fairfax-Falls Church CSB provides assessment, referral, crisis intervention, case management, counseling, emergency services, hospital discharging, infant- toddler services, youth services, Intensive Case Management teams, residential treatment, day treatment, detoxification, jail diversion, peer support, vocational and medication/psychiatric services to those needing Mental Health, Substance Abuse and Intellectual Disability services.
d. Region Served: Services are provided to citizens of Fairfax County and the Cities of Falls Church, Fairfax and Herndon.
e. Provider's experience in providing services to homeless/at-risk individuals and those with SMI and/or co-occurring SUDs: From the beginning of the establishment of the CSB, services were provided to the homeless population. The CSB started providing outreach services in the late 1970's in collaboration with the community faith-based and non-profit organizations. Shortly afterwards shelters were constructed which included on site services from the CSB. When the McKinney-Vento Homeless Act was approved, title VI provided funds specifically for PATH outreach workers along with shelter plus care, single room occupancy program, emergency and transitional shelter program and the housing demonstration program. We participated in the collaboration with other programs using these funds for housing for SMI and co-occurring disordered clients. In addition to PATH workers we have ICM workers that provide outreach services as a part of our continuum. We participate in the Continuum of Care and provide ongoing collaboration and consultation with other community providers to help meet the housing needs of the SMI and co-occurring homeless individuals. In FY'1999 the State of Virginia nominated the Fairfax County PATH team as recipients of the Exemplary Program Initiative Award stating that "this program has consistently displayed excellence in both program design and the delivery of PATH and other related services".
f. Description of housing or services that are specifically targeted to PATH-eligible consumers: PATH workers refer vulnerable unengaged clients to a unique shelter, Mondloch House, which provides CSB services in collaboration with a non- profit organization. In addition, we work with Pathways Homes Housing First Model to provide ongoing services to chronically homeless clients who have transitioned to permanent housing. In the CSB residential programs, homeless individuals are prioritized for placement. The CSB also has dedicated Housing First Programs for homeless clients with substance abuse/co-occurring disorders that need a harm reduction approach. Additionally, we have partnered with neighboring jurisdictions that have available housing programs for SMI and Co-occurring persons

2. Program Budget and Federal Funds Requested: (Attach detailed budget using Excel file provided by DBHDS):

a. Amount of federal PATH funds requested: PATH funded, $164,542

b. Source and amount of Provider's minimum required 33% match funds: Fairfax County Government, $127,731

c. A brief narrative describing the items in the attached budget:
PATH funding, $164,542: $164,542 or 56.3% (3) Mental Health Therapist, FTE

Fairfax County Government funding, $127,731:
$96,404 or 43.7% (3) Mental Health Therapist, FTE
$ 31,327 Consumer support: identification related purchases, bus tokens and transportation.

Miscellaneous operating expenses: recurring monthly phone service; annual information technology replacement and maintenance; office supplies; assigned agency vehicle usage; and local mileage.

3. Collaboration with Local HUD Continuum of Care (CoC): Describe the organization's participation in the HUD Continuum of Care program, other local planning activities and program coordination initiatives, such as coordinated entry and coordinated assessment activities. If you are not currently working with the CoC, briefly explain the approaches to be taken by the agency to collaborate with the local CoC.

PATH workers actively partner with local COC in several important ways. Every year PATH staff plan, train and participate in the Point in Time count for the unsheltered people in Fairfax County. PATH is also involved with the COC by working together on the recent 100,000 Homes initiative. PATH workers were on the Registry Week planning committee for that initiative and helped identify places to administer vulnerability indexes, as well as help administer them. This is an ongoing initiative for the COC over the next few years. PATH workers also meet frequently with the regional COC groups that problem solve ways to help connect the unsheltered people to housing. Finally, PATH workers are a significant part of the yearly hypothermia prevention program in Fairfax County through planning, providing on site assistance at the shelters and providing training to volunteers that help in the program. The PATH supervisor has been involved with planning for coordinated assessment of homeless in our community by attending workgroups that are creating policy and workflow describing the new coordinated assessment process. The PATH team will follow the workflow created and use all necessary forms that are required by the COC for these purposes.

4. Collaboration with Local Community Organizations: Provide a brief description of partnerships and activities with local community organizations that provide key services (i.e., outreach teams, primary health, mental health, substance abuse, housing, employment, etc.) to PATH eligible clients, and describe coordination of activities and policies with those organizations. Provide specific information about how coordination with other outreach teams is achieved.

Fairfax County's goal is that every person who is homeless or at risk of being homeless is able to access and maintain appropriate affordable housing and services. Coordinating this effort for the County is the Office to Prevent and End Homelessness (OPEH). We provide services to

PATH clients in partnership with OPEH and other county agencies including the Department of Housing and Community Development, the Department of Family Services, the Department of Systems Management for Human Services, the Public Health Department, Public Schools, Police Department, and the Office of Emergency Management. In addition we work with numerous faith-based and non-profit organizations to serve the needs of PATH clients. These agencies include Christian Relief Services, NA/AA, Northern Virginia Family Services, Lutheran Social Services, OAR, New Hope Housing, Cornerstones, United Community Ministries, the Lamb Center, FISH, Western Fairfax Christian Ministries, ACCA, SOME, FACETS, Rising Hope, Catholic Charities, ECCO, Multi-Cultural Clinical Center, NAMI, Good Shepherd Housing, and Shelter House. Our PATH outreach workers are actively involved in the county's Homeless Healthcare Program which provides primary care Nurse Practitioners and a CSB Psychiatric Nurse Practitioner. Community Outreach Workers focus on help in linking clients to affordable mainstream medical and dental services. In coordination with the Public Health Department, Cornerstones and the Department of Family Services, there are six medical respite beds dedicated to the homeless with acute medical illnesses. There is a community health care network (CHCN) which is a partnership of health professionals, physicians, hospitals and County government. CHCN provides primary health services for low income, uninsured, residents at three locations in the county. The CSB collaborative efforts include the Housing First Programs through Pathways Housing Inc., New Hope Housing, FACETS and Reston Interfaith which provide harm reduction permanent housing and case management services. PRS, Inc. uses the clubhouse model for job training, life skills, social skills and recovery services to PATH clients and others. Our vocational services include Department of Rehabilitative Services, Consumer Employment Program and Service Source. Two client run drop-in centers provide peer support help with basic needs, day programming and service referrals. Other drop-in sites for PATH clients include the Lamb Center, First Christian Church, NVFS Bailey's Shelter, Cornerstones Shelter and Rising Hope Mission Church. In the winter many PATH clients who live outside go to hypothermia shelters which are run by non-profit organizations under contract with Fairfax County. PATH staff schedule dates and times on a weekly basis with the different non-profit organizations as well as the health department to do outreach in the community. PATH staff serve 3 different regions in Fairfax County. Each region is served by a specific PATH staff who will coordinate outreach with the different non-profits and the Fairfax county health department of its respective region. The psychiatric nurse will also accompany these outreach efforts. In several occasions, the PATH team have joined their outreach efforts with Fairfax Detox staff as well.

5. Service Provision: Describe the plan to provide coordinated and comprehensive services to eligible PATH consumers. Please address the following information.

a. Projected number of adult consumers to be contacted with PATH funds: 1000

b. Projected number of adult consumers to be enrolled using PATH funds: 230

c. Percentage of adult consumers projected to be "Literally Homeless," and activities to maximize the use of PATH funds to serve adults who are literally homeless as a priority population: 98%

Our PATH workers' primary focus is on identifying and engaging homeless people in the community which includes the streets, woods, camps, etc. We use case management strategies focused engagement by assisting with basic needs and encouraging those that need MH

treatment toward connection to our continuum of care.

d. Strategies that will be used to target PATH funds for street outreach and case management as priority services.

PATH workers will actively participate in shelter drop-in programs, hypothermia programs, consumer run drop-in programs and other community run drop-in programs for homeless persons. We will be collaborating with providers at those sites as well as meeting the unsheltered people that attend in order to engage and screen them for any mental health needs. We partner several times weekly with other community case managers and nurses to go out into the woods and camp sites that are known to have unsheltered people living there in order to engage and screen homeless persons that may be in need of MH or co-occurring treatment as well. We work with Office to Prevent and End Homelessness and local Police to take referrals about unsheltered people on the streets and respond by sending PATH workers out to engage those people. We have outreach supplies such as hats, gloves, sleeping bags, water, food, clothing, etc. to provide to unsheltered people that we encounter as a way to help keep them safe and engage them at the same time. We conduct a clinical assessment at shelters, jail, drop-in centers, the woods, other community settings, etc. when the unsheltered person that we are engaging is ready for a more thorough assessment in order to help determine the appropriate level of treatment needed.

e. Indicate whether your organization provides, pays for, or otherwise supports evidence-based practices and other training for local PATH-funded staff, including training and activities to support migration of PATH data into HMIS.

Motivational Interviewing techniques and the Recovery Principles are fully incorporated into our outreach assessments and treatments. We provide ongoing training inside the CSB and have contracted with outside trainers as well. Brief Solution Focused therapy is used to prevent the re-occurrence of homelessness and to help the chronically homeless client successfully transition into community living. We use the Housing First model to provide harm reduction in meeting the client where they are and promoting recovery. We are developing and implementing communications between our current EHR and HMIS. An estimate time for this implementation is 2016. We are also working with our state PATH contact to formalize this process through consultation and training.

f. Describe gaps in the current service system and how PATH will assist consumers in addressing those gaps.

Some of the gaps include limited medical detoxification beds, barriers to housing such as criminal offenses, credit checks, and most importantly lack of affordable housing. Currently Fairfax County is working to plan and create more SRO's/efficiency apartment units but the resources are scarce. There continues to be is a lack of psychiatric beds at our state hospital. This results in displacing clients out of the area and limited hospital stays. We only have one Adult Living Facility (Stevenson Place), resulting in having clients move to out of area ALF's away from their community supports. There is a stigma in Fairfax that there are no homeless due to the wealth of residents. As a result the CSB, OPEH and other organizations are working to

educate the residents and gain volunteer support as well as monetary support to help the homeless population.

g. Describe services available for consumers who have both serious mental illness and substance use disorder.

Our co-occurring continuum of services provides Evidence Based Practices such as Motivational Interviewing, Harm Reduction, and the Principles of Recovery and Housing First. The full range of CSB co-occurring services is available to all clients at various stages of recovery. These services include emergency services, crisis stabilization, prevention, case management services, residential services, psychiatric services, vocational/day support, suboxone treatment, detoxification services, CATS, Prince William Hospital, Alexandria Detox, PACT and the ICM programs. Specific residential treatment programs that focus on co-occurring treatment are New Horizons and Cornerstones. These co-occurring programs offer apartment living aftercare beds to help integrate clients back into the community.

h. Describe strategies for making suitable housing available to PATH consumers (e.g., indicate the type of housing usually provide and the name of the agency that provides such housing).

In its commitment to address homelessness, Fairfax County has refocused its efforts through implementation of the 10 Year Plan to End Homelessness and the creation of an Office to End Homelessness. We work closely with the Office to End Homelessness, and are an integral part of fully implementing the community 10 year plan to end homelessness. The County's Housing Opportunities Support Teams (HOST) has a strong focus on prevention, housing, and rapid re-housing, with housing locators throughout the community. The CSB provides a range of transitional housing programs such as group homes, apartment programs and some extension aftercare beds. The Housing First Program is a collaborative effort between Pathway Homes and the CSB to provide permanent housing for PATH clients. Non-profit organizations such Reston Interfaith, FACETS and New Hope Housing offer permanent Housing First units with case management services. Transitional and permanent housing are available to this population via a large number of community-based providers. These providers include: Pathways Inc., Christian Relief Services, FACETS, Brain Injury Services, Northern Virginia Family Services, Department of Family Services, Department of Housing, Lutheran Social Services, New Hope Housing, Reston Interfaith, United Community Ministries, Good Shepherd Housing, PRS Inc., and Shelter House.

i. If you plan to implement one or more Virginia PATH Innovative Practices, indicate which one(s) and describe the implementation plan:

We participate in two of the innovative practices; SOAR and Targeted Street Outreach. SSI/SSDI, Outreach, Access and Recovery (SOAR) Services to PATH Consumers was implemented in 2009. Several of our PATH workers are trained in this program to provide full assistance with the application process. We collaborate with our local Social Security offices, Disability Determination Services, the national SOAR technical assistance advisor for Virginia and the State PATH/SOAR team. We will continue to "Focus Services on Targeted Street Outreach" clients. Our PATH workers' primary focus is on identifying and engaging people in the community which includes the streets, woods, camps, etc. We offer Mental Health and Psychiatric services in non-traditional settings (e.g., tents, streets, etc.) to individuals who are

unwilling to come to our site based Mental Health Centers.

j. Briefly describe your plan for providing the following PATH-allowable services:

Outreach:
PATH workers outreach individuals "where they are" in the community for assessment and engagement, taking resources, such as sleeping bags, food and bus tokens to the client. Daily, PATH workers visit camps, streets, emergency shelters, hypothermia shelters, peer support drop in centers and non-profit homeless drop in centers. Engagement and linking to mainstream services is the primary focus of these interactions. PATH workers facilitate/coordinate drop-in groups (in-reach) throughout the County. In the north county area, this occurs two times weekly at the Cornerstones Shelter. In south county it occurs twice weekly at the Community Mental Health Center. In central county PATH supported drop-ins are available twice a week at the First Christian Church. These services augment a drop-in offered at Bailey's Crossroads Community Shelter other days during the week. During these groups, clients have access to showers, washers and dryers, meals, and other needed items, such as underwear, coats in winter, etc. There are also onsite services at the drop-ins including: a medical nurse practitioner from the Public Health Department, a CSB psychiatric nurse practitioner, and a non-profit outreach worker with our homeless healthcare program. Additionally, PATH workers receive referrals from individual and outside agencies

Screening and Diagnostic Treatment:
An initial eligibility screening occurs with all identified potential clients and a more comprehensive assessment is completed when individuals are willing to engage in mental health or co-occurring treatment services. PATH workers refer to psychiatric emergency services, detoxification services, or emergency medical care when needed. On-going assessments occur throughout the engagement process to determine appropriate case management needs. Psychiatric screenings are done by the Psychiatrist and Nurse Practitioner. An emphasis is placed on engagement into mainstream services, collaborative case management, and linking the individual with affordable housing resources.

Habilitation and Rehabilitation: N/A

Community Mental Health Services:
The PATH workers provide referrals and linkage to CSB mainstream emergency and outpatient services. PATH participates in outreach and crisis intervention with our mobile crisis and detox diversion units. PATH clients have access to our low cost medications through our Genoa pharmacy clinics, patient assistance programs and samples. We also provide psychiatric medication as needed.

Alcohol or Drug Treatment Services:
PATH workers use Motivational Interviewing and harm reduction techniques to provide supportive counseling and engagement for individuals with co-occurring disorders. PATH provides referrals and coordination to Detox, Suboxone treatment, outpatient and residential treatment programs.

Staff Training: The Fairfax Falls Church CSB has a strong commitment to providing evidence based/best practices training to all staff. Trainings have included and continue to include: Trauma sensitive services, DBT, working with homeless veterans, motivational interviewing, suicide assessment/prevention training, ethics in behavioral health, MANDT, CPR, First Aid, OSHA, Blood borne Pathogens and Human Rights and the REVIVE training. Additionally we have participated in webinars on SAMHSA, PATH, SOAR and National Healthcare for the Homeless websites. PATH staff provides training to other CSB, County and non-profit staff about working with mentally ill homeless clients. The County offers additional onsite training and e-learning courses on a variety of subjects for professional development
Case Management: PATH workers provide non-traditional case management services and they are a significant part of the engagement process. PATH staff uses motivational interviewing and recovery techniques to work with the clients "where they are." Goals are consumer driven and focused on obtaining resources and housing, in addition to mental health/co-occurring services. Accessing a needed resource for an individual helps to build trusting relationships to provide a foundation for change. Case management includes assessment to determine service needs, identification of resources to meet those needs, referrals to the specific resources, assistance in actual procurement of resources; i.e., assisting with applications, and monitoring follow up and progress. These goals are reviewed and documented quarterly, and adjusted upon mutual consent
Supportive and Supervisory Services in Residential Settings: PATH provides support during client transition periods from the streets to shelters and other supportive housing. We continue to follow clients through the transition period as they begin to make the adjustment from homelessness. On-going collaboration occurs with the new service provider to plan and coordinate the transition at the clients pace.
Minor Renovation: N/A
Planning of Housing: The CSB is an active participant in the COC and the Office to Prevent and End Homelessness 10 year plan. PATH staff provides input and feedback regarding planning, programming and resources for the expansion of housing for homeless outreach clients. The CSB was instrumental in successfully advocating for Single Room Occupancy permanent housing units, which was an unmet need in Fairfax County.
Technical Assistance in Applying for Housing: N/A
Improving the Coordination of Housing Services: The CSB is an active participant in the COC and the Office to Prevent and End Homelessness 10 year plan. PATH staff provides input and feedback regarding planning, programming and resources for the expansion of housing for homeless outreach clients.
Security Deposits: PATH does not provide direct funds but uses other resources. Those resources included funds from the CSB, the Office to Prevent and End Homelessness, non-profits and faith-based organizations.

Costs Associated with Matching Eligible Homeless Individuals with Appropriate Housing Situations: PATH does not provide direct funds but uses other resources. They included funds from the CSB, the Office to Prevent and End Homelessness, non-profits and faith-based organizations
One-time Rental Payments to Prevent Eviction: PATH does not provide direct funds but uses other resources. They included funds from the CSB, the Office to Prevent and End Homelessness, non-profits and faith-based organizations
Referrals for Primary Health Services, Job Training, Education Services and Relevant Housing Services: Referrals to these mainstream services are a significant part of our PATH outreach and engagement efforts. PATH works with the County agencies, CSB, non-profit agencies, Community Healthcare Network, vocational training services, faith-based communities, and other private organizations to link clients for stabilization and re-integration into the community. We focus on connecting clients to ongoing services which continue to be available after they are housed.

6. HMIS Data Integration: Describe your HMIS transition plan, with accompanying timeline, to begin using HMIS to collect and report PATH data in HMIS by July 1, 2016. If you are fully utilizing HMIS for PATH services, please describe plans for continued training and how you will support new staff. Indicate any technical assistance needs you may have in meeting the HMIS data requirements.

IT staff with CSB is currently actively working with OPEH and the HMIS contact with the State to coordinate this so Fairfax CSB will be in compliance by 2016. The CSB PATH team and IT department have integrated the elements required for reporting into the existing medical record, so an export will be possible in the future. The IT department has met with HMIS administrators and collaborated around technical assistance issues.

7. SSI/SSDI Outreach, Access, Recovery (SOAR): Describe your plan to train PATH staff on SOAR. Indicate the number of PATH staff trained in SOAR and the number of PATH-enrolled consumers assisted through SOAR during State Fiscal Year 2013, and the approximate number of staff to be trained in SOAR for State Fiscal Year 2015.

Fairfax County CSB PATH program has 4 staff trained in SOAR. The State Coordinator will be working with the COC to expand SOAR in our region and PATH will play an integral part in that expansion.

8. Program demographics and cultural competency: Describe the following.

a. The demographics of the target population.

PATH Race/Ethnicity Categories	% Community (Identified Homeless)	% PATH Staff
American Indian or Alaska Native:	*	16%
Asian:	*	0
Black or African American	25%	16%
Hispanic or Latino:	18%	16%
Native Hawaiian or Other Pacific Islander:	*	0
White:	47%	52%
Two or More Races	*	0
*10% Asian/Other/Bi- or Multiracial/Unknown		

b. The demographics of the staff serving PATH consumers. See chart 8a.

c. How staff providing services to the target population will be sensitive to age, gender and racial/ethnic differences of consumers.

Diversity is an on-going priority and focus of the CSB with a special committee that coordinates with State in providing training and consultation to staff in cultural competence. Because the County is one of the most diverse in the U.S., PATH workers are very experienced in working with individuals from different cultures, religions, ages and sexual preferences. The CSB has a multicultural, multi-linguistic team with therapists and psychiatrist who support the PATH staff in providing off site assistance to clients of all cultures. In additions to having a number of bi-lingual staff, the CSB contracts with on call translator services which are available in person and over the phone. Human Rights and other CSB forms have been translated into multiple languages. We also work with different non-profit and faith-based organizations to link clients to legal, immigration, social support and community resources that are culture specific. We participate in a regional consortium providing mental health and co-occurring deaf services to individuals. PATH staffs are fluent in sign language and the use of a TTY system

d. The extent to which PATH staff receive training in cultural competence.

There are monthly multi-cultural trainings offered on a variety of topics. Other trainings offered include Language and Cultural Competence, Sexual Harassment and a County wide Diversity Conference.

e. The extent to which the organization adheres to the Culturally and Linguistically Competent (CLAS) Standards. The CLAS standards can be accessed at http://www.ThinkCulturalHealth.hhs.gov.
The CSB has a multicultural, multi-linguistic team with therapists and psychiatrist who support the PATH staff in providing off site assistance to clients of all cultures. In additions to having a

number of bi-lingual staff, the CSB contracts with on call translator services which are available in person and over the phone. Human Rights and other CSB forms have been translated into multiple languages. We also work with different non-profit and faith-based organizations to link clients to legal, immigration, social support and community resources that are culture specific. We participate in a regional consortium providing mental health and co-occurring deaf services to individuals. PATH staffs have access to use of a TTY system.

9. Consumer and Family Involvement: Describe how individuals who are homeless and have serious mental illnesses, and family members will be involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards. (See attached Appendix I – Guidelines for Consumer and Family Participation.)

The CSB has a very active Office of Consumer and Family Affairs and the director works with the executive staff at the CSB to assist families and consumers with advocacy, training, giving feedback and influencing policy. The CSB mission states that it "*partners with individuals, families, and the community to empower and support"* clients. Transformation work also continues in the form of the CSB Recovery Initiative. Homeless consumers, advocates and staff are an integral part of the work to improve the CSB service system. Peer Support employees, including some that were formally homeless, are an important part of our service delivery system. In addition to individual support to clients they provide ongoing WRAP groups throughout the county. Volunteers who were former PATH clients are a part of all PATH homeless drop-ins and outreach efforts. Many formerly homeless clients serve on the board of the consumer run drop-ins. PATH staffs refer to and support these drop-ins through outreach activities. PATH workers inform and take clients to meetings for county budget and housing issues to encourage client participation in the process. Active and former clients sit on our Consumer Advisory Board which reports to CSB executive staff and participates in planning, developing and prioritizing services. The CSB assists in funding the consumer run drop-ins and in providing scholarships to attend training opportunities throughout the state. PATH clients who live outside in tents and in the shelters have attended and enjoyed some of these trainings. The CSB has a dedicated Human Rights and Consumer Advocacy staff member to assist consumers and to educate CSB staff. Our Human Rights Policy is posted throughout CSB sites and has been translated in several languages.

10. Outreach to Homeless Veterans: Describe how your PATH program identifies and outreaches to homeless veterans with SMI, and the services available to them in your catchment area. How does PATH interface with your veterans' service continuum?

PATH contacts outreach workers from the VA directly and partners with the VA outreach worker and COC to connect Veterans to housing and case management needs. The VA provides a continuum of case management and housing services that is very comprehensive in the NOVA area.

11. Describe your PATH program's efforts to minimize the challenges and foster support for PATH clients with a criminal history, such as collaboration with local jail diversion and/or other programs. If you can, estimate the percent of PATH clients with a criminal history.

PATH utilizes the CSB jail diversion services as a referral source for some of our homeless clients who have a criminal history. PATH also provides clinical assessments to individuals at the local jail who upon discharge would become homeless living in a shelter and/or the streets. PATH staff has also been partnering with the local police districts and participating in their roll calls in an effort to divert homeless individuals to PATH attention rather than the judicial system. Some examples of how PATH staff have partnered with the police include riding along with the police, meeting the police at a specific address in order to assist homeless individuals who would otherwise be resistant to the police. Following leads the police might provide of homeless individuals living in tents, in the woods, or the streets during the hypothermia season has been helpful to PATH staff.

PATH Site Name:	**Fairfax-Falls Church Community Services Board**				
Budget FFY 2017/SFY 2017 (2016-2017 PATH Year)			PATH Funded	Match	Match Source (Cash or In-kind)
Staff Title	*Annualized* Salary	FTE			
Mentall Health Therapist	$57,162	1.00	$36,012	$21,150	Cash
Mentall Health Therapist	$58,224	1.00	$36,681	$21,543	Cash
Mentall Health Therapist	$63,393	1.00	$39,938	$23,455	Cash
Total Staff Salary	$178,779		$112,631	$66,148	Cash
Fringe	$82,167		$51,765	$30,402	Cash
	Total Personnel		**$164,542**	**$96,404**	cash match
Travel (Outreach travel, travel for training, state meetings, etc.)					
Use of Agency Vehicle + local travel				$7,606	
	Total Travel Costs			$7,606	

Equipment (Personal property/equipment having useful life of more than one year)			
Total Equipment Costs		$0	

Supplies (Office Supplies, Outreach Supplies, Computer Software)			
Office Supplies		$1,000	
Outreach Supplies		$13,107	
Supplies			
Total Supplies Costs		$14,107	

Contractual			
Annual information technology charges for PC replacement and maintenance		$3,758	
Cell phone service fee		$1,800	
Desk Phones		$2,153	
Copier		$591	
Total Contractual Costs		$4,544	

Other (List and Describe Each)			
Medication Assistance			
Identification related purchase costs (incl. Birth certificates)		$500	
Rental Assistance			
Bus Tokens; Transportation		$4,570	
Total Other Costs	0	$5,070	
Total Proposed Budget	**$164,542**	**$127,731**	Is match > or = to 1/3 of federal allocation? **Yes**

Virginia PATH Local Intended Use Plan, FFY 2016/SFY 2017
PATH Program Year 2016-2017

1. Description of Provider Organization:
a. Name: Hampton Newport News Community Services Board
b. Organization Type: Community Mental Health Provider
c. Description of Services Provided: MH/SA/IDD assessments, case management and treatment, PACT, MH Residential, Homeless Services/PATH, Road2Home Project, Intensive Day programs for mental health and substance abuse, IDD Residential, IDD Supported Living, Medications Management, Adult Day Care, Regional Deaf Services, Substance Abuse Prevention & Early Intervention, Psychological Assessments and Evaluations, Comprehensive Outpatient Services, MH Mobile Crisis, Emergency and Crisis Services, In-home Treatment, Criminal Justice Services, SA Treatment, Adolescent Residential, Independent Living, Crisis Inpatient Services, Intensive Adolescent Outpatient SA Services, Service Coordination to pregnant and post-partum SA women and children, Opioid Replacement Services, SA Support Services, Juvenile Detention Services, Therapeutic Day Treatment In-School, Hampton Drug Treatment Court and Newport News Drug Court, Wounded Warrior, Jail Diversion program, CIT program, Peer Recovery Services, and Regional Crisis Stabilization Program, and IDD Mobile Crisis and Respite
d. Region Served: The Cities of Hampton and Newport News, Virginia
e. Provider's experience in providing services to homeless/at-risk individuals and those with SMI and/or co-occurring SUDs: HNNCSB has been providing services to the target population for over 44 years and for 22years through the PATH program. It was one of only 18 ACCESS Demonstration Project sites in the nation from 1994-1999. Since 1997, through the development and management of extensive homeless housing programs. As evidenced by the many positive outcomes, such as the high percentage of placement of PATH clients in permanent housing, staff and agency administration consistently demonstrate the high degree of knowledge of the needs of the target population and the resources available to serve them throughout the region.
f. Description of housing or services that are specifically targeted to PATH-eligible consumers: The HNNCSB provides a continuum of housing and services for persons who are homeless with SMI. The following are a listing of those programs: Emergency Housing, Shelter Plus Care Housing, Safe Haven Housing (Safe Harbors) & Permanent Supported Housing (Project Onward), PATH, Prevention and Rapid Re-housing funding, Newport News Homeless Outreach Project, and all mental health, substance abuse, intellectual and developmental disability services provided by the HNNCSB are available for PATH-eligible consumers. In addition, Dresden Apartments, a 32-unit complex is managed by the HNNCSB, provides a preference for homelessness as part of its tenant selection process. Added this year is Road2Home, a SAMHSA/CABHI funded project in partnership with DBHDS and NorfolkCSB.
2. Program Budget and Federal Funds Requested: (Attach detailed budget using Excel file provided by DBHDS):
a. Amount of federal PATH funds requested: $101,826
b. Source and amount of Provider's minimum required 33% match funds:

Our minimum match of $33,603 will come directly from funds from the HNNCSB.

c. A brief narrative describing the items in the attached budget:
The HNNCSB is requesting $101,826 in PATH funding with a match of $43,240 which is over the match requirement. The total budget for this project is $145,066 for fiscal year 2016.
Staffing and fringe benefits: Two full-time staff positions are engaged in this project, PATH Outreach Specialist and PATH Outreach Assistant, at a total cost of $60,811. Benefit costs are $19,396 which includes payroll taxes, health insurance, disability and life insurance, contribution to the Virginia Retirement System, and worker's compensation insurance.

Travel Expense: Local mileage at the rate of 48.5 cents/mile and is budgeted for $3,500.

Equipment: Three (3) Office lines for internet for the PATH offices are budgeted at $130 for the year.

Supplies: Office supplies for the PATH office total $650 per year. Outreach supplies - bottled water, socks, food, and other items for the clients - total $3,000 for the year.

Contractual: Security for the PATH facility (9am to 4 pm), 1 day a week totals $3000 a year. Cell phones for both staff members run $1500 for an entire year.

Other Expenses: Medical Assistance is at $2000 to purchase client prescriptions and over-the-counter medications that they cannot afford. Rental Assistance is at $1000 and this pays for one time rental assistance, security deposits, and other related expenses. Bus tokens and client transportation are budgeted at $2,000 for the year. Non travel staff training costs $300 per year. Administrative support of the PATH staff and program is $21,763. Rental of office space, insurance on that space, and janitorial services for the PATH offices is $15,255 for the year.

3. Collaboration with Local HUD Continuum of Care (CoC): Describe the organization's participation in the HUD Continuum of Care program, other local planning activities and program coordination initiatives, such as coordinated entry and coordinated assessment activities. If you are not currently working with the CoC, briefly explain the approaches to be taken by the agency to collaborate with the local CoC.
HNNCSB has six staff members who actively participate in the Greater Virginia Peninsula Homelessness Consortium, which is the local CoC for this region. The two PATH staff members attend all general meetings and trainings. The Homeless Services Supervisor participates in the Services Coordination And Assessment Network (SCAAN), which is the coordinated intake system currently in place. As a SCAAN member, she interacts with other local organizations to engage those persons identified as needing PATH services. Through SCAAN she also utilizes different streams of funding and resources that can benefit the PATH clients. Another member of the team attends the HMIS meetings which ensure HMIS compliance and data quality. The HNNCSB Resource Development Specialist serves on the Leadership Team, Housing Resources Team, and the Program Monitoring Committee, co-chair) and has been significant in the development in the regional of the coordinated intake hotline – now in its 2nd year. The PATH team provides engagement services for all organizations in the CoC. The HNNCSB Director of Property and Resource Development is one of the founding members of the Peninsula CoC and the Mayors and Chairs Commission on Homelessness and authors the

Homelessness sections of the HUD Annual Action Plan for the City of Hampton and the City of Newport News as well as providing input into the Consolidated Plans for both cities. One member of HNNCSB Homeless Services is the Chair of the CoC's Regional SOAR Team.

4. Collaboration with Local Community Organizations: Provide a brief description of partnerships and activities with local community organizations that provide key services (i.e., outreach teams, primary health, mental health, substance abuse, housing, employment, etc.) to PATH eligible clients, and describe coordination of activities and policies with those organizations. Provide specific information about how coordination with other outreach teams is achieved.

Following assessments by the PATH staff all clients receive referrals and linkages to appropriate medical, dental, health, employment, vocational services and other appropriate housing providers, including the Free Clinics, local health departments, Health Care for the Homeless, the Veterans Administration, and SouthEastern Virginia Health Systems (SEVHS - formerly Peninsula Institute for Community Health). Job training and education referrals include VEC, local education programs, and GED/literacy classes. Housing service referrals include the Hampton Redevelopment and Housing Authority, Newport News Redevelopment and Housing Authority, local disability housing providers, HUD-funded low-income housing providers, HNNCSB permanent supported housing and other permanent housing providers, Assisted Living Facilities, Elderly and Disabled Housing providers, Veterans Administration Housing, Domestic Violence Housing and private market housing.

HNNCSB offers PATH clients a myriad of services on-site that are accessed by the PATH Outreach Specialist at the HNNCSB's Homeless Services offices and throughout the two cities served. These services include: emergency services, regional crisis stabilization unit, case management, PACT, outpatient mental health services, medication services, intensive day services, partial hospitalization program, access to in-patient treatment and discharge planning, services for pregnant women with substance abuse histories and women with children with substance abuse disorders, extensive substance abuse services including: day treatment, residential treatment services, opiate replacement clinics, SA case management, and clinical staff which includes a psychiatrist specializing in providing services to, and coordinating services for, clients with co-occurring mental illnesses and substance abuse disorders. HNNCSB has staff available to PATH clients to assist with preparation of applications for Social Security, Social Services, Medicaid, and other mainstream benefits and to assist in the appeals process if clients are denied benefits. PATH staff was trained in SOAR in 2005 and uses SOAR to assist clients with expediting SSI and SSDI applications. One of the HNNCSB Homeless Services staff is Chair of the CoC Regional SOAR Team.

HNNCSB has also developed an extensive array of housing options available for the PATH clients, including: Emergency Housing, Shelter +Care housing, Safe Harbors (Safe Haven Model-permanent housing), Project Onward Housing, HNNCSB Mental Health Residential Supervised housing, a 32 unit apartment complex with homelessness as a tenant preference, and a total of 48 units with Project Based Voucher rent subsidies. Emergency Housing, Shelter +Care, Safe Harbors, and Project Onward provide PATH clients with preference. Children's Services are also available and have been used on occasion as a referral source for children of PATH clients, when appropriate. A family case management team was developed for families with children with mental health needs. Through state and federal grants, HNNCSB provides

extensive homelessness prevention and rapid rehousing services to HNNCSB clients, including PATH clients.

PATH eligible clients are provided services through linkages offered by the PATH staff. Temporary housing services are provided by the HNNCSB, Peninsula Rescue Mission, Transitions Family Violence Services, Menchville House, Veterans Homeless Housing programs, and other partners in the community. These year-round shelters provide referrals to the PATH staff if the need is recognized. They encourage on-site outreach efforts made by the PATH outreach staff.

Newport News LINK and Hampton HELP both coordinate winter shelters that target the non-sheltered homeless – PORT and A Night's Welcome. They operate approximately from late October through early April. PATH staff is assigned to both winter shelters and make multi-weekly visits. A Homeless Outreach Specialist was added to the homeless services staff and provides intensive outreach to the city of Newport News. The Homeless Outreach Specialist makes referrals to PATH when appropriate. PATH clients are provided showers, food, and clothes washing opportunities at Clean Comfort operated by the Newport News Office of Human Affairs. This is a key outreach site for PATH staff.

Healthcare for the Homeless provides primary health care to PATH clients. Services include medication assistance, transportation to appointments, and linkages to additional health services on an as-needed basis. Healthcare is also provided to PATH clients through the two local Health Departments. Referrals are made to PATH from Healthcare for the Homeless. Outreach efforts are conducted at the clinic sites. Dental services are provided through the local Health Departments, SVHS dental clinic and the HELP dental clinic. SVHS offers full dental care on a sliding scale with a small one time registration fee.

Coordination with other outreach teams is done on many levels but most of the coordination occurs after the client is identified. The PATH team works with the VA outreach and homeless services to make ensure the veterans are properly engaged and receive needed services. HNNCSB PATH team notifies and plans with the Norfolk PATH team when clients go to the year around shelter located in that city. PATH and the new Road2Home SAMSHA grant are working together in outreach efforts to determine the best program for the consumer. Also during SCAAN the clients are assessed to determine the best team to service their needs.

5. Service Provision: Describe the plan to provide coordinated and comprehensive services to eligible PATH consumers. Please address the following information.

a. Projected number of adult consumers to be contacted with PATH funds:
A minimum of 325 contacts will be made over the course of the year utilizing PATH funding.

b. Projected number of adult consumers to be enrolled using PATH funds:
The total number of PATH clients enrolled in FY 2016 is targeted at 180

c. Percentage of adult consumers projected to be "Literally Homeless", and activities to maximize the use of PATH funds to serve adults who are literally homeless as a priority population:
It is estimated that 162 of the enrolled clients or 90% will be literally homeless. 162 or 90% of the federal number will be homeless.

d. Strategies that will be used to target PATH funds for street outreach and case management as priority services.

The PATH team focuses on street outreach - visiting campsites, abandoned buildings, and other places not meant for human habitation on a regular basis. They take food, cooking supplies, clothes, and other useful household/personal care items. They engage people slowly and earn their trust so that they will be more willing to connect to services.

The PATH team has developed an outreach partnership with multiple downtown feeding, showering, cleaning, and disbursement centers, including Clean Comfort where the homeless can go to shower and clean their clothes, PORT and A Night's Welcome – winter shelter programs, all area emergency and transitional shelter programs, the Veteran's Administration, Health Care for the Homeless, Health Care for Homeless Veterans, Departments of Human Services, Crisis Stabilization, and Crisis Intervention Team Training – where PATH staff assist in this nationally acclaimed training for Police Officers and first responders. In addition, city employees on the HNNCSB Board, who work with Police, Fire and EMT for the City, provides PATH Supervisor with information and access to city policing efforts regarding homeless individuals and campsites.

Once the client is enrolled in the PATH program, staff provides intensive case management services to begin mainstream benefits applications and treatment. The amount of case management received by the client is dependent upon what the client desires and consents to.

e. Indicate whether your organization provides, pays for, or otherwise supports evidence-based practices and other training for local PATH-funded staff, including training and activities to support migration of PATH data into HMIS.

The HNNCSB provides and pays for a number of evidence-based practices that benefit PATH clients. The most noteworthy of these practices is the SOAR Program. Since 2005, the PATH team has been trained and utilized SOAR to provide full assistance with SSI/SSDI and other benefit applications. Through this program the staff has developed effective working relationships with DDS and SSA staff and practitioners providing DDS consultative exams which enable benefits to be activated more quickly. One member of HNNCSB Homeless Services is the Chair of the CoC's Regional SOAR Team.

The HNNCSB also provides several best practice housing-first models for PATH consumers. Admittance into housing with the HNNCSB is not dependent on an immediate engagement in services. Housing is provided first, as available, and the consumer is slowly engaged in services until they are able to consent to permanent supported housing and enter a very mild lease. Along with the Housing First programs and policy approach, our Safe Haven program is also a best practice model offered to PATH clients. This housing model for the chronically homeless offers most services on-site through almost seamless communications, engagement, and commitment to meeting the needs of the person – where they "are" at the moment. The consumers may enter this housing after being in some type of emergency housing or directly from the streets.

HNNCSB and PATH staff actively uses and are committed to Prevention and Rapid Rehousing

as a best practice model – moving individuals quickly from homeless situations into permanent housing, reducing time spent in shelters or on the streets as much as possible. Rapid Re-housing, as a means of diverting individuals from shelter stays or extended shelter use is a housing best practice and one that the HNNCSB PATH program uses through its collaboration within the regional Continuum of Care. Like Housing First, Rapid Re-housing involves moving an individual experiencing homelessness directly into permanent housing, using graduated financial assistance and housing focused case management, while at the same time offering appropriate support services to the individual based upon their needs and choices. Funding that supports this evidenced based practice comes through a regional grant from the Virginia Department of Housing and Community Development.

PATH staff also participates in Crisis Intervention Team Training, which trains police, fire, and other first-responders in effectively diverting non-violent offenders with mental health issues from jail into various programs and services rather than jail – sometimes without any criminal charges for the non-violent offense. This best practice provides first-responders with extensive education about the issues surrounding homelessness, especially for those with mental illnesses, as well as providing them with considerable resources to tap into when they encounter people with mental illnesses who are homeless. PATH is one of the primary contacts due to CIT training.

The HNNCSB PATH program, for the 5 years prior to last year, entered data into HMIS on all enrolled PATH clients, but was advised to stop that practice until the PATH program decides the data points. Earlier this year, data points were decided and April 1, 2015 the HNNCSB PATH program once again began entering data into HMIS. Training, equipment, and HMIS licenses are provided to the PATH staff to ensure data when entered is done quickly and appropriately. The PATH manager and supervisor designed the PATH enrollment sheet to match HMIS required data fields so that the data can be taken from the intake forms and inputted into HMIS by the PATH supervisor or the trained PATH staff. A data quality report is generated monthly to indicate data errors, if any. The HNNCSB participates in the Continuum of Care HMIS subcommittee and attends all meetings. The HNNCSB will implement FY 2016 plans to add contacts to that as well.

f. Describe gaps in the current service system and how PATH will assist consumers in addressing those gaps.

There has been no replacement of the 50-bed Salvation Army Family Shelter that closed over 10 years ago. Their 50-bed shelter was condemned due to serious building code problems. In addition the region lost one of the largest family emergency shelters on the Peninsula – Friends of the Homeless, another 50-bed shelter. No other year-round shelter has expanded to increase the number of beds lost. After this, in order to not lose the state-supported funding to the local area because of the family shelter closing, the City of Newport News, along with the Salvation Army, applied for funding for additional hotel/motel vouchers for individuals and families facing homelessness. To support this initiative, service providers initiated the SCAAN team (Shelter Coordination and Assessment Network). PATH is actively involved with the bi-weekly interagency collaboration. The City is no longer applying for the shelter bed money and discontinued that program, but SCAAN has evolved into a very successful major regional effort to case manage homeless families and individuals and has become the coordinated intake point

for homeless persons in the region. The PATH team will also work with the homeless hotline for the region which is to go live later this year.

Both winter shelter programs experienced some decrease in demand for overnight shelter this past winter and were able to accommodate all homeless requiring this type of shelter. However, more rules were enacted and enforced that may have helped with operations, but resulted in more individuals on the "do not admit" lists or being temporarily not admitted, with the majority of these persons being the PATH target population. When the winter shelters close, there remains a considerable gap in shelter space for single men and women who often do not meet the admissions criteria of the remaining shelters, including those with serious health problems.

Changes at the Veterans Administration resulted in national competition for the VA Per Diem Housing grants. As a result of this change, only 2 service providers in this part of Virginia were awarded a Per Diem Housing grant during the past decade for homeless veterans – the one on the Peninsula is small and serves up to 14 female veterans and their children and the Salvation Army's 60-bed Transitional Housing for Homeless Veterans has been shut down due to needing to vacate their building on the VA campus. Currently, it does not look like the transitional housing program will reopen. The HNNCSB PATH team participated in the recent Veteran 100 day challenge and helped the Peninsula house over 135 homeless Veterans. The team continues to work to help homeless Veterans.

The catchment area continues without a social detox unit, reducing the substance abuse treatment options for PATH participants on the Peninsula and creating a gap where none had existed in the past. Referrals can be made to Virginia Beach Detox. Emergency Services does have some funds for co-existing disorders that can assist with payment of service, but vacancies are limited due to competition from multiple catchment areas. HNNCSB is working with regional entities to develop a Healing Place within Hampton Roads, which hopefully will open in the next two years.

Other gaps in local services continue to grow. A large gap is locating affordable permanent housing. Hampton Redevelopment and Housing Authority (HRHA) reports an average of 12 months to three years wait for public housing. HRHA's Section 8 program has been closed for a significant time to new applicants and did not open their Section 8 waiting list at all in 2010, 2011, 2012, 2013, 2014 or 2015. Hampton also leveled an older public housing complex and is planning on rebuilding only 1/3 of the original units. Most of the residents will receive housing vouchers to relocate, thus the Section 8 program most likely will not open anytime soon. Newport News Redevelopment and Housing Authority (NNRHA) is scheduling appointments for housing this year but has yet to begin. Following an initial appointment, it is 60-90 days before applications are accepted and then applicants go on a year+ waiting list. NNRHA's Section 8 waiting list closed in January of 2000. NNRHA did not open their Section 8 waiting list in 2011 or 2012 and only opened it for 4 days in 2013 and 2015. NNRHA provides leasing services for the Warwick SRO (Single Room Occupancy). This is a desirable location for PATH clients without families or dependents. The waiting list for the SRO is 6-12 months. Although there are some private sector housing and apartment options that are income-based, securing housing usually takes over 6 months to achieve. Often the private sector's low-income options are less desirable due to additional utility payments, deposits, and rent requirements and

restrictions. Market rate monthly rent averages around $850.00 to $1200.00 which is usually not affordable for PATH clients, even with benefits. Shelter stays do not meet the time requirements for public housing waiting lists. Rooming and boarding houses are also frequently used by PATH clients as an alternative to shelter while waiting for public housing or other low income housing, although both cities have made it extremely difficult to operate legitimate boarding homes. Zoning changes in both the City of Hampton and City of Newport News restricts the number of unrelated adults in boarding and rooming houses to 4 and 3, respectively, with extensive planning authorization over those numbers, thereby reducing the income potential for property owners to recoup the cost of providing this type of housing. This is resulting in fewer boarding home providers and more boarding homes closing their doors. Also Newport News and Hampton passed zoning restrictions that no longer allow for motel/hotel stays over 30 days, except in an extended stay motel, which is usually monetarily out of the reach of the average PATH client.

g. Describe services available for consumers who have both serious mental illness and substance use disorder.

The HNNCSB added a Substance Abuse Case Management Team and a SA staff psychiatrist in 2001.The employees in these services have considerable experience working with people with co-occurring disorders. There is an intensive substance abuse day treatment program called Next Step, which is available to the target population. HNNCSB also operates a licensed Opioid Replacement Clinic.

Emergency housing is available for those individuals with co-occurring mental illnesses and substance abuse disorders. This is short term housing that could prevent a hospitalization or provide a safe place until treatment is available. Persons with co-occurring disorders are eligible residents for HNNCSB Shelter + Care, Safe Haven program, permanent supported housing programs, and prevention and rapid rehousing resources.

HNNCSB has a psychiatrist on staff that provides outpatient services to individuals with substance abuse as their primary diagnosis as well as co-occurring mental health diagnoses.

One local hospital and the Warwick SRO housing program offer 12-step meetings geared to the mentally ill substance abuser. Drug testing is available to the PATH staff if the need arises to test PATH clients. Information on area 12-step meetings is available to all dually diagnosed clients. In addition, HNNCSB offers AA and NA meetings, hosts the local SAARA chapter, in addition to our substance clinic called Partners in Recovery. Detox services can be accessed with an out-of catchment referral to Virginia Beach and Medical Detox is available at the local psychiatric and medical hospitals. The HNNCSB also provides onsite peer support for dually diagnosed individuals.

The HNNCSB has a crisis stabilization unit in Hampton. Norfolk also has developed a crisis stabilization unit with a dual-diagnosis tract and up to a 10 day stay. These services are available to all PATH clients with co-occurring disorders.

h. Describe strategies for making suitable housing available to PATH consumers (e.g., indicate the type of housing usually provide and the name of the agency that provides such housing).

Over the past several years, the HNNCSB has expanded the development of a variety of housing options to meet the expressed housing needs of consumers, to help provide consumers with safe, decent and affordable housing provided by a landlord with an understanding of their needs and willingness to work with residents to avoid evictions or unstable housing conditions, and to increase access to the amount of affordable housing available to the PATH consumers. Housing options available through HNNCSB are open to persons with co-occurring serious mental illnesses and substance abuse disorders. HNNCSB offers PATH clients housing options that include: payments to prevent evictions of PATH clients (at-risk of homelessness) and financial assistance to access housing. PATH funds coupled with other funding help PATH clients obtain housing.

In 1997, HNNCSB developed an emergency housing program offering shelter, food, and services to individuals with mental illnesses and substance abuse disorders who were inappropriate for other shelter programs or who had exhausted other program time requirements. This program provides 8-beds, 4 beds for women and 4 beds for men. Housing, food and support services, including assistance with benefits applications, are offered. This shelter remains full year round.

In 1999, the HNNCSB developed a Shelter+Care permanent housing program in partnership with the Newport News Redevelopment and Housing Authority. This program provides permanent supported housing to homeless, seriously mentally ill clients through a grant provided by HUD's Continuum of Care Supportive Housing Program. 12 apartments have been designated to the Shelter+Care program, assisting up to 21 individuals at a time with permanent housing. The Shelter+Care program recently added two additional beds to their inventory. These apartments are located in the Adams Woods Apartment Complex which is operated by the Hampton-Newport News Community Services Board, the same site as the Emergency Housing Program.

The Hampton-Newport News Community Services Board has three additional apartment complexes that it operates: Queens Court, Dresden, and Bay Port Apartments with mental health case management and PACT on-site services as needed and enrolled. Queen's Court houses up to 30 individuals; Bay Port has 16 units, and Dresden 32 units. PATH clients are eligible to apply for these permanent housing programs. Referrals to residential services can be generated by the PATH staff. PATH funds assist PATH clients accessing housing options, if necessary.

The PATH Outreach Specialist is well trained in assisting PATH clients in the application of both public and private market housing by helping to obtain needed documentation and identification for the application and assisting with denials and turn-downs by advocating on behalf of PATH clients and filing appeals. Additionally, the PATH Outreach Specialist attempts to stretch the shelter stay and emergency housing stay to meet the waiting period of most housing lists. The PATH staff advocates for the mentally ill homeless population with different housing providers. The PATH staff also links to additional supportive services to help reduce the risk of the client not maintain their housing.

In 2003, HNNCSB was awarded a HUD Supportive Housing grant to provide a Safe Haven, a

housing first model. This 22-bed program operates in leased units in the city of Hampton and Newport News, and provides housing and service-engagement strategies for PATH clients. The PATH staff is the referral source for participants and continues to provide case management services, along with the Safe Harbors staff, until the individuals indicate a readiness for mainstream mental health services. The HNNCSB also operates a 16 bed permanent supported housing program for individuals exiting the Safe Harbors program or those from the street but are easily engaged.

As well, the HNNCSB provides a housing oversight program of area boarding homes on behalf of clients. In this capacity the HNNCSB helps to ensure that safe and decent housing is provided within these unlicensed settings, assists in the resolution of conflicts between the resident and landlord and helps to assist with transition from boarding houses to other housing options. In addition, PATH funds assist PATH clients with some housing rental assistance to obtain housing in these boarding homes.

The HNNCSB with the NNRHA manages a 48 unit apartment complexes for the disabled and/or elderly. Three Shelter+Care apartments are now located in this complex. The homeless population receives a priority at this complex.

i. If you plan to implement one or more Virginia PATH Innovative Practices, indicate which one(s) and describe the implementation plan:
Providing SSI Outreach Services to PATH Clients (SOAR)

☐ PATH staff completed SOAR training and has been using SOAR since 2005.
☐ PATH staff provides full assistance with SSI/SSDI applications using SOAR since 2005.
☐ PATH staff has contacts & formed effective working relationships with DDS & SSA staff.
☐ PATH has effective relationships with practitioners providing DDS consultative exams.
☐ PATH assists clients with appointments and exchanges information with practitioners.
☐ PATH provides data to State contact on SSI activities as an attachment to the PATH quarterly report.

The PATH team has developed an outreach partnership with multiple downtown feeding, cleaning, and disbursement centers, including: Clean Comfort where the homeless can go to shower and clean their clothes, PORT and A Night's Welcome – 2 winter shelter programs, all area emergency and transitional shelter programs, the Veteran's Administration, Health Care for the Homeless, Health Care for Homeless Veterans, Departments of Human Services, Crisis Stabilization, and Crisis Intervention Team – where PATH staff assist in this nationally acclaimed training for Police Officers.

The PATH team focuses on street outreach visiting campsites, abandoned buildings, and other places not meant for human habitation on a regular basis. They take food, cooking supplies, clothes, and other useful household/personal care items. They engage people slowly and earn their trust so that they will be more willing to connect to services.

The PATH program receives on average 3-6 referrals a week from the crisis stabilization unit. Local emergency rooms and the police will contact the PATH staff for people in the emergency

room that they feel may need the services. The staff visits the emergency rooms to determine if the person is appropriate for PATH services. The HNNCSB also sets aside one day a week focusing on "walk-in" service where the homeless can obtain food and supplies and talk to a PATH staff person if desired without an appointment.

j. Briefly describe your plan for providing the following PATH-allowable services:

Outreach:
Outreach is provided by the HNNCSB PATH staff to all area shelters, soup kitchens, day programs, churches, woods, bridges, abandoned buildings and other areas frequented by homeless people. "In-reach" is provided every Wednesday at the HNNCSB for walk-in appointments. "In-reach" clients have been referred by other community agencies or by word of mouth from the homeless population.

Screening and Diagnostic Treatment:
Outreach/In-reach services include mental health and substance abuse screenings, clinical assessments, and diagnostic services to best identify appropriate services and referrals.

Habilitation and Rehabilitation:
Referrals for PATH clients are made to two area substance abuse day treatment groups: Partners in Recovery and Next Step outpatient treatment. PATH clients also can receive one-on-one mental health counseling at the HNNCSB dual diagnosis clinic. Mental health referrals are made to the Partial Hospitalization Program; and educational programs and services. All the above programs accept dual diagnosed clients. PATH clients who are veterans are linked to rehabilitation programs at the Hampton Veterans Administration Medical Center. These services are not PATH funded but are available to the PATH clients.

Community Mental Health Services:
Referrals and linkages are provided for all PATH clients to community mental health services following assessments by PATH staff.

Alcohol or Drug Treatment Services:
Referrals are made to outpatient treatment, residential treatment, and case management services targeted for individuals with substance use disorders. Services are offered to pregnant women and post–partum women who need substance abuse treatment, through HNNCSB's Project Link and the Southeast Family Project. These programs also accept dual diagnosed clients. In addition, PATH clients have access to two area Drug Courts – one in Hampton and one in Newport News. PATH will also make referrals to the H-NN Crisis Stabilization program, Norfolk Crisis Stabilization program and to the Virginia Beach Recovery Center. Both programs offer a stabilization program for the dual diagnosed client. The stay at both of these programs can be up to 14 days.

Staff Training:
HNNCSB PATH outreach staff provides training, upon request, to other entities to help coordinate services and to best serve the target population. PATH participates in the training of police officers enrolled in Crisis Intervention Training (CIT). This nationally recognized program offers instruction, information, site and provider visits, role playing exercises and extensive resource materials. PATH staff provides information and training for each of the week-long course.

Case Management:
The PATH outreach staff provides community based case management services until such time as the client becomes fully engaged in mental health services and is willing to be

referred to mainstream case management services.
Supportive and Supervisory Services in Residential Settings: HNNCSB PATH outreach staff works with Mental Health Residential Services to assist PATH clients with transitioning and maintaining housing placement for the first several months of their residency. PATH staff provides referrals and placement in HNNCSB emergency housing and area shelters. They assist clients with applications and placement in transitional or permanent supported housing and provide housing counseling. HNNCSB is participating in the regional Prevention and Rapid-Rehousing projects that help provide limited rental assistance to gain access to housing. Other Support Services include bus tickets and/or transportation to appointments, medication purchases, food, clothing, personal care purchases, and help with payment of eye and dental services. These services are provided to PATH clients in shelters, residential settings, and to those living on the streets or other non-residential settings.
Minor Renovation: This service is provided to PATH clients but is not PATH funded. Linkage is made to other community resources for these services by the PATH staff. This activity is handled through collaborative partnerships with local PHA's and the Office of Human Services.
Planning of Housing: HNNCSB PATH is an integral partner in the HNNCSB Office of Property and Resource Development process. Through ongoing OPRD planning and assessment, the full continuum of housing options – from emergency shelter to private market housing is discussed and developed. Through this process, a system was developed to oversee private boarding house operators. Also, HNNCSB developed and operates its own Emergency Housing, Shelter Plus Care, Safe Haven, and Permanent Supported Housing programs and has opened three apartment complexes, 16, 32 and 48 units, for persons with disabilities, in order to expand housing opportunities for HNNCSB consumers. The PATH Program Director, Manager and Supervisor are participants in this on-going and long-range planning process. PATH staff is also extensively involved in the Continuum of Care Housing Resource Committee which is involved with regional housing planning efforts. The Director of Property and Resource Development is on the state VHDA Disabilities Housing Solutions Council, the VHDA Multifamily Advisory Council, VHDA Seniors Housing Solutions Council, and Creating Opportunities Housing Committee, the Governor's Discharge Policies Council – Housing Committee, and the regional Mayors and Chairs Commission on Homelessness.
Technical Assistance in Applying for Housing: All PATH clients are eligible to receive technical assistance when applying for housing, if they request assistance. This includes support filling out applications, attending interviews, obtaining identification and follow up to track the status of the application. On PATH "in-reach" days the telephone is available for existing PATH clients to make contacts with community and housing agencies.
Improving the Coordination of Housing Services: HNNCSB PATH staff is an active member of the area Greater Virginia Peninsula Homelessness Consortium (GVPHC). The GVPHC provides monthly interagency opportunities for regular discussions among housing providers of the target population. Subcommittees of the Task Force on Homelessness include: Permanent Housing, Coordinated Services, HMIS Oversight, Advocacy, and Project Monitoring and Review. The HNNCSB PATH staff participates in all these meetings, committees, and discussions. The

PATH Supervisor was elected and serves as the co-chair for the entire organization. This regular interaction and coordination has resulted in a new and improved referral process and the development of several housing projects for disabled and chronically homeless individuals, including the HNNCSB-operated Safe Harbors and Project Onward, and Shelter +Care housing projects. In addition the PATH Supervisor is part of the regional SCAAN team (Shelter Coordination and Assessment Network) – which evaluates the needs of new shelter residents quickly developing appropriate and coordinated services and rapidly finding housing. This innovative and collaborative triage team reduces the time individuals and families experience homelessness.

Security Deposits:
Security deposits are a service provided by HNNCSB PATH program and other funding sources. Referrals are also made to both Hampton and Newport News Departments of Human Services housing programs, and Homelessness Prevention Program grant project. Referrals are made to other community resource sources to help PATH clients obtain these funds.

Costs Associated with Matching Eligible Homeless Individuals with Appropriate Housing Situations:
These costs can be obtained through PATH funds or by making referrals to other community resources such as Rapid Rehousing funding. Several area non-profits assist with housing costs. Several churches in the area have furniture and household goods warehouses. HPP funds are available in Hampton and Newport News. The local United Way has a consumer credit program to assist with credit issues. Past bills with previous housing can be paid through these resources as well as support from local churches. Advocacy is a good tool to use with previous and future landlords. For housing projects operated by HNNCSB, furniture and household items are paid for through PATH or other grant funds so that the individuals have all essential items. The HNNCSB is constantly looking and applying for grants and other programs to assist with costs.

One-time Rental Payments to Prevent Eviction:
Again, this service can be accessed by all PATH clients through our local HPP, FEMA, and other community resources, such as DHCD rapid re-housing and prevention funds. HNNCSB PATH has paid rental payments to avoid eviction.

Referrals for Primary Health Services, Job Training, Education Services and Relevant Housing Services:
All clients receive referrals and linkages to appropriate medical, dental, health, housing, and vocational services following assessments by PATH staff. Some of the referrals are to the Free Clinics, local health departments, Health Care for the Homeless, and SEVHS. Job training and education referrals include DRS, Vocational Services, local education programs and GED classes. Housing service referrals include the Hampton Redevelopment and Housing Authority, Newport News Redevelopment and Housing Authority, local disability housing providers, HUD & CoC-funded low-income private housing providers, HNNCSB permanent supported housing and other permanent housing providers, Assisted Living Facilities, Elderly and Disabled Housing providers, and private market housing.

6. HMIS Data Integration: Describe your HMIS transition plan, with accompanying timeline, to begin using HMIS to collect and report PATH data in HMIS by July 1, 2016. If you are fully utilizing HMIS for PATH services, please describe plans for continued training and how you will support new staff. Indicate any technical assistance needs you

may have in meeting the HMIS data requirements.

The HNNCSB PATH program, for the 5 years prior to last year, entered data into HMIS on all enrolled PATH clients, but was advised to stop that practice until the PATH program decided the data points. Earlier this year, data points were decided and April 1, 2015 the HNNCSB PATH program once again began full utilization of the HMIS system. FY 2016 the HNNCSB plans to add contacts to HMIS as well. Training, equipment, and HMIS licenses are provided to the PATH staff to ensure data is entered quickly and appropriately. The PATH manager and supervisor designed the PATH enrollment sheet to match HMIS required data fields so that the data can be taken from the intake forms and inputted into HMIS by the PATH supervisor or the trained PATH staff. The HNNCSB participates in the Continuum of Care HMIS subcommittee and attends all meetings. The information entered is reviewed via reports from the HMIS provider at least once a month at the CoC HMIS committee meeting, which the PATH supervisor attends. New staff attends a formal one-on-one training with the HMIS provider for the region. The PATH supervisor provides support in the work place and if needed additional training can be obtained through the regional HMIS provider. Currently the HNNCSB does not require any technical assistance, but if needed the HMIS administrator will be contacted for assistance.

7. SSI/SSDI Outreach, Access, Recovery (SOAR): Describe your plan to train PATH staff on SOAR. Indicate the number of PATH staff trained in SOAR and the number of PATH-enrolled consumers assisted through SOAR during State Fiscal Year 2013, and the approximate number of staff to be trained in SOAR for State Fiscal Year 2015.

Currently the PATH Supervisor is trained in SOAR, and is currently processing SOAR applications. The PATH team plans to train the new Outreach Specialist in SOAR in FY 2016. There are no plans to add the PATH assistant to the SOAR team in 2017 at this time. The HNNCSB has other non-PATH homeless staff members, who are trained in SOAR and who assist PATH clients. In FY 2015 the PATH staff collectively assisted 12 PATH clients through the SOAR process.

8. Program demographics and cultural competency: Describe the following.

a. The demographics of the target population.
The demographics of the target PATH population are as follows:

- American Indian or Alaska Native NN 0.5% Hampton 0.4%
- Asian NN 3% Hampton 2.2%
- Black or African American NN 40.6% Hampton 49.6%
- Hispanic or Latino NN 4.2% Hampton 4.5%
- Native Hawaiian or Other Pacific Islander: NN 0.2% Hampton 0.1%
- White NN 51.1% Hampton 42.7%
- Other NN 0.4% Hampton 0.5%

b. The demographics of the staff serving PATH consumers.
The Supervisor of Homeless Services is a Caucasian female. PATH staff consists of one African American female (outreach specialist) and currently the assistant position is vacant and being advertised. The Outreach Specialist for Newport News, who works with the PATH staff, is an African American male. Through this combination of staff the majority of the target population's demographics are represented.

c. How staff providing services to the target population will be sensitive to age, gender and racial/ethnic differences of consumers.

To increase racial/ethnic competence, the Hampton Newport News Community Services Board requires staff training to address the issues of diversity. It is an annual mandatory training for all employees in addition to Human Rights and Confidentiality Training. A broad range of community resources aids the PATH case manager and outreach assistant with linkages to services that address the areas of race, religion and culture. The PATH staff has the knowledge and experience of supervisors and other staff as an available resource for consultation if needed.

The region's immigrant population has been growing over the past year, particularly the Latino/Latina community. To ensure that language is not a barrier the PATH staff utilizes translation services. These services are provided by existing HNNCSB staff or through other community agencies. The region has also experienced an increase in the Asian population and interpretation services can be obtained through local refugee agencies. Most key HNNCSB written materials have been translated into Spanish. The HNNCSB contracts with a teacher who provides on-site American Sign Language classes to interested staff members on a regular basis. The HNNCSB is also adding a language line which will provide interoperation services for most languages.

As part of regular HNNCSB program evaluations, PATH clients are asked to complete Consumers Satisfaction Surveys. The PATH Supervisor ensures that these surveys are distributed, collected, the results analyzed, and suggestions incorporated into the program.

Two formerly homeless individuals and formerly PATH clients have been members of the Local Human Rights Commission. Consumers and/or family members are currently on the HNNCSB Board of Directors. Two formerly homeless individuals are members of the HNNCSB Consumer and Family Advocacy Council which has been an active participant in communicating the needs of homeless individuals and persons with disabilities with regard to program development. Homeless and formerly homeless individuals with disabilities and PATH clients participate in Community Meetings addressing operational and policy issues. The meetings are chaired by consumers, including one formerly homeless chairperson. The HNNCSB has hired several formerly homeless individuals through consumer-hire positions or regular staff positions. In this capacity, these program support staff provides valuable information with regard to the development, management, operations, supervision and evaluation of programs appropriate to meeting the service needs of individuals with regard to the diversity of those needs of consumers.

The HNNCSB has created a Peer Recovery Services program that works with all HNNCSB programs, including PATH, to assist with meeting the diverse needs of people served. Wellness Recovery and Action Plan workshops and classes are presented with special groups for women, younger adults, and children. Peer Recovery Services holds training for HNNCSB to assist all staff gaining increased knowledge and skills working with the diversity of the clients served.

HNNCSB is the host site for the local National Alliance for the Mentally Ill (NAMI) chapter, providing staff support to this important advocacy group. NAMI Hampton-Newport News meets the first Monday of every month at the Community Services Board. Information on NAMI is

available to family members and participation is encouraged.

d. The extent to which PATH staff receive training in cultural competence.

Experience - HNNCSB has provided services to the target population for well over 20 years – through PATH and as one of only 18 national ACCESS Demonstration Project sites from 1994-1999, then through the development and management of extensive homeless housing programs. As evidenced by the many positive outcomes, such as the high percentage of placement of PATH clients in permanent housing, staff and agency administration demonstrate extensive knowledge of the needs of the target population and the resources to serve them throughout the region.

Training and staffing - To increase cultural competence, the Hampton Newport News Community Services Board offers staff training to address the issues of diversity. It is mandatory for all employees to attend Cultural Diversity Training annually in addition to Human Rights and Confidentiality Training and the new Person Centered training. A broad range of community resources aids the PATH case manager and outreach assistant with linkages to services that address the areas of race, religion and culture. The PATH staff has the knowledge and experience of supervisors and other staff as an available resource for consultation if needed.

Language – The region's immigrant population has been growing over the past year. This has been handled through existing CSB staff or through other community agencies. The region has an increase in the Asian population and interpretation services can be obtained through local refugee agencies. The HNNCSB's Limited English Proficiency Plan has been reviewed and approved by CARF and the VA Department of Rail and Public Transportation. The HNNCSB also has a LEP Title V plan in place.

Materials – The HNNCSB during the annual training provides and utilizes a wide variety of materials. The staff also utilizes materials when engaging the population that are gender, age, and culturally appropriate. For example, the HNNCSB provides clients rights in several different languages and for those with limited literacy a picture version is available as well as a verbal review via staff member.

Evaluation- As part of regular HNNCSB program evaluations, PATH clients are given Consumers Satisfaction Surveys to evaluate for deficiencies in the program. The PATH Supervisor ensures that these surveys are distributed, collected, the results analyzed, and suggestions incorporated into the program.

Community representation and Implementation - Two formerly homeless individuals and formerly PATH clients have been members of the Local Human Rights Commission. Consumers and/or family members are currently on the HNNCSB Board of Directors. Two formerly homeless individuals are members of the HNNCSB Consumer Advocacy Council and has been an active participant in communicating the needs of homeless individuals with regard to program development. Homeless and formerly homeless individuals and PATH clients participate in community meetings addressing operational and policy issues. The meetings are chaired by consumers, including one formerly homeless chairperson. The HNNCSB has hired several formerly homeless individuals through consumer-hire positions or regular staff positions. In this

capacity, these program support staff provides valuable information with regard to the development, management, operations, supervision and evaluation of programs appropriate to meeting the needs of homeless individuals.

HNNCSB is the host site for the local National Alliance for the Mentally Ill (NAMI) chapter, providing staff support to this important advocacy group. NAMI Hampton-Newport News meets the first Monday of every month at the Community Services Board. Information on NAMI is available to family members and participation is encouraged. HNNCSB also hosts the local Substance Abuse and Addiction Recovery Alliance chapter.

To increase cultural competence, the Hampton Newport News Community Services Board offers staff training to address the issues of diversity. It is mandatory for all employees to attend Cultural Diversity Training in addition to Human Rights and Confidentiality Training. A broad range of community resources aids the PATH Outreach Specialist and Outreach Assistant with linkages to services that address the areas of race, religion and culture. The PATH Outreach Specialist and Outreach Assistant have the knowledge and experience of supervisors and other staff as an available resource for consultation if needed. In addition, staff members working with PATH attend annual Fair Housing and Virginia Landlord Tenant Act workshops to keep current on issues that continue to impact PATH consumers due to race, culture, disability, ethnicity, etc. PATH staff and Supervisor attend the annual national Health Care for the Homeless Conference where additional training is obtained including cultural competency information.

e. The extent to which the organization adheres to the Culturally and Linguistically Competent (CLAS) Standards. The CLAS standards can be accessed at http://www.ThinkCulturalHealth.hhs.gov.

The HNNCSB ensures that clients receive effective, understandable, and respectful care in a manner compatible with the cultural health beliefs and practices and preferred language of the client. Consumers are given a copy of their patient rights annually and it is explained in their preferred learning method. Human Rights and other forms provided in a variety of languages and platforms to ensure that the consumers are fully informed. Translation services are offered as necessary and requested when reading forms and consents. An example of this is a picture Human Rights form for those individuals who cannot read. Translation services are also provided by staff and other non-profits in the area for those with English as a second language. Grievance procedures are also provided in this manner and consumers can be assisted by staff members in filling out a complaint form. Staff is trained annually on cultural awareness through online and class room core training. For most staff "Person Centered Care" was added to the training curriculum. The HNNCSB continually develops and plans for culturally diverse care. The HNNCSB VI plan for Limited English Proficiency was reviewed and approved in 2012 by CARF and the VA Department of Rail and Public Transportation. The agency also plans and develops resources and data utilizing the EMR to determine gaps in programs, policies and procedures that are provided to the diverse consumers served. Data on the patient's race, ethnicity, spoken and written language are collected in this system as well. The HNNCSB goes to great lengths to provide culturally competent and respectful care on all levels.

9. Consumer and Family Involvement: Describe how individuals who are homeless and have serious mental illnesses, and family members will be involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For

example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards. (See attached Appendix I – Guidelines for Consumer and Family Participation.)

Program Mission - HNNCSB believes strongly in the policy of including homeless and formerly homeless persons in the operations and policy development of our services, to the extent that their opinions affect decisions at all levels of the organization. HNNCSB does not include homeless/formerly homeless persons because it is required – but because it is good business.

Program Planning - PATH clients, living in the HNNCSB Emergency Housing, are responsible for the daily operation of the shelter. These homeless individuals plan the shopping, cooking, and menu planning. They determine chore lists and community living rules with PATH staff helping to ensure that the rules are followed. House meetings are held to allow residents to work out conflicts and handle interpersonal issues; staff is available to mediate the proceedings.

PATH clients participate in the development of their own Individual Service Plan which identifies various goals and outcomes the resident hopes to obtain, including mental health/substance abuse services, housing, obtaining appropriate benefits, and vocational/ employment goals. Family members are encouraged to participate in treatment planning when consent is given by the client and confidentiality of all parties adheres to policy.

Training and Staffing – All staff at the HNNCSB is extensively trained each year on a number of various issues, including consumer's rights and family issues. The HNNCSB believes that all employees are valuable assets, but especially those that have utilized the services, and therefore has a number of employees that are active or past consumers. Consumers are also included in the CIT training offered to first responders through the HNNCSB. They provide a critical point of view and service in these training courses.

Informed Consent - At intake consumers are fully informed about the services that are offered at the HNNCSB and those services are provided on a voluntary basis without threats or coercion, and the consumer may receive or reject services at any time.

Rights Protection - At intake consumers and family members are informed verbally and in writing of their rights concerning services, information disclosure, treatment options, their right to choose the most appropriate services in their opinion, confidentiality policies and contact names, addresses and phone numbers for complaints, appeals, and consumer advocates.

Program Administration - The HNNCSB has a Consumer and Family Member Advisory Council that works to provide guidance and oversight to the organization. Consumers and/or family members sit on various projects and companies associated with the HNNCSB. A formerly homeless individual heads up the Peer Recovery Services Program at the HNNCSB. Peer Specialists are currently working at the Crisis Stabilization Unit, PACT, Psychosocial Rehab, and Residential Services.

Program Evaluation – As part of regular HNNCSB program evaluations, PATH clients are given Consumers Satisfaction Surveys. The PATH Supervisor ensures that these surveys are distributed, collected, the results analyzed, and suggestions incorporated into the program. A

Peer Specialist works on the Quality Management Team.

Two formerly PATH clients have been members of the Local Human Rights Commission. Consumers and/or family members currently sit on the HNNCSB Board of Directors. Two formerly homeless individuals sit on the HNNCSB Consumer and Family Advocacy Council and has been an active participant in communicating the needs of homeless individuals with regard to program development. Homeless and formerly homeless individuals and PATH clients participate in community meetings addressing operational and policy issues. The meetings are chaired by consumers, including one formerly homeless chairperson. The HNNCSB has hired several formerly homeless individuals through consumer-hire positions or regular staff positions. In this capacity, these program support staff provides valuable information with regard to the development, management, operations, supervision and evaluation of programs appropriate to meeting the needs of homeless individuals.

10. Outreach to Homeless Veterans: Describe how your PATH program identifies and outreaches to homeless veterans with SMI, and the services available to them in your catchment area. How does PATH interface with your veterans' service continuum?

The HNNCSB PATH team interfaces and treats homeless veterans with SMI the same as all other PATH clients. Most veterans are already connected to services so they are ineligible for PATH services but the PATH team will still assist them in resource location. For those who are eligible the team works to connect them to required and requested services including but not limited to the VA, Wounded Warrior, HNNCSB, and other community programs. The HNNCSB staff works extensively with the veteran service continuum in the area through the Continuum of Care, the regional VA, and the local Military Affairs Committee. The HNNCSB also is working with the VA on the new Ending Veteran Homelessness Campaign that began at the end of 2014. The resource development specialist attended and participated in the planning process and the Director of Property and Resource management is on the state leadership team. One of the homeless services providers and the resource development specialist are currently participating in the campaign, connecting veterans to services and preforming assessments. During the 100 day challenge the region housed 136 homeless veterans, some of them located and referred by the PATH team. The HNNCSB PATH team and homeless services department intends to continue its effort to outreach and identify homeless veterans with SMI.

11. Describe your PATH program's efforts to minimize the challenges and foster support for PATH clients with a criminal history, such as collaboration with local jail diversion and/or other programs. If you can, estimate the percent of PATH clients with a criminal history.

The HNNCSB employs staff who are housed in both city jails and the regional jail. They also work with multiple diversionary programs. If a PATH client is incarcerated, staff is notified and depending on the charges works to mitigate the issues either through diversion or other jail-based mental health resource. PATH works to keep clients out of jail, but several charges, compounded by unpaid fines, can lead to several months in jail. PATH staff can contact the jail-based services staff to facilitate on-going communications and contacts with the PATH client. The client is welcome to return to the PATH program upon exiting the jail system if this happens. The PATH team works with Newport News and Hampton probation and parole to

assist individuals with mental illnesses and substance abuse disorders, during reentry planning and activities. PATH staff also serves on the Newport News Police Homeless Team to help with understanding and developing linkages to resources and programs.

The HNNCSB also provides a week-long training to the police and sheriffs deputies called Crisis Intervention Team training. During this training law enforcement staffs learn how to identify and successfully manage a person with mental illness to de-escalate situations and resolve potential criminal charges if possible. CIT is a best practice assisting first responders when responding to incidents with persons who are homeless and/or have behavioral health issues and crises. PATH participates in a portion of this training helping to inform and explain homelessness in the region – issues, resources, and agencies, as well as how homelessness affects those with behavioral health problems, and how police can interact with this population effectively.

PATH understands that criminal histories negatively affects access to housing, acceptance, and employment in the community. PATH works with local agencies to overcome barriers to these key needs, as well as to expedite the process of obtaining housing, employment, benefits, etc. Two such agencies that PATH collaborates with are the Office of Human Affairs VA Cares program for felons re-entering into the community and Workforce Development specializing in training for felons re-entering the work force. PATH works with housing providers to appeal unfavorable decisions and has success overcoming barriers and obtaining positive outcomes with this process. Of particular note is the linkage between PATH and HNNCSB Property Management which has an outstanding record assisting individuals with criminal histories overcome housing rejections and denials through the PHA appeal process.

PATH also works with the re-entry program with Department of Corrections during SCAAN meetings. This connection has proven helpful in restarting benefits prior to client/offender being released from DOC and helping to triage the client/offender needs when they re-enter the community.

We estimate that at least 85% of PATH clients have some type of criminal history.

PATH Site Name: Hampton-Newport News CSB					
Budget FFY 2016/SFY 2017 (2016-2017 PATH Year)			PATH		Match Source
Staff Title	***Annualized*** Salary	FTE	Funded	Match	(Cash or In-kind)
PATH Outreach Specialist	$39,035	1.00	$39,035	$0	cash
PATH Outreach Assistant	$21,776	1.00	$21,776	$0	cash
Resource Dev. Specialist	$56,515	0.05		$2,826	cash
Clinical Serv. Admin	$87,209	0.05		$4,360	cash
Total Staff Salary	$204,535	4	$60,811	$7,186	
Fringe	$67,997		$19,396	$3,585	
	Total Personnel		**$80,207**	**$10,771**	
Travel (Outreach travel, travel for training, state meetings, etc.)					
Use of Agency Vehicle and staff mileage - Outreach			$3,500	$0	cash
	Total Travel Costs		**$3,500**	**$0**	

Equipment (Personal property/equipment having useful life of more than one year)			
Internet	$130	$0	
Total Equipment Costs	**$130**	**$0**	

Supplies (Office Supplies, Outreach Supplies, Computer Software)			
Office Supplies	$500	$150	cash
Outreach Supplies	$3,000	$0	cash
Total Supplies Costs	**$3,500**	**$150**	

Contractual			
Security	$3,000	$0	cash
Cell Phones	$1,500	$0	cash
Total Contractual Costs	**$4,500**	**$0**	

Other (List and Describe Each)			
Medication Assistance	$2,000	$0	cash
Rental Assistance	$1,000	$0	cash
Bus Tokens and Client Transportation	$2,000	$0	cash
Staff Training (non-travel registration and costs)	$200	$90	cash
Administrative Costs	$4,789	$16,974	In Kind
Office Space Rental	$0	$15,255	cash
Total Other Costs	**$9,989**	**$32,319**	
Total Proposed Budget	**$101,826**	**$43,240**	Is match > or = to 1/3 of federal allocation?

Virginia PATH Local Intended Use Plan, FFY 2016/SFY 2017
PATH Program Year 2016-2017

1. Description of Provider Organization:
a. Name: Loudoun County Community Services Board (LCCSB)
b. Organization Type: Community Services Board (LCCSB)
c. Description of Services Provided: LCCSB is the provider organization. The LCCSB provides therapy, case management and support services to persons with mental illnesses, including those who are homeless through various treatment programs and treatment teams. The treatment programs available are Developmental Services, Emergency Services, Outpatient Therapy, Community Support Services, Mental Health Residential Services, Prevention, Psychosocial Rehabilitation and Substance Abuse Services.
d. Region Served: Loudoun County, to include Sterling, Hamilton, Hillsboro, Leesburg, Lovettsville, Middleburg, Purcellville, Round Hill and South Riding
e. Provider's experience in providing services to homeless/at-risk individuals and those with SMI and/or co-occurring SUDs: Our two FTE PATH clinicians have a combined 53 years of experience working with SMI, dually diagnosed populations. Their experiences range across numerous settings, including in-patient, in-home, community based, and street outreach services, which provide them with unique insights on the barriers to access and secure stable housing. The team's understanding of numerous micro and macro level barriers surrounding issues of homelessness also serves their ability to effectively advocate for their clients.
f. Description of housing or services that are specifically targeted to PATH-eligible consumers: PATH clinicians work closely with the local shelters (Northern Virginia area) for placement options that are conducive to their needs. PATH continues to partner with Loudoun County Department of Family Services (DFS) to expand the PSH (permanent supportive housing program). The program began in 2014 with only two apartments and three more were added shortly after. In fiscal year 2016 15 more units of PSH were added. Growth in this program is greatly needed to truly address the challenge of housing the county's most vulnerable residents. MHSADS staff applied for a DBHDS grant for PSH and the RFP was not awarded. PATH has worked closely with DFS to access available grants and provide technical assistance in housing applications. Eligible clients are referred to and assisted with navigating the DFS Local Only Shelter fund, which assists people with securing one month of rent in their time of transition. PATH also worked closely with DFS, the Continuum of Care, and local shelters with identifying clients eligible for state level funds, including the Homeless Solutions Grant, Homeless Prevention Program and Rapid Rehousing. The Loudoun County Friends of Mental

Health is another local non-profit group which provides stipends of up to $300 per month over a 6 month period or a one-time, lump sum. The stipend supports individuals diagnosed with a severe mental illness.

2. Program Budget and Federal Funds Requested: (Attach detailed budget using Excel file provided by DBHDS):

a. Amount of federal PATH funds requested: $50,182

b. Source and amount of Provider's minimum required 33% match funds: Loudoun CSB agency match $94,072

c. A brief narrative describing the items in the attached budget:
The budget reflects partial salary for one FTE PATH clinician, program operating expenses, training and related travel expenses, client emergency funds, food and supplies.

3. Collaboration with Local HUD Continuum of Care (CoC): Describe the organization's participation in the HUD Continuum of Care program, other local planning activities and program coordination initiatives, such as coordinated entry and coordinated assessment activities. If you are not currently working with the CoC, briefly explain the approaches to be taken by the agency to collaborate with the local CoC.

The Loudoun County Continuum of Care (CoC) meets regularly to discuss issues concerning homelessness among the various non-profit, faith based, government, and private groups advocating for the needs of our homeless citizens. The CoC serves to network and provide a consolidated support for any housing related initiatives in the Loudoun community. A major focus of the CoC is the coordinated assessment process for PSH.

The PATH program plays an active role in the Outreach, GAP, Point-In-Time, and Coordinated Assessment work groups within the CoC. The CoC completed the uniform screening/assessment and accompanying documents as part of the assessment process, including a Housing Assistance Referral Form, Housing Barrier Assessment, and a Service Levels Guide to help providers determine the level of assistance/support needed by homeless consumers. All of these practices support coordinated entry.

4. Collaboration with Local Community Organizations: Provide a brief description of partnerships and activities with local community organizations that provide key services (i.e., outreach teams, primary health, mental health, substance abuse, housing, employment, etc.) to PATH eligible clients, and describe coordination of activities and policies with those organizations. Provide specific information about how coordination with other outreach teams is achieved.
PATH has unique and valuable partnerships with numerous local community organizations:

1) Loudoun Free Clinic – provides free healthcare services to the uninsured and indigent in the community. It partners with local specialists and INOVA Hospital, as well as the University of Virginia Health System to provide medical care and treatment to our clients, as well as access to prescribed medical tests, procedures, and medications. PATH's partnership with the Free Clinic has led to an informal system where we consult

with the patient service coordinator to schedule PATH client intakes in cases of significant medical concerns. We work directly with all parties to facilitate the eligibility screening and will accompany clients with problematic behaviors to the facility and subsequent appointments there, if necessary.

2) Local Law Enforcement – PATH partners with the Leesburg Police and Loudoun County Sherriff's Office to obtain information relevant to identifying possible consumers with mental health issues. Their referrals have been helpful in targeting our outreach efforts to specific locations (e.g., tent encampments) and sometimes individuals.
3) Loudoun County Friends of Mental Health – PATH partners with LCFMH to target eligible clients with a serious mental illness for "A Place to Call Home" grant. We assess client's level of need, motivation, and degree of sustainability to determine if they would benefit from housing grants.

4) Loudoun Cares – A non-profit referral network that receives calls from PATH eligible clients in the community who are looking for assistance in things ranging from car repairs, emergency food to housing leads.
5) Good Shepherd Alliance, Volunteers of America (VOA), Loudoun Abused Women's Shelter - PATH works closely with the various shelter staff in Loudoun County to provide outreach, engagement, and linking to mainstream services. The case managers provide us with referrals to outreach and assess potentially eligible clients with a serious mental illness. VOA provides PATH with access to their shelter and drop in centers to outreach to clients, and then works closely with the case managers to support our mutual clients with their various needs and progress on identifying housing during their 89 day stay at the shelter.
6) PATH works closely with the Loudoun Mental Health Intensive Community Treatment Team (ICT) in order to provide outreach services within Loudoun County to engage individuals (independently and jointly). In addition, this past year, the ICT team joined the PATH team in conducting the PIT count. PATH had plans to do outreach with DFS and other CoC staff while conducting the PIT, however, the blizzard of 2016 prevented these partners from doing so.
7) Loudoun County Sheriff's Office personnel (CIT trained) partner with PATH to accompany staff during outreach activities.

5. Service Provision: Describe the plan to provide coordinated and comprehensive services to eligible PATH consumers. Please address the following information.

a. Projected number of adult consumers to be contacted with PATH funds: 100

b. Projected number of adult consumers to be enrolled using PATH funds: 65

c. Percentage of adult consumers projected to be "Literally Homeless", and activities to maximize the use of PATH funds to serve adults who are literally homeless as a priority population: 50%, PATH utilizes Listserve to supplement resources necessary to assist those that are "literally homeless."

d. Strategies that will be used to target PATH funds for street outreach and case management as priority services.

The PATH team determines the immediate needs of the consumers in the Loudoun County area. Every year the concerns change and being sensitive to the needs are vital in

strategic planning for street outreach and engagement. Most of the outreach agencies in the Loudoun community provide very similar items that are readily accessible.

We will create outreach tools that include backpacks, bug spray, cotton under garments, winter gear, handy wipes, and trash bags. The team will outreach to targeted "hot spots" like Starbucks, public library, bus stops, the wooded areas (W O &D, and neighborhood trails), airport and the locations identified by local law enforcement agencies.

Engagement by the team will incorporate motivational interviewing skills that will be creative, intuitive, and spontaneous. The initial engagement will include a physical health and safety check, review of basic needs, and distribution of the Loudoun Passport to Services. PATH often encounters consumers who are SMI, intractable, and resistant to support. Our team will continue to proactively monitor and triage the needs of these consumers. The team will triage and prioritize cases on a weekly basis through consultations and/or "grand rounds" where cases are analyzed during team meetings and targeted for additional support or outreach efforts.

e. Indicate whether your organization provides, pays for, or otherwise supports evidence-based practices and other training for local PATH-funded staff, including training and activities to support migration of PATH data into HMIS.

The PATH team will participate in an annual Ethics training offered to mental health providers. In support of advancing their knowledge, ability and skills in service delivery through evidenced based practices, PATH providers are trained in motivational interviewing. As required by MHSADS, the staff will complete HIPAA, Human Rights, Therapeutic Options, OSHA, CPR/ First Aid. The HMIS database is managed by Department of Family Services HMIS administrators, who will be providing updates and trainings as indicated.

f. Describe gaps in the current service system and how PATH will assist consumers in addressing those gaps.

Loudoun County does not have a substance abuse rehabilitation center, so the consumers with no insurance or income that are released from medical detoxification or "drunk tank" often relapse because of no long term recovery center.

Loudoun County does not have detoxification services. The Substance Abuse Services arm of the Department has contracted arrangements with detoxification and rehabilitation centers statewide to accommodate the emergent need with the SUD population**.** The PATH clinicians coordinate with the Substance Abuse Program Manager with placement and funding resources. Also the consumers will complete an application for community benefits and Medicaid. Once the Medicaid is approved, a referral will be completed for placement and treatment. In the meantime, PATH will support the consumer with recovery planning and accessing community AA/NA network.

Affordable housing is a major gap in resources for this population. The Affordable Dwelling Unit (ADU) program is an alternative to HCV or direct rental at full amount.

However three obstacles exist with this program for our consumers: 1) the applicant must have good credit; 2) many have existing criminal histories often making them ineligible; 3) there are not sufficient units available to access in the county. The market value of the apartment rentals in the county fluctuate based upon supply and demand; the units are above the affordable resources of the homeless consumers transitioning to self-sufficiency. Many resort to renting rooms, home sharing options, and extended stay settings.

There are limited medical services for PATH clients who are uninsured and lack income. Many access the ER and do not receive follow up care due to lack of insurance and/or funds to pay for medical services. PATH will connect consumers to the Loudoun Free Clinic or Healthworks (formerly Loudoun County Community Health Center) to provide care and follow up through the end of critical treatment. Some providers are pro bono or establish an income based scheduling system for payment. PATH works closely with these entities to empower clients to access regular medical care and treatment to avoid unnecessary hospitalization(s) and/or worsening of their condition which may undermine their stability in the community.

Prescription refills and medication maintenance funding is provided through Department of Family Services client emergency funding. There are limited funds for individuals who access this service, which caps out at $500.00 per year for individuals. The lack of financial resources for medical needs prompts the worker to access other agencies such as Loudoun Cares who solicits assistance from local churches. There are other granted resources that can be accessed through mental health agency and prescription companies (i.e., patient assistance programs). The coordination happens by the case managers and advocates involved with the consumers' case.

Public transportation services are limited in Loudoun County are cost prohibitive for our consumers. PATH clinicians have to get creative in accessing transportation options for people with limited income options that do not have their own vehicles. We coordinate with DFS and/or access PATH funds to purchase bus passes. PATH periodically coordinates with local shelters, thrift stores, and churches to solicit donated bicycles or funds to purchase affordable bicycles.

g. Describe services available for consumers who have both serious mental illness and substance use disorder.

PATH clinicians engage the consumer to assess mental status and effects of substance abuse. The contact can determine if consumer is a danger to himself or others. This contact may lead to coordination with the LCCSB Emergency Services Unit (ES) and/or law enforcement if there are safety and risk issues. Individual's actively using and/or experiencing withdrawal may be referred to ES and our Substance Abuse Teams to determine if they are appropriate candidates for County funded detoxification programs and/or residential treatment.

PATH clinicians and LCCSB clinical staff can connect co-occurring diagnosed consumers to our agency for an intake to receive outpatient substance abuse services, which include things like

individual, group and family therapy, as well as psycho-education. There are specific groups also offered to target the special needs of consumers with co-occurring disorders. PATH often times encounters consumers resistant to traditional outpatient SA treatment. We engage in motivational interviewing and help explore a client's willingness to change. PATH can connect clients to various recovery meetings and sponsors with some familiarity with their special needs. Schedules of substance abuse meetings (e.g., AA, NA, Alanon, etc.) in the local community are provided to the co-occurring diagnosed consumers.

The Intensive Community Treatment Team (ICT) also provides services to co-occurring clients who are generally more intractable and resistant to services. These clients have a history of non-compliance with traditional outpatient SA services and an inability to manage their illness, sometimes leading to psychiatric hospitalizations and/or interactions with law enforcement. PATH works closely with this team and has successfully transitioned multiple clients into this mainstream mental health service.

h. Describe strategies for making suitable housing available to PATH consumers (e.g., indicate the type of housing usually provide and the name of the agency that provides such housing).

The PATH clinicians will network with and advocate for the enrolled consumers motivated to access or maintain stable housing in the community. The case manager will provide resources during the assessment process and technical assistance with research, applications, meetings, and planning with this move. One helpful tool with searching for housing has been CraigsList®. Most consumers are not savvy with navigating social networking sites and viable options are found in this arena. The case managers will assess their computer competency, will demonstrate the program, will develop workable knowledge with them and link to other consumers who are efficient with the computer.

A previously mentioned strategy involves getting clients signed up for the transitional housing program via GSA known as Peace House. The wait list is usually long and can take several months or over a year before a person's name comes up if they are assessed to be good candidates for the program. Another promising source of housing assistance would come from the Friends of Mental Health, which is a private non-profit advocacy group who raise funds to provide housing assistance.

PATH has collaborated with DFS (Department of Family Services) to expand the pilot PSH (Permanent Supportive Housing)Program to house the most vulnerable of all Loudoun County residents. The program targets the chronically homeless who are also limited by a physical or psychiatric disability.

i. If you plan to implement one or more Virginia PATH Innovative Practices, indicate which one(s) and describe the implementation plan:

PATH has successfully piloted an integrative healthcare (iCARE) model with HealthWorks (Loudoun FQHC) as a way to provide behavioral and physical healthcare coordination. Patients are not turned away for an inability to pay and their treatment is comprehensive.

j. Briefly describe your plan for providing the following PATH-allowable services:

Outreach:

PATH worker and supplemental clinicians will outreach to designate areas and referred sites where homeless individuals are identified.

The PATH Program will engage consumers into treatment who do not access traditional services. The consumers will be identified via referrals, active outreach, including at the drop-in centers and shelters, as well as in-services to the community agencies that provide support and advocacy to the homeless community.

The active outreach will be conducted with a two-man team to the sites on the W O & D trail, malls, and side streets in neighborhoods. PATH will also coordinate with local law enforcement as needed, to target known locations and areas where officers have identified persons.

The outreach engagement strategy is developed by coordinating with the Loudoun Continuum of Care. This group has created a vision to collaborate all available resources for the homeless consumers in Loudoun County. The efforts of the team follow a mission to offer, with dignity, through education and collaboration a seamless network of understandable resources to all Loudoun County homeless consumers that encourage self-sufficiency. This group identifies gaps in services and provides alternatives to bridging the gaps and removing obstacles for the homeless consumers of Loudoun County. Some locations that consumers congregate to access resources in the community are libraries, resource centers, and transit buses.

The staff will provide the individual immediate resources, information flyers – Passport to Services with contact numbers, bus passes, and hygiene packs to increase visibility of the program. Additional information is provided to spread the wealth of knowledge about supports so PATH can be utilized in the community. We will implement preventative and proactive interventions to persons who are in need of support for basic needs, supportive counseling, consistent connection to establish supportive rapport, and referral to resources.

Screening and Diagnostic Treatment:

The screening process occurs throughout the case, including eligibility screening to comprehensive clinical assessment. The PATH outreach worker will have initial contact with the consumers via telephone or face to face and will complete their demographics, a "Needs Assessment," and formulate a diagnostic impression. PATH clinicians also provide 6-8 hours of direct face-to-face contact during in-reach at the Homeless Services Center, which provides them another point of contact for screening and assessment. These assessments will sometimes reveal that a consumer is not eligible for PATH services, which prompts a referral to a more appropriate level of services.

The outreach worker will receive preliminary information from community referral sources that assist with identifying the needs of the consumers. The PATH clinician will provide

support during the mental health center intake and transitional case management guidance until the consumer is opened to their permanent clinician in the CSB. Referrals come from numerous sources in the community, which provides valuable collateral information and opportunities for PATH staff to assess for client needs and possible crises. Loudoun County Mental Health Emergency Services adds crisis intervention support regularly to provide continuum of care throughout the system.
Habilitation and Rehabilitation: The needs assessment completed throughout the case management identifies the short and long term recovery goals of the consumer. Medical, safety, employment, and self-sufficiency plans are discussed and prioritized in the PATH plan. The rehabilitation services available through CSB services include Psychosocial Rehabilitation Services, which is an environment to stimulate recovery for the consumer. The CSB provides guidance with applications to the regional rehabilitation placements in the Commonwealth of Virginia. At times, funding is provided for the indigent consumer as to remove the barrier with the recovery need.
Community Mental Health Services: PATH services link consumers to mental health centers, support groups, and local community providers to include, but not limited to community wellness groups, AA/NA, pastoral counseling, grief and bereavement support, and self-help groups. PATH provides transitional support until the consumer has established clinical case management services and connection to mainstream services.
Alcohol or Drug Treatment Services: PATH services link the consumers to substance abuse treatment facilities in order to assist with detoxification, rehabilitation, and recovery. Following substance abuse rehabilitation completion, PATH provides transitional support and stability with assisting the consumer, family, and sponsors with pledge to recovery plan.
Staff Training: PATH staff members may provide in-service training to shelter staff, Continuum of Care committee members, Community Service Board, Emergency Services local emergency response teams, and homeless consumers. These trainings and presentations help identify the needs of the homeless consumers, increase community awareness, and provide effective information for improved service delivery.
Case Management: Motivational interviewing is the strategy used to identify the consumers changing needs and develops reasonable, workable plans for their transition and connection to mental health services, entitlements, and stable housing. The enrolled consumer agrees to work as a team with PATH clinicians and access resources that will aide in their transition to independence and stable housing. The collection of data, history, plans, entitlements, and connection to services is clearly documented in the electronic health care record. The HMIS data base collects the PATH contacts and activities in collaboration of federal efforts and incentives for

the homeless population. The team provides case management services to consumers until they are able to be served by an available and appropriate clinical system. The PATH case manager will assist the consumer with the needs identified from the needs assessment and consumer plan. The development of the plan includes goals chosen by the consumer and workable objectives the consumer can embrace. The PATH team will create plans during transition when the consumer chooses not to access the CSB for their mental health needs. Coordination of services is provided by the outreach counselor until they are no longer needed. Some consumers have an identified recovery system in their own network of providers that they developed independently.
Supportive and Supervisory Services in Residential Settings: The PATH Outreach services utilize an individualized transition plan to assist the consumers deemed appropriate for residential placement. The worker will refer the client to a residential program in the least restrictive environment that will address the consumer's needs and recovery goals. PATH will coordinate the placement and transfer of services with the consumer's team as the consumer may be considered active with PATH due to his imminent risk of homelessness. The PATH case manager will confirm attainment of the new mainstream service via follow up meeting with the consumer and the assigned case manager to close out the PATH related services.
Minor Renovation: n/a
Planning of Housing: Loudoun PATH responds rapidly to consumers housing questions. The consumers function on all levels and the team appropriately provides planning and technical assistance for permanent housing. A comprehensive plan for housing is developed with the consumer, supportive family members, shelter workers, and other supports involved in the case in relation to their capabilities and resources. An important aspect of the plan is to prevent poor planning and choices from earlier situation. The PATH clinician helps the consumer build on their strengths, develop a workable budget plan, and pursue housing options that they can maintain.
Technical Assistance in Applying for Housing: PATH supports enrolled consumers from start to finish with the applications for housing. PATH has supported consumers with application fees, negotiating landlord agreements, realtor fee adjustments, Housing Choice Voucher application process to completion, credit report gathering, criminal background checks, referrals to credit counseling with Virginia Cooperative Extension, housing searches, and first time home purchasing programs and additional case management supports where applicable.
Improving the Coordination of Housing Services: PATH provides extensive communication between different social agencies to support consumers on the streets, exiting shelters, or even those at risk of losing their housing. PATH

has formed a solid network of providers in the shelter system, DFS, realtors, and others in the community to increase awareness of housing opportunities, affordable rentals, housing shares, etc.

Security Deposits:
The PATH program does not currently have funding for security deposits, but works closely with DFS, churches, and community groups, such as the Loudoun County Friends of Mental Health. PATH has weekly contact with the DFS Emergency Support Unit, which provides rental assistance funds (i.e., Local Only Shelter Fund) and technical assistance with applying for state funds that come available for consumers accessing housing. PATH can also solicit donations from local community agencies and faith based groups, which has been made easier with the CoC Listserve. PATH also works with the Friends of Mental Health to access funds for eligible clients through their "Place to Call Home" grant.

Costs Associated with Matching Eligible Homeless Individuals with Appropriate Housing Situations:
The planning of housing has identified unexpected expenditures. The need for these costs will be assessed and determined via PATH case management. The Program will assist with access to furniture, emergency transportation, and credit issues. Again, the CoC Listserve has proved to be a valuable tool where we send out a confidential case vignette describing needs and community partners can respond in kind.

One-time Rental Payments to Prevent Eviction:
PATH will coordinate access to funding streams in the community in support of establishing permanent housing These consumers have been identified as being an imminent risk of homelessness and have obvious need. The Emergency Support Unit of DFS has access to funding to prevent eviction and the agency will coordinate the needs of the consumer as identified by PATH. PATH also accesses Loudoun County Friends of Mental Health and CoC Listserve participants.

Referrals for Primary Health Services, Job Training, Education Services and Relevant Housing Services:
The PATH clinicians complete a needs assessment with the client for supplemental services. As the plan develops, referrals will be provided, and if necessary assist the client with making the contacts to medical practitioners related to their healthcare issues. Also as clients return or enhance their education and careers referrals to Department of Rehabilitation Services and Loudoun Public School Vocational Training Center are made.
The PATH Program works closely with the local clinics, mobile health unit, emergency rooms and physicians who provide pro-bono or services on a sliding scale to the consumers in need. Consumers returning to the work force access the Department of Rehabilitation Services and the Workforce Resource Center programs in Loudoun County to reinforce skills and improve marketability for securing employment. The PATH team members provide transportation, supportive counseling, and proactive planning to assist consumers in the job search process.
PATH coordinates with Job Link, OAR, Crossroads Jobs and the Workforce Resource Center

to improve linkage to employers, skills training classes, and job search options.
The PATH Program is part of the integrative care (iCARE) pilot with HealthWorks (Loudoun FQHC) in order to provide comprehensive behavioral and physical healthcare.

6. HMIS Data Integration: Describe your HMIS transition plan, with accompanying timeline, to begin using HMIS to collect and report PATH data in HMIS by July 1, 2016. If you are fully utilizing HMIS for PATH services, please describe plans for continued training and how you will support new staff. Indicate any technical assistance needs you may have in meeting the HMIS data requirements.

Currently, we use a process that the HMIS Administrator (DFS) implemented. We utilize a limited export process that automatically opens consumers to Harmony from the County EHR. This does not assist in addressing the numerous other data elements needed to be gathered but does help tally the number of new openings in our HMIS system (Harmony). PATH attended two work sessions for HMIS implementation and multiple webinars. Continued training will be led by DFS to address questions by PATH clinicians.
Currently PATH is collecting data on a paper form template that mirrors Harmony. In May PATH will pilot data entry into Harmony. May and June will be the timeframe to resolve any issues/barriers for HMIS completion. By June 30, 2016 PATH Clinicians will be fully using HMIS for PATH services.
There are no identified technical assistance needs at this time. Continued training will be led by DFS to address questions by PATH clinicians.

7. SSI/SSDI Outreach, Access, Recovery (SOAR): Describe your plan to train PATH staff on SOAR. Indicate the number of PATH staff trained in SOAR and the number of PATH-enrolled consumers assisted through SOAR during State Fiscal Year 2015, and the approximate number of staff to be trained in SOAR for State Fiscal Year 2017.
We currently have one PATH Clinician trained in SOAR. The other PATH Clinician will complete SOAR training as soon as possible. One SOAR approval was granted for PATH-enrolled consumers during State Fiscal Year 2015.

8. Program demographics and cultural competency: Describe the following.

a. The demographics of the target population.

American Indian or Alaska Native:	0%
Asian:	0 %
Black or African American:	27%
Hispanic or Latino:	0%
Native Hawaiian or Other Pacific Islander:	0 %
White:	71 %
Other:	2 %

b. The demographics of the staff serving PATH consumers.
White: 100%

c. How staff providing services to the target population will be sensitive to age, gender and racial/ethnic differences of consumers.
The team is sensitive to the needs of the population based upon the collective personal and professional experience of the staff. The varied trainings encourage professionalism and ability to work with all demographics. No staff works alone and the team address clinical issues pertaining to competent, sensitive practice during our meetings and/or clinical supervision. PATH depends on our trainings, education and specialized experiences to offer comprehensive case planning and supports to the consumers. Consumer needs vary and as such the PATH Clinicians seek consults as necessary.

d. The extent to which PATH staff receive training in cultural competence.
The PATH clinicians respond with care and sensitivity to the needs of the homeless community. In the event that a cultural issue is an obstacle in supporting the transition of the consumer to successful placement and connections, the team will access knowledge from other PATH providers and agencies like the Multicultural Center of Fairfax, VA who have varied experience in addressing these challenges. Furthermore, the SAMHSA - PATH outreach resource portal is extremely helpful because it reviews a myriad of topics that focus the issues at hand. In addition, Cultural Differences in the Workplace training is provided and available by the Loudoun County Human Resources department and the CSB will incorporate cultural diversity training into Human Rights Training as to comply with the State training requirement for CSBs. And to support the sensitive engagement by the PATH clinicians and specialist, webinars and articles are accessed via the Policy Research Associates (www.prainc.com) website.

e. The extent to which the organization adheres to the Culturally and Linguistically Competent (CLAS) Standards. The CLAS standards can be accessed at http://www.ThinkCulturalHealth.hhs.gov.
The CSB offers cultural diversity training through our Human Resources Department. PATH and the rest of the MH/SAS/DS Department are required to complete an annual training called Target Solutions, which addresses issues concerning workplace diversity. The CSB has printed literature and forms both in English and Spanish, while providing access to the language line when consumers are trying to access mental health. A non-English speaking individual or family contacting the CSB for services requiring telephone interpretation will be routed to Universe Technical Translation, Inc. Consumers who are seen face to face and require interpretation will be connected to International Language Solutions for interpretation services. Written translation services may also be accessed via these vendors contracted by the CSB. The CSB's electronic health record also requires that we collect demographic information on the clients we serve.

9. Consumer and Family Involvement: Describe how individuals who are homeless and have serious mental illnesses, and family members will be involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For

example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards. (See attached Appendix I – Guidelines for Consumer and Family Participation.)

There are a few avenues for homeless consumers to access in order to provide feedback and convey needs 1) the Loudoun Community Services Board meeting, 2) the Loudoun Peer Council meeting, and 3) the Loudoun County Continuum of Care meeting. The CSB meeting is open to the public and allows open commentary. The Loudoun Peer Council describes their organization as "*We are not a program; we don't have a building or address; we are just people in recovery (peers) that want to help anyone suffering from mental health issues in Loudoun County."* It is open to all and is a conduit to the CSB to hear the voice of the consumer. The CSB incorporates the information received from the community and the consumer for improvement in PATH program development. All consumers are encouraged to contact the board and council. In addition, the CoC has a current consumer of homeless services as a representative member.

10. Outreach to Homeless Veterans: Describe how your PATH program identifies and outreaches to homeless veterans with SMI, and the services available to them in your catchment area. How does PATH interface with your veterans' service continuum?

PATH Clinicians screen every outreached individual for possible veteran status. If the veteran does not have possession of his or her DD214 then they receive assistance in getting this vital document. Depending on the needs and desires of the person, referrals are made to the VA Medical Center (WVA) and Friendship Place (DC). PATH has established a good rapport with the VA Medical Center outreach worker and as a result they will perform assessments in the field within a week. During this fiscal year DFS added a Veterans Services Coordinator position which significantly contributes to the veterans' service continuum. PATH refers veterans to that program for assistance.

11. Describe your PATH program's efforts to minimize the challenges and foster support for PATH clients with a criminal history, such as collaboration with local jail diversion and/or other programs. If you can, estimate the percent of PATH clients with a criminal history.

Loudoun CSB has Mental Health staff offices located at the Adult Detention Center (ADC). The Mental Health Clinicians coordinate re-entry with PATH Clinicians. PATH provides case management services immediately to this population in an effort to avert further contact with the criminal justice system. The Loudoun Workforce Resource Center (operated by DFS) has an educational program for overcoming employment barriers for individuals with criminal history.

At least 50% of PATH clients have a criminal history.

PATH Site Name: Loudoun Community Services Board					
Budget FFY2016/SFY2016 (2016-2017 PATH Year)			PATH		Match Source
Staff Title	***Annualized*** Salary	FTE	Funded	Match	(Cash or In-kind)
PATH Clinician	$65,766	1.00	$0	$65,766	
PATH Clinician	$60,388	1.00	$41,682	$18,706	
Total Staff Salary	$126,154		$41,682	$84,472	
Fringe	$43,775				
Total Personnel			**$41,682**	**$84,472**	$126,154
Travel (Outreach travel, travel for training, state meetings, etc.)					
Use of Agency Vehicle				$3,750	
Training Travel				$375	
Training Conference Costs			$1,000		
Total Travel Costs			$1,000	$4,125	$5,125
Equipment (Personal property/equipment having useful life of more than one year)					
Laptops				$3,445	
Total Equipment Costs			$0	$3,445	$3,445

Supplies (Office Supplies, Outreach Supplies, Computer Software)			
Minor Equipment	0	$450	
Outreach Supplies	1,750	$100	
Mailing/Printing	500	$100	
Food	600	$100	
Total Supplies Costs	2,850	$750	3,600

Contractual			
Cell phone service fee	0	200	
Laptop-Internet Service	0	540	
I-Pad-Internet Service		540	
Total Contractual Costs	0	1280	1,280

Other (List and Describe Each)			
Medication Assistance	500	0	
Identification related purchase costs (incl. Birth certificates)	250		
Rental Assistance	3,000		
Bus Tokens/Transportation	250		
Staff Training (non-travel registration and costs)	400		
Client Car Repair	250		
Total Other Costs	4,650	0	4,650
Total Proposed Budget	**50,182**	**94,072**	

Virginia PATH Local Intended Use Plan, FFY 2016/SFY 2017
PATH Program Year 2016-2017

1. Description of Provider Organization:
a. Name: Norfolk Community Services Board
b. Organization Type: Community Mental Health Center- The Norfolk Community Services Board (NCSB) is a department of the City of Norfolk and provides community based public mental health, intellectual disabilities and substance abuse disorders services.
c. Description of Services Provided: NCSB has over 44 years of experience planning, establishing, evaluating, maintaining, providing, and promoting the development of an effective and efficient system of Mental Health, Intellectual Disabilities, Substance Use Disorders, Prevention, and Rehabilitation services for the citizens of Norfolk. The NCSB provides a continuum of services including Prevention, Infant Development, Children's services, Emergency Services which is a twenty-four hour mobile crisis unit, Crisis Stabilization which is a community based short-term crisis unit, Intake and Outpatient Counseling, Integrated Care Clinic, Veterans Services, Opiate replacement, Case Management, Mental Health Supportive Services, Program of Assertive Community Treatment, Treatment Courts, and Crisis Intervention Team (CIT) Assessment Center. NCSB works collaboratively to ensure effective community partnerships within the City of Norfolk and with regional partners to ensure that persons who are vulnerable have access to an integrated system of services.
d. Region Served: Norfolk, VA
e. Provider's experience in providing services to homeless/at-risk individuals and those with SMI and/or co-occurring SUDs: The NCSB has been operating a Projects for Assistance in Transition from Homelessness (PATH) team, providing outreach and services to persons experiencing homelessness and mental health/ substance use disorders, for over 24 years. In FY 2014, the Norfolk CSB PATH program provided outreach to 248 individuals experiencing homelessness. Funding for the PATH program is performance-based and Norfolk's PATH team has been historically competitive in this area. The NCSB also has a Program of Assertive Community Treatment (PACT) team which provides an array of services through a multidisciplinary team of providers to over 100 consumers annually with serious mental illness and co-occurring disorders. Many of the consumers referred to PACT are at high risk of homelessness or enter the program while still homeless; the intensive services provided by PACT assist consumers with stabilizing their services and housing. Since 2002, Norfolk CSB has also operated the Shelter Plus Care Program which provides affordable housing with support services to persons with disabilities — including mental health and substance use disorders — for persons experiencing homelessness in Norfolk. Beginning in October 2015, Norfolk CSB began the Road2Home program. This is a 3 year federal grant to provide outreach, support and services to single adults experiencing homelessness and disabling behavioral health disorders. This also includes veterans. Norfolk CSB also has experience serving persons experiencing homelessness and who have mental health and substance use disorders as a portion of the consumers in other programs within its

service system.
These include, but are not limited to:
> Mental Health Support Services — Provides training in activities of daily living which assists consumers with securing and stabilizing housing in the community.
> Crisis Stabilization — Provides acute crisis services for those at risk of hospitalization or homelessness.
> Emergency Services — Provides crisis response in the community 24 hours a day, 7 days a week, 365 days of the year.
> Mental Health Case Management — Provides case management services that include referrals to community resources and coordination of care.
> Multiple housing options operated by CSB and Residential Options — Making transitional and permanent housing available to consumers of mental health and substance abuse services

f. Description of housing or services that are specifically targeted to PATH-eligible consumers:
Housing:
Shelter Plus Care: This is a HUD Homeless Program that provides vouchers for housing with support services for persons experiencing homelessness and have disabling conditions. PATH has the ability to make targeted referrals to this program operated by Norfolk CSB.

Regional Efficiency Supportive Housing "SRO" program (Gosnold, Cloverleaf, South Bay, Heron's Landing and Crescent Square): These buildings have identified units for persons experiencing homelessness from Norfolk. The PATH program helps to facilitate referrals and assists persons in accessing this housing resource operated by Virginia Supportive Housing.

Housing First "My Own Place": This is a program launched by Norfolk CSB in partnership with the Office to End Homelessness in 2008 and is operated by the partner non-profit, Virginia Supportive Housing. Although the program is open to persons of all disabilities that meet Chronic Homeless criteria, the Norfolk PATH program is considered a primary referral source and a partner in outreach and engagement for this program.

The City of Norfolk's Office to End Homelessness HOME – Tenant Based Rental Assistance Program. This program assists persons experiencing homelessness with rental subsidies while PATH connects them to stabilization services and case management services so they may become self-sufficient through increased income and/or more permanent subsidy.

NCSB continues to work with the City of Norfolk and Norfolk Redevelopment and Housing Authority to identify new opportunities to increase housing opportunities for PATH-eligible consumers.

Road2Home Permanent Supportive Housing funds-PATH clients that are also Road2Home eligible can also be considered for a housing voucher with ongoing Road2Home staff support.

Services:
Along with PATH-Provided Outreach, Engagement, Case Management, and Housing

Acquisition, the Norfolk PATH program has SSI/SSDI Outreach, Access, and Recovery (SOAR) Certified staff. Norfolk CSB is also a Governors Access Plan (GAP) enrollment site and provides direct outreach to access this benefit.

Although not targeted to PATH-eligible individuals, persons needing a service transition are able to be served regardless of their housing status by our community programs for mental health and substance use disorders. Services range from acute interventions such as Crisis Stabilization to more ongoing stabilization services such as mental health and substance abuse case management, wellness, integrated care between psychiatry and primary care, support services, and the newly enhanced programs with peer support services. The newly developed Crisis Intervention Team partnership with the Norfolk Police Department will provide a new point of entry and engagement with connection to ongoing services in NCSB programs.

Norfolk CSB has also worked to decrease or eliminate barriers to treatment access through rapid or when possible same day intake and rapid referral to critical services. The implementation of the GAP program has greatly benefited PATH consumers, providing an insurance product to increase options for accessing treatment and medications.

2. Program Budget and Federal Funds Requested: (Attach detailed budget using Excel file provided by DBHDS):

a. Amount of federal PATH funds requested:106,585

b. Source and amount of Provider's minimum required 33% match funds:$35,528 required; $60, 454 actual.

c. A brief narrative describing the items in the attached budget: The PATH budget primarily covers staff salaries including 2 full time case managers. Additional costs include: bus tickets, hygiene kits, medication and personal identification assistance, and housing transition costs. Please see the attached budget for full details. This year a long-time CSB employee transitioned to the PATH team, requiring the CSB to provide additional funds to meet the salary requirements for this transitioned staff. This amount is reflected in the budget. These additional funds are not a permanent match commitment to the PATH program, but an investment to retain this staff member.

3. Collaboration with Local HUD Continuum of Care (CoC): Describe the organization's participation in the HUD Continuum of Care program, other local planning activities and program coordination initiatives, such as coordinated entry and coordinated assessment activities. If you are not currently working with the CoC, briefly explain the approaches to be taken by the agency to collaborate with the local CoC.

In 2011, Norfolk Continuum of Care (CoC) merged with the jurisdictions of Western Tidewater and Chesapeake to form the Southeastern Virginia Homeless Coalition. The supervisor of PATH and Shelter Plus Care programs attends monthly CoC meetings where work is done to preserve critical resources, identify gaps in the service system, promote effective coordination of homeless services, and ensure that standards of care are met.

The CoC works collaboratively with the Southeastern Virginia Homeless Coalition to coordinate a continuum of care for homeless individuals. PATH staff attends the Southeastern Virginia Homeless Coalition monthly meetings and partners with other homeless service providers, many of whom are also CoC members. The PATH supervisor also attends CoC sponsored HMIS meetings.

New in 2015/2016- PATH staff began working one night a week at NEST (Norfolk's winter shelter). This has allowed a more collaborative effort to engage hard to reach individuals. PATH staff were successful with this engagement by also providing support to the NEST volunteer staff. Norfolk CSB also has opened up Friday mornings as "walk in days" where any person experiencing homelessness can come in and see a PATH worker for assistance.

PATH staff also works collaboratively with the Norfolk Office to End Homelessness to identify local needs and coordinate outreach efforts. In addition, PATH serves as team leads in the Point-in-Time Count and Project Homeless Connect.

CoC's and Coordinated Assessment Process:

The CoC had redesigned the coordinated assessment process. They now have the Singles Service Coordination Committee (SSCC). This committee is attended by key partners to include: NCSB Housing and Homeless services, NCSB mental health case management program, Norfolk Road2Home, Norfolk HART team, Norfolk Office to End Homelessness, Salvation Army, Union Mission, Barrett Haven, The Planning Council, Virginia Veteran and Family Support, and Virginia Supportive Housing. Utilizing the VI SPDAT 2.0 (vulnerability index) as an assessment tool this year has assisted the continuum with identifying and placing the most at risk of our homeless population. All members of the PATH team attend this meeting bi-monthly to present cases and take referrals.

4. Collaboration with Local Community Organizations: Provide a brief description of partnerships and activities with local community organizations that provide key services (i.e., outreach teams, primary health, mental health, substance abuse, housing, employment, etc.) to PATH eligible clients, and describe coordination of activities and policies with those organizations. Provide specific information about how coordination with other outreach teams is achieved.

In addition to CoC collaborations, PATH collaborates with many local organizations; including but not limited to:

Norfolk Community Services Board – PATH staff effectively partners with staff from various internal programs to link homeless consumers to needed services. Referrals are made to Intake, Road2Home, I-Care (psychiatric and primary care services), Mental Health Case Management, Outpatient Counseling, Substance Abuse Services, and Crisis Stabilization. PATH staff collaborates with program staff and follows the consumer through the process to ensure access to service is successful.

Norfolk Road2Home- This is a 3 year federal grant to provide outreach, support and services to single adults experiencing homelessness and disabling behavioral health disorders. PATH staff and Road2Home staff are in constant communication regarding cases and make referrals to each other on a regular basis.

Hampton Roads Community Health Center (HRCHC) – HRCHC is the local FQHC and Health Care for the Homeless (HCH) Program. Primary care and prevention are the focus of this medical team. PATH staff stays current regarding their eligibility/service policies and links homeless consumers who are uninsured and in need of medical care. NCSB has added staff at two of the Norfolk HRCHC locations to provide service integration. In addition to the three community clinics available to PATH consumers, HRCHC has added a fourth clinic at one of the NCSB facilities, increasing access to integrated care for PATH consumers. All of the HRCHC sites are HCH-available locations.

Bon Secours Care-A-Van: A mobile medical unit that travels throughout the Hampton Roads area
providing health care to adults and children who are uninsured. All services are free. The Care-A-Van provides general medical care, routine evaluation and treatment of common acute illnesses. PATH staff stay informed of the van location/schedule and provides referrals to homeless persons who need affordable medical care.

Union Mission Shelter and Day Center– Provides emergency shelter, transitional housing, meals, clothing, shower, laundry facilities, and an outreach office. PATH staff members have an outreach office at Union Mission and are frequently on-site to provide outreach and case management services to homeless persons. Union Mission staff has cell phone numbers for PATH staff in order to facilitate prompt interventions when needed. In addition, PATH staff provides training to shelter staff regarding PATH services and resources for homeless individuals. PATH staff link consumers to their employment specialist.

The Salvation Army – Provides emergency shelter and transitional housing as well as assisting individuals with day services including clothing vouchers, lockers, laundry services, voicemail and telephone services. PATH staff members have an outreach office at Salvation Army and are frequently on-site to provide outreach and case management services to homeless persons. Salvation Army staff has cell phone numbers for PATH staff in order to facilitate prompt interventions when needed. In addition, PATH staff provides training to their staff regarding PATH services and resources for homeless individuals. This collaboration promotes flexibility with the resources offered to PATH consumers, e.g. after hours support is provided to PATH consumers. PATH staff link consumers to their employment specialist.

The Norfolk Emergency Shelter Team (NEST) -- Provides meals and shelter to homeless adults during the winter months. NEST is a coalition of churches that provides overnight shelter on a rotating basis. Transportation to the shelter is provided every evening during the winter months of November – April. PATH staff are now present at each church site weekly to provide support and to conduct assessments. They also hand out resources available within the community.

St. Columba Day Center – Provides transitional housing for single adults, rental and utility

assistance, food pantry, clothing closet, etc. St. Columba also has a prescription drug program that provides prescription medication assistance to individuals who are homeless in the city of Norfolk. PATH staff have a working relationship with the manager and staff that includes open communication which helps to facilitate prompt services for PATH consumers.

Ghent Area Ministries -- A faith-based outreach ministry dedicated to assisting those in need in the Norfolk community through financial assistance, resources, and services. Those with financial difficulties receive help with rent, utilities, prescriptions, food, local transportation, and obtaining state IDs. Additionally, clients receive assistance through The Coat Closet and the Food Pantry. PATH staff collaborates with the director who has their mobile numbers in order to request prompt outreach/intervention and, in turn, Ghent Area Ministry staff are flexible in providing assistance to PATH consumers, e.g. they are willing to provide services for homeless clients who do not have ID's, etc.

Virginia Supportive Housing: Non-profit organization that provides various services to improve individuals economic self-sufficiency and housing stability while promoting mental health and substance abuse recovery. PATH staff work closely with all local Virginia Supportive Housing staff, providing support, linkage to services, and advocacy as needed.

SSA: PATH staff members are SOAR trained and local SSA representatives participated in the training. PATH staff has a local contact that helps to resolve problems related to benefit acquisition, improve communication and ensure that the application process goes smoothly.

Housing Authority: Norfolk Redevelopment and Housing Authority provides a continuum of housing options to households of all incomes seeking affordable housing. PATH workers assist consumers with applying for placement on housing waitlist and navigating the application process. Norfolk CSB held a housing clinic in February of 2016 to assist homeless individuals with applying for NRHA sponsored housing.

Norfolk DSS/DHS: HART Team (homeless outreach and services team), food stamps, Medicaid, SSA application assistance and adult services. PATH staff coordinates with HART team and may refer/share clients. NCSB has a partnership with DSS that includes DSS eligibility workers being co-located in NCSB service centers. PATH staff members have excellent working relationships with local eligibility workers which facilitates walk-in appointments and prompt activation of benefits.

Faith Community: Numerous sites provide soup kitchen, pantry and clothing services, and occasional emergency shelter. PATH workers utilize contact information at local churches to facilitate referrals to these services and respond to calls with concerns about homeless consumers. This relationship allows for some services to be provided to PATH consumers after hours.

Norfolk's Office to End Homelessness (OTEH): The OTEH serves to develop coordinated service**s** within Norfolk and neighboring localities to end homelessness. PATH staff works closely with OTEH to engage in both outreach and in-reach activities throughout the City of Norfolk and the planning and implementation of Project Homeless Connect.

Salvation Army ARC Program – Provides substance abuse residential treatment. The PATH case manager knows the manager and can facilitate a smooth transition from shelters to the residential program when appropriate. The ARC program is open to PATH referrals due to the involvement and responsiveness of PATH staff.

Veterans Administration: The Veterans Administration provides services to homeless Vets through community outreach, medical services and housing options through the use of Veterans Affairs Supportive Housing (VASH). PATH staff collaborate with the veterans' administration outreach team in a coordinated effort to ensure Veterans are linked to appropriate services.

Virginia Veteran and Family Support: As of FY15, the Virginia Veteran and Family Support program's Eastern team is located in the NCSB facility within the Housing and Homeless Services Division. This co-location has greatly enhanced services to PATH-eligible veterans including: joint outreach, access to VA services and benefits, and access to housing programs for veterans.

5. Service Provision: Describe the plan to provide coordinated and comprehensive services to eligible PATH consumers. Please address the following information.

a. Projected number of adult consumers to be contacted with PATH funds: 230

b. Projected number of adult consumers to be enrolled using PATH funds: 120

c. Percentage of adult consumers projected to be "Literally Homeless", and activities to maximize the use of PATH funds to serve adults who are literally homeless as a priority population: 86%

d. Strategies that will be used to target PATH funds for street outreach and case management as priority services.

The Norfolk PATH team has utilized targeted street outreach as the primary method of engagement since the beginning of the program. The PATH workers spend a significant part of outreach time identifying and engaging persons on the streets, in woods or camps, and other areas where homeless persons are found. This ensures that the most vulnerable or least likely to be served are reached by our staff. For those not willing to immediately engage, the PATH workers have the flexibility to continue trying, be creative, and provide safety education while working to develop a professional relationship with the individual. It is our goal that no person experiencing mental illness and homelessness in Norfolk goes without having an outreach attempt made to engage them in services.

The Norfolk PATH team has a strong history of partnership to maximize community impact of the program. The street outreach component in the community has grown and PATH works with them as a team, even hosting the Street Outreach monthly coordinating meetings and continuously providing co-outreach services. Norfolk has worked on Housing First initiatives, the 100k Homes initiative, and the Homeless Veterans Challenge. Norfolk PATH program also has been a key partner for providing outreach and follow-up for Project Homeless Connect and

the Annual Point in Time Count. Our Emergency Services Preadmission Screening program is under the Clinical Acute Division and this program works closely with the PATH workers as well. The crisis counselors are extremely mobile and conduct most of their crisis evaluations in settings such as client homes, on the street, or in local emergency rooms. Individuals identified as homeless and in need of services are referred to those services as well as our PATH team for follow up and further outreach as needed. These individuals can also be referred to our 24 hour crisis stabilization program. The application of the new Crisis Intervention Team (CIT) will continue to enhance opportunities for effective outreach interventions.

The NCSB has also partnered or developed relationships with local medical clinics to address medical and psychiatric needs. These relationships include but are not limited to the Sentara Norfolk General Hospital, Park Place Medical Center, Bon Secours Medical Van, and the Lions Club Eye Vision and Hearing Program, and the Park Place Dental Clinic. Connections to the GAP Medicaid program will greatly enhance access to medical and psychiatric care during the outreach phase of services.

Outreach in locations where persons who are homeless gather is critical to success of the program.

PATH has established partnerships to provide outreach at the St. Columba Day Center, Salvation Army Shelter and Day Center, Union Mission Shelter and Day Center, Norfolk public libraries, and Norfolk Department of Parks and Recreation. Norfolk PATH program in partnership with the Office to End Homelessness also provides outreach to locations identified by codes and the Norfolk Police Department.

The PATH program is able to target their time and resources to ensure that they not only provide outreach and engagement, but have the time and focus to provide case management services to coordinate care, maintain connections, and ease the person into the next phase of services without a gap in service delivery.

The above information represents part of a collective pool of resources that assist PATH staff with providing effective outreach and case management services to homeless individuals in Norfolk.

e. Indicate whether your organization provides, pays for, or otherwise supports evidence-based practices and other training for local PATH-funded staff, including training and activities to support migration of PATH data into HMIS.

The NCSB supports evidence-based practices and provides PATH staff the opportunity to attend trainings. The following EBP trainings have included; Housing First, Rapid Exit from Homelessness, Critical Time Intervention, Supported Employment, Motivational Interviewing and Stages of Change. PATH staff also attended the National Conference to End Homelessness from July 15th-17th in Washington DC. PATH staff also attended a 2 day training in Richmond, Virginia on the PATH HMIS implementation.

f. Describe gaps in the current service system and how PATH will assist consumers in addressing those gaps.

Shelter Availability

Individuals with substance abuse problems face multiple barriers to accessing housing while suffering from addiction, as most shelters require sobriety to access their service. Lack of shelters for those actively working on their recovery provides a significant gap in services as they are “screened out” of most housing options. This also can be a barrier for persons who are actively symptomatic from psychiatric conditions. Finally, safe shelter for youth and persons in the LGBT community is a gap in the system.

Lack of Substance Abuse Services

Currently, the City of Norfolk has no local detox center, little outpatient detoxification services other than Opioid Treatment, and very limited residential substance use treatment facilities. Most individuals seeking detoxification services have to wait for an available bed through a neighboring city and it is extremely difficult to access the 28-day residential treatment programs many of which are out of state and require a stable housing plan at entry. Many of the programs that are available are abstinence-based or "cold turkey" programs and they have not been very effective for the homeless population.

The provision of care for the Indigent is fragmented as many of the uninsured use hospital emergency rooms after delaying treatment for routine illnesses or chronic diseases. The fragmentation of care has contributed to capacity constraints in local hospitals. There are increasing numbers of illness acuity in both inpatient and outpatient settings and increases in hospital service use. Services are available through community health centers and free clinics but many indigent individuals with go without care. This will be partially mitigated through the GAP program for persons with Serious Mental illness and under 60% of FPL.

Other gaps include: Adequate numbers of affordable permanent housing options for single adults, low-barrier housing, partial hospitalization (day) services, employment training, affordable health care and dental care, prescription assistance, homeless prevention and respite care for medically fragile homeless persons.

In an attempt to diminish the gaps in service, the outreach worker will assess the needs and level of care for clients to include case management and outpatient services. They will be screened initially to assess whether or not their immediate needs can be met by enrolling in any of the existing programs offered by the Norfolk Community Service Board. If the participant doesn't meet the criteria of any of the existing programs, the consumer will be assessed and guided to the appropriate community resource. PATH staff participates in the Southeastern Virginia Homeless Coalition and affiliated committees which allows them to learn about new resources and partner with other homeless providers in order to assist consumers with closing the gaps.

g. Describe services available for consumers who have both serious mental illness and substance use disorder.

Integrated Services: We have internal integrated care services that is available for consumers.

Crisis Stabilization is able to integrate MH and SA services. A recent increase in outpatient groups have expanded services available for substance abuse recovery with co-occurring mental illness.
Primary Health: Resources include Hampton Roads Community Health Clinics, Sentara Ambulatory Care Center, Bon Secours Care-A-Van, and EVMS Hopes Clinic. These clinics work with PATH on a referral basis. Hampton Roads Community Health Centers are the local HCH provider sites and PATH also assists in providing homeless certifications so their clients can access services under that grant. Access to primary care increases through the GAP program and care can be coordinated by PATH and the CSB.

Mental Health: There are numerous mental health providers in the community for persons with insurance, however, NCSB is the only mental health provider for persons who have no ability to pay. These services include but are not limited to psychiatry, outpatient counseling, and case management. PATH consumers who have insurance are assisted with accessing services at their provider of choice, including the local psychosocial programs.

Substance Abuse: Norfolk has a strong network of 12 step recovery programs and several faith based programs to assist in recovery. Also, the Salvation Army ARC, Recovery Center and The Recovery Place programs are located in Virginia Beach and serve Norfolk citizens. Otherwise, Norfolk CSB is the only substance abuse provider for persons who are indigent and Norfolk is one of only 3 public Opioid Clinics in Hampton Roads.

h. Describe strategies for making suitable housing available to PATH consumers (e.g., indicate the type of housing usually provide and the name of the agency that provides such housing).
The NCSB collaborates with the CoC and Norfolk Homeless Consortium to network with other providers of homeless services and stay abreast of housing options. PATH staff members have established working relationships with housing providers which assists them with being able to link their consumers to suitable housing. Some of those housing options are listed below:

Union Mission: Provides emergency shelter, transitional housing, and permanent SRO type housing.

Salvation Army: Provides emergency shelter and a recent expansion to limited longer term shelter.

St. Columba Center: Provides transitional housing.

For Kids: Provides family emergency shelter, transitional housing, and permanent supportive housing.

Barrett Haven: Provides transitional housing for women.

YWCA: Provides emergency shelter and transitional housing.

NEST: Provides emergency shelter during winter months.

Virginia Supportive Housing (SRO): Gosnold Apartments, Cloverleaf Apartments, South Bay, Herons Landing and Crescent Square. Apartments offer affordable, safe housing for single adult,

chronically homeless and disabled individuals.

Virginia Supportive Housing (Housing First): Provides permanent supportive housing to Chronically Homeless individuals through a scattered site model.

NCSB Shelter Plus Care: Provides scattered site permanent supportive housing to homeless individuals with disabilities, including those with mental health and substance abuse disorders.

Norfolk Road2Home Permanent Supportive Housing funds-funded through DBHDS PATH clients that are also Road2Home eligible can also be considered for a housing voucher with ongoing Road2Home staff support

ROI: Owns two buildings for rent to CSB consumers at entry and can be retained after graduating from CSB services. Also provides an additional 6 units of post treatment supportive shelter housing for persons with substance use disorders.

In addition, the NCSB works with NRHA, local boarding homes and landlords to locate safe, affordable housing resources

i. If you plan to implement one or more Virginia PATH Innovative Practices, indicate which one(s) and describe the implementation plan:

SOAR:

Currently both PATH staff are trained and received SOAR certification. NCSB Executive Director is SOAR trained and serves as the Local Coordinator. PATH staff assists consumers throughout the application process and have relationships with staff at the local SSA and DDS offices. They maintain regular communication with the DDS staff to ensure that all information has been provided and to offer assistance in order to facilitate approval of benefits. PATH staff has good working relationships with psychiatric providers, in fact they attend the appointments when requested by consumers and also send written communication to the physician that highlights the behaviors/symptoms they have observed that would interfere with maintaining employment. PATH staff will provide an attachment to their quarterly reports indicating SOAR activity.

Targeted Street Outreach:

PATH staff spends time identifying and engaging homeless individuals on the streets, parks, camps, and in other places where homeless persons may be found. They perform outreach to some of these areas 3 times per week given the number of homeless persons that are known to commonly congregate there. They communicate with Norfolk staff and citizens regarding homeless needs and areas where they may be located. During outreach they provide safety education and offer services to meet imminent needs and continue contact in order to establish a trusting relationship that may open the door to enrollment into needed services and housing. Targeted street outreach is the primary method of work for this program. The number of street outreach encounters will be provided in quarterly reporting.

j. Briefly describe your plan for providing the following PATH-allowable services:

Outreach:
The PATH team will provide active outreach by seeking out homeless individuals where they may live or congregate. They will seek out individuals in non-traditional settings such as on the streets, under bridges, woods, or in shelters. The PATH team will also provide 'in-reach' by being available at locations or sites known to be frequented by homeless individuals such as day centers and emergency shelters. This method also allows homeless individuals to approach the PATH worker when they feel comfortable to do so. Indirect outreach is provided through the ongoing education of PATH services to the community of service providers, shelters, meal sites, and drop-in centers.

PATH staff participate on local and regional taskforces and partnership groups, including the Continuum of Care to ensure that awareness of PATH services is promoted. The Norfolk PATH Homeless Project has a standing seat on the Single Adults Subcommittee of the Continuum of Care, is a co-planner of the annual Point-in-Time Count, and coordinates the outreach services for Project Homeless Connect. These activities provide a constant reminder to the community of the services available by PATH as well as opportunities to spread the word in the homeless community about the PATH program.

Screening and Diagnostic Treatment: During the outreach and engagement process, individuals are evaluated as information becomes available. PATH workers are skilled in identifying mental health and substance use issues as well as interviewing to explore other needs, such as medical and health conditions. Norfolk PATH uses a needs assessment where information on needs and resources can be documented as the information is collected. Once the individual from PATH is enrolled, the worker ensures that the information to screen for needs and the PATH presumptive mental health eligibility is documented.
This is a continuum of assessment services to include brief eligibility screening by the PATH team, referral to a licensed clinician or psychiatrist for further clinical evaluation as needed, or a referral to a crisis counselor for a crisis evaluation. Follow up referrals to other services such as long term case management would occur after the evaluation process.

Habilitation and Rehabilitation:
Norfolk PATH provides PATH consumers with direct training and assistance in learning (or re-learning) skills for recovery and community integration. PATH workers "go with and walk with" consumers to medical appointments, shelter intakes, mainstream benefits and resources appointments, the grocery store, setting up bank accounts, and talking to Social Security, to name a few. PATH workers model ways to navigate these systems and empower the consumers to advocate on their own behalf. PATH staff also model and teach daily living skills. As PATH consumers improves their skills, the PATH workers provide only the support they need. Norfolk PATH believes in a recovery-oriented outreach and service delivery model, consumer empowerment, and the fundamentals of the Critical Time Intervention that can be applied in this type of program.

Community Mental Health Services: As part of the NCSB team, the PATH program may refer directly to the NCSB for ongoing community based mental health supportive and treatment services. This may include a range of services to include but not limited to

outpatient counseling, psychosocial rehabilitation services, psychiatric services, the NCSB PACT team, case management services, mental health support services, crisis intervention, medication assistance, and crisis stabilization services. PATH staff may also refer to other mental health providers, such as private psychiatrists, therapists, and mental health support providers for homeless persons who are insured. For PATH consumers not interested in enrolling in mental health services, the PATH team provides outreach, supportive counseling and case management services. PATH case management may include activities such as assisting with housing applications, connecting with medical providers, assisting with benefit application, providing education regarding fair housing laws, the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act. PATH staff members are Qualified Mental Health Providers and are knowledgeable about community resources which equips them to provide services to PATH consumers who have mental illness and to overcome housing barriers by implementing reasonable accommodation requests with providers
Alcohol or Drug Treatment Services: PATH staff may refer directly to NCSB substance abuse services - this is a range of services to include but is not limited to outpatient counseling, intensive outpatient, co-occurring group counseling, Opioid replacement programs, substance abuse transitional housing, psychiatric services, and crisis stabilization services. They may also refer to other local organizations such as The Recovery Place, Recovery Center, Salvation Army ARC, Twelve Step Groups, etc.
Staff Training: The NCSB PATH Program has and will continue to provide targeted in-service trainings to individuals who work for CSB's, shelters, mental health clinics, and other sites so as to assist in individual knowledge or skill development. The PATH workers will also function as liaisons in their outreach and training efforts by identifying a specific training need and linking that organization or individual with the best contact. PATH staff are SOAR certified and the Executive Director is also certified as a SOAR trainer.
Case Management: The PATH worker will assist PATH eligible consumers in accessing community resources. Activities may include but are not limited to referrals to housing, financial planning, access to benefits, referrals to local CSB's, shelter alternatives, or medical care. If a referral is made to another provider or there is a need for long term case management, the PATH worker will continue to monitor and assist the consumer for three months to ensure a seamless transition
Supportive and Supervisory Services in Residential Settings: The PATH worker or team will continue to monitor and provide support to outreached individuals during their transition from homelessness into residential settings. These services include support services in emergency shelter and a three month transition time of support services once housed.
Minor Renovation:N/A
Planning of Housing: Norfolk PATH participates in discussions regarding the development of housing through NCSB, Continuum of Care and regional meetings, and through activities related to the regional SRO developments, Housing First, and other housing opportunities that could benefit PATH consumers. As a department of the City of Norfolk, the Executive Director participates in city-wide housing and community planning and was a team member on the

development plan of PlaNorfolk2030.
Technical Assistance in Applying for Housing: The Norfolk PATH staff are knowledgeable about local housing enrollment criteria and application processes. They provide enrolled consumers with individual assistance and guidance in applying for housing, including homeless specific programs such as Transitional Housing and Permanent Supportive Housing through Housing First and SRO housing. They also provide direct assistance with applying for Housing Choice (Section 8) vouchers, VASH for veterans, Public Housing, Section 811 programs, and Section 202 for persons who are elderly. Also, PATH staff is knowledgeable about Fair Housing, the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act. This provides PATH with the capacity to help consumers access housing, overcome barriers to housing, and implement reasonable accommodation requests to access and stabilize housing resources. Norfolk PATH also has access to the Norfolk Housing Broker to assist in identifying landlords for consumers with high housing barriers. The broker can assess concerns and provide guidance on navigating the rental market.
Improving the Coordination of Housing Services: The Norfolk PATH program is an active member of the Norfolk Homeless Consortium which is a part of the local Continuum of Care. PATH participates in discussions with service providers regarding appropriate housing resources, services needed in housing programs, and the need for additional housing for the homeless population. PATH also works to improve the coordination of housing services to consumers through community resources and internally at NCSB. PATH staff are currently participating in the development and implementation of a Central Intake process for single adults. The goal is to develop a single point of entry for homeless individuals seeking housing or other needed services.
Security Deposits: Norfolk PATH will provide security deposits for consumers when no other funds can be identified and within the State and Federal guidelines. All financial assistance events are documented in the individual's PATH file and would be on a short-term basis.
Costs Associated with Matching Eligible Homeless Individuals with Appropriate Housing Situations: Norfolk's PATH program provides assistance in matching consumers to housing. Activities include housing search, locating units, collaborating with housing providers and landlords, assisting PATH clients with completing and mailing applications, acquiring documents needed to apply, paying application fees, and providing transportation for housing search
One-time Rental Payments to Prevent Eviction: Norfolk PATH may provide one-time rental payments for PATH consumers who are at risk of eviction and no other funding is available.
Referrals for Primary Health Services, Job Training, Education Services and Relevant

Housing Services:
The PATH case manager will provide outreach services to homeless individuals with mental health and substance use disorders. They will be responsible for the assessment and subsequent referral to mental health and substance abuse resources for homeless clients with co-occurring mental health and substance use diagnoses. Additionally, PATH staff will work with community resources and referral agencies to identify and activate support services for clients. For insured PATH consumers, referrals for psychiatric and medical services may be made to NCSB or to private providers in the community. Hampton Roads Community Health Clinics are used for those who do not receive and/or qualify for medical benefits and/or are eligible for HCH services. Eggleston Services, Urban League of Hampton Roads, Vet Center, Virginia Employment Commission etc. will be used to link the consumers with job placement and the consumers will be linked to education services through the Norfolk Public School System.

Through the City of Norfolk Office to End Homelessness' Project Homeless Connect, PATH workers refer to and assist homeless individuals with attending the event where they will have access to a broad range of services, including medical check-ups, eye screenings, legal services, employment assistance, and more. PATH staff makes referrals to the housing resources/programs noted in this document and assists with the application/transition process.
:

6. HMIS Data Integration: Describe your HMIS transition plan, with accompanying timeline, to begin using HMIS to collect and report PATH data in HMIS by July 1, 2016. If you are fully utilizing HMIS for PATH services, please describe plans for continued training and how you will support new staff. Indicate any technical assistance needs you may have in meeting the HMIS data requirements.
PATH staff began entering data into HMIS as of 4/1/16. This is for new PATH enrollees. PATH staff will work on entering in existing clients into HMIS with a target date of June 1, 2016.

7. SSI/SSDI Outreach, Access, and Recovery (SOAR): Describe your plan to train PATH staff on SOAR. Indicate the number of PATH staff trained in SOAR and the number of PATH-enrolled consumers assisted through SOAR during State Fiscal Year 2013, and the approximate number of staff to be trained in SOAR for State Fiscal Year 2015.
Both PATH case managers have been trained and received SOAR certification. PATH staff assists consumers throughout the application process and have relationships with staff at the local SSA and DDS offices. They maintain regular communication with the DDS staff to ensure that all information has been provided and to offer assistance in order to facilitate approval of benefits. PATH staff has good working relationships with psychiatric providers, in fact they attend the appointments when requested by consumers and also send written communication to the physician that highlights the behaviors/symptoms they have observed that would interfere with maintaining employment.
From July 2015 till current, PATH has assisted 5 persons with SOAR, resulting in 2 approvals of renewed/repaired status or new status – resulting in SSA (SSI/SSDI benefits).

The CSB currently has only one PATH staff worker on staff and anticipates hiring an additional

PATH worker that will be trained in SOAR.

8. Program demographics and cultural competency: Describe the following.

a. The demographics of the target population.

Age Distribution	Percentage	Race/Ethnicity	Percentage
Under Age 18	20.7%	White	49.1%
Age 65 and over	9.5%	African American	43.1%
		American Indian	0.6%
		Asian	3.5%
		Pacific Islander	0.2%
		Hispanic/Latino	7.2%
		2 or more races	3.4%

Population size: 246,139
Individuals living below poverty level:18.2%

b. The demographics of the staff serving PATH consumers.

	CPT	Full Time	PPT	Grand Total
American Indian		1		
Asian	3	5		
African American	10	118	3	
Caucasian	6	90	5	
Hispanic/Latino		2		
Other		1		
Grand total	19	217	8	=244 total staff

Two full time staff: Caucasian. The racial demographics of the Road2Home team assist with facilitating a broader mix of staff available to co-provide services with PATH.

c. How staff providing services to the target population will be sensitive to age, gender and racial/ethnic differences of consumers.
Norfolk Community Services Board provides Cultural Diversity training and testing to new employees and requires annual training updates in order to ensure cultural competency among staff. This training is designed to educate staff regarding the need to be cognizant of how cultural differences can impact services and the ability to effectively engage consumers; staff members are taught about the importance of providing services in a manner that is sensitive to the unique needs of diverse clients, including differences in age, gender and ethnicity. The PATH program also has access to intake counselors who are bilingual and referral capacity to the LGBT Center for persons of that community in need of a more targeted intervention or safe resources.

d. The extent to which PATH staff receive training in cultural competence.
Norfolk Community Services Board provides Cultural Diversity training and testing to new employees and requires annual training updates in order to ensure cultural competency among staff. This training is in addition to the organizational value and active recruitment of a culturally diverse workforce that is representative of our consumer base.

Focus areas of training in cultural competence encompasses an understanding of different communication needs and styles of client population, culturally competent oral communication, culturally competent written and oral communication, communication with community, and intra-organizational communication.

e. The extent to which the organization adheres to the Culturally and Linguistically Competent (CLAS) Standards. The CLAS standards can be accessed at http://www.ThinkCulturalHealth.hhs.gov.

These efforts and goals recognized that culture and language have considerable impact on how consumers access and respond to behavioral healthcare services. To ensure equal access to quality health care by diverse populations, the Norfolk CSB:

1. Promotes and support the attitudes, behaviors, knowledge, and skills necessary for staff to work respectfully and effectively with consumers and each other in a culturally diverse work environment.
    - All staff persons employed by the agency are required to participate in cultural diversity training during orientation and at least annually thereafter. At least one requisite class for new hires is taught by consumers.
    - The agency implements strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.
    - The agency offers and provides language assistance services, including interpreter services, at no cost to consumers with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
    - The Norfolk CSB's Intranet site contains a listing of Limited English Proficiency Resources and makes weekly office space available to the Statewide Program Coordinator for Deaf and Hard of Hearing services.
    - Staff are instructed and expected to uphold the rights of all consumers and to intervene as appropriate in situations involving cultural insensitivity, racial bias, and/or prejudice.
    - Includes family members and/or identified others in service planning/delivery, as appropriate.
    - Consumers serve on numerous, varied committees within the agency, to include a Consumer Advisory Council (which reports directly to the Executive Director), Wellness Committees (at the Integrated Care Clinic), and the (Intellectual Disabilities") Medicaid Waiver Slot Assignment Committee.

2. Promotes and supports the use of culturally sensitive and appropriate materials, resources, and environments.
    - The agency displays pictures, posters, artwork and other décor that reflect the cultures and ethnics backgrounds of consumers. Currently, the matted and framed artwork of consumers hangs in the lobby of our Integrated Care Clinic.

- The Norfolk insures that magazines, brochures, and other printed materials in reception area are of interest to and reflect the different cultures of consumers.
- Printed materials disseminated by the agency consistently take the literacy levels of consumers into account.
- Videos, films or other media resources for health education, treatment or other interventions reflect the cultures and ethnic backgrounds of consumers.
- Satisfaction Surveys and comment cards are consistently available to consumers, all with a space for the writer to identify their preferred language. Requisite surveys from DBHDS, etc. are administered in Spanish as well as English.
- Written (and posted) notices regarding agency and governmental regulations are Human Rights provided in bi-lingual formats whenever possible.
- Facilitates the publication and dissemination of a bi-monthly newsletter written by and for consumers.
- The agency liberally uses constituent volunteers and additionally employs Peer Support Specialists.

The Norfolk CSB ensures that data on consumers' race, ethnicity, and spoken and written language are collected in heath records, integrated into the organization's management information systems, and reported to designated agencies as required.

9. Consumer and Family Involvement: Describe how individuals who are homeless and have serious mental illnesses, and family members will be involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards. (See attached Appendix I – Guidelines for Consumer and Family Participation.)

The NCSB employ consumers and we are working on increasing employment opportunities for individuals with serious mental illnesses and substance use disorders. In addition, the NCSB Board of Directors consists of volunteers from the City of Norfolk to include consumers and the families of consumers. The CSB Board currently has one member who has a history of services for behavioral health and is formerly chronically homeless

Consumers are active participants in their treatment; they provide informed consent and actively participate in their plan of care. Consumers are fully informed of their rights at the initiation of services and annually thereafter. Consumers also participate in surveys to determine what things help or hinder their progress.

<u>Consumer Advisory Council</u>

The Consumer Advisory Council (CAC) consists of NCSB consumers who have agreed to serve as advisors to the NCSB on consumer-related issues. Many serve as volunteers for the Norfolk CSB. Several members of the CAC are also members of the Norfolk CSB Board of Directors.

PATH staff will begin to provide an annual presentation to the CAC beginning this fiscal year.

10. Outreach to Homeless Veterans: Describe how your PATH program identifies and outreaches to homeless veterans with SMI, and the services available to them in your catchment area. How does PATH interface with your veterans' service continuum?

PATH staff works in collaboration with the Virginia Veteran and Family Support as well as the VA outreach workers. Once a homeless veteran is identified by PATH the linkage is immediately made for VA services. If the client is not eligible for VA services then PATH continues to assess the individual for PATH eligibility. If the individual is not PATH eligible then linkage to other outreach services happens. PATH staff will be working the new 100 day challenge to end veteran homelessness as well.

11. Describe your PATH program's efforts to minimize the challenges and foster support for PATH clients with a criminal history, such as collaboration with local jail diversion and/or other programs. If you can, estimate the percent of PATH clients with a criminal history.

Currently, PATH has several methods of assisting persons with criminal justice involvement including: collaborations with Mental Health Docket and Mental Health Court; collaboration with CSB jail liaison and restoration services; close partnership with the Crisis Intervention Team; and success to overcome barriers to housing for persons with criminal justice history. The PATH program data entry does not currently collect history of criminal justice involvement, but for the upcoming year we can add "incarcerated in the past 30 days" that is an existing data point available in our electronic health record or can accommodate requests for additional data collection from the PATH program as advised.

PATH Site Name: Norfolk Community Services Board					
Budget FFY 2016/SFY 2017 (2016-2017 PATH Year)			PATH Funded	Match	Match Source (Cash or In-kind)
Staff Title	***Annualized*** Salary	FTE			
Program Supervisor *(10% M. Honan)*	56,314	0.10		$5,631	In-Kind
Case Manager III	$40,805	1.00	$40,005	$800	
Case Manager II	$55,060	1.00	$38,500	$16,560	
Total Staff Salary			$78,505	$22,991	
Fringe			$27,366	$5,688	In-Kind
Total Personnel			**$105,871**	**$28,679**	
Travel (Outreach travel, travel for training, state meetings, etc.)					
Use of Agency Vehicle/upkeep of current PATH vehicle				$5,200	In-Kind
Training Travel			$714	$1,286	In-Kind
Mileage Reimbursement - Local Travel				$1,200	In-Kind
Total Travel Costs			**$714**	**$7,686**	

Equipment (Personal property/equipment having useful life of more than one year)			
Total Equipment Costs	**$0**	**$0**	
Supplies (Office Supplies, Outreach Supplies, Computer Software)			
Office Supplies		$500	In-Kind
Outreach Supplies		$2,000	In-Kind
HMIS/ART License		$440	In-Kind
Total Supplies Costs	**$0**	**$2,940**	
Contractual			
Building rent *(2% of total positions housed in ORC)*		$11,649	In-Kind
Total Contractual Costs	**$0**	**$11,649**	
Other (List and Describe Each)			
Medication Assistance		$1,000	In-Kind
Identification related purchase costs (incl. Birth certificates)		$500	In-Kind
Rental Assistance		$4,000	In-Kind
Client Transportation		$2,500	In-Kind
Staff Training (non-travel registration and cost)		$1,500	In-Kind
Total Other Costs	**$0**	**$9,500**	
Total Proposed Budget	**106,585**	**60,454**	Is match > or = to 1/3 of federal allocation? Yes

Virginia PATH Local Intended Use Plan, FFY 2016/SFY 2017
PATH Program Year 2016-2017

1. Description of Provider Organization:
a. Name: Portsmouth Behavioral Healthcare Services
b. Organization Type: Mental Health (Community Service Board)
c. Description of Services Provided: Portsmouth Department of Behavioral Healthcare Services (PDBHS) provides mental health, intellectual disability, substance use and co-occurring disorder services to the citizens of the City of Portsmouth. Services provided are: 24 hour/7 days a week emergency services, outpatient treatment for mental health and substance use, case management services, restoration services, crisis case management, crisis stabilization, supportive and residential services, jail diversion, co-occurring, Methadone, SA prevention, psycho-social rehabilitation day support, HIV/AIDS education and homeless outreach and permanent supportive housing services.
d. Region Served: City of Portsmouth
e. Provider's experience in providing services to homeless/at-risk individuals and those with SMI and/or co-occurring SUDs: For the past 29 years the Portsmouth Department of Behavioral Healthcare Services has provided services to the homeless mentally ill population beginning in 1987 when the funding was provided by the Stuart B. McKinney Act. Over a period of time a fairly comprehensive program has emerged using a combination of PATH funds for case management services, state and local funds for temporary housing, medical care, food, water, federal funding for permanent housing and in-kind services for day support, out-patient and crisis intervention services. The Portsmouth Department of Behavioral Healthcare Services has provided mental health services for approximately 35 years and over the past 10 years has adopted best practices for serving the co-occurring population.
f. Description of housing or services that are specifically targeted to PATH-eligible consumers: There are a number of services in Portsmouth such as the HER shelter for homeless battered women. Housing services specifically targeted to PATH eligible consumers are: 2nd Chance Housing and IMPACT(integrated community-based Mental Health and housing programs), Shelter Plus Care, (supportive housing program and case management for homeless mentally ill, chronic substance abusers and/or HIV/AIDS), South Bay (SRO), and SABRE (a single adult barrier reduction housing program offered through PARC). Oasis Social Ministry provides vocational skills, food, clothing and meals. Portsmouth Volunteers for Homeless (PVH) provides winter shelter. Programs that some PATH consumers would be eligible for are licensed adult homes and transitional housing through Union Mission, Community Alternatives Management Group (CAMG), and Salvation Army Adult Recovery Center (ARC) program.
2. Program Budget and Federal Funds Requested: (Attach detailed budget using Excel file provided by DBHDS):
a. Amount of federal PATH funds requested: $53,715 See attached budget
b. Source and amount of Provider's minimum required 33% match funds: See attached budget

c. A brief narrative describing the items in the attached budget: The attached budget will enable the agency to remove the preliminary barriers that have been long standing problems to accessing mental health and co-occurring, housing and employment services, prevent homelessness for those persons at risk, provide financial assistance and support for newly housed persons with minimal resources, and close some of the gaps in the services delivery system. Having resources to obtain the necessary documents, pay deposits, purchase medications, household items, bus tickets, fast food/food vouchers will lead to the rapid housing of homeless persons and long term stable housing.

3. Collaboration with Local HUD Continuum of Care (CoC): Describe the organization's participation in the HUD Continuum of Care program, other local planning activities and program coordination initiatives, such as coordinated entry and coordinated assessment activities. If you are not currently working with the CoC, briefly explain the approaches to be taken by the agency to collaborate with the local CoC. PDBHS works closely with Portsmouth's CoC. CoC meetings are attended on a regular basis and have been for many years. The Program Administrator for the PATH program is the current secretary for the PHAC (Portsmouth Homeless Action Committee) of which all CoC members are required to hold membership in. The Program Administrator has also had an active role in developing and implementing the coordinated entry and coordinated assessment which is now in use by the Portsmouth CoC.

4. Collaboration with Local Community Organizations: Provide a brief description of partnerships and activities with local community organizations that provide key services (i.e., outreach teams, primary health, mental health, substance abuse, housing, employment, etc.) to PATH eligible clients, and describe coordination of activities and policies with those organizations. Provide specific information about how coordination with other outreach teams is achieved.

DBHS works with Oasis Social Ministry and Oasis Opportunity Center. DBHS has also given their support to the faith based organization CCIA. The PATH case manager provides onsite time at Oasis Social Ministry and consumers are referred to PATH by that agency. PATH refers consumers to Oasis Opportunity Center (OOC) for vocational training and job placement. OOC also refers PATH eligible consumers to PATH. The PATH case manager is an identified partner with Portsmouth Volunteers for the Homeless (PVH). The PATH case manager has been involved with the Portsmouth Police Department for training CIT officers. The PATH case manager works closely with PDBHS mental health and substance use services to get PATH consumers assessed as soon as possible. The PATH case manager also refers clients to the Maryview Foundation, Public Health Department, and Hampton Roads Community Health Center for medical issues. The PATH case manager works with Portsmouth Department of Social Services to obtain supportive services and benefits. The PATH case manager coordinates with other outreach teams through the PCAN meetings which are held 2x a month. All case managers and outreach workers of the Portsmouth CoC agencies are expected to attend.

5. Service Provision: Describe the plan to provide coordinated and comprehensive services to eligible PATH consumers. Please address the following information.

a. Projected number of adult consumers to be contacted with PATH funds: 110

b. Projected number of adult consumers to be enrolled using PATH funds: 80

c. Percentage of adult consumers projected to be "Literally Homeless", and activities to maximize the use of PATH funds to serve adults who are literally homeless as a priority population: 70%. Activities include outreach involving assessing and making referrals to various housing and/or shelters, support services, and for mental health services.
d. Strategies that will be used to target PATH funds for street outreach and case management as priority services. . PATH funds pay for 1 full time case manager. This PATH case manager has set days and times at Oasis Outreach Ministries, Portsmouth Public Library, and Third Avenue Baptist Church. The PATH case manager will carry bottled water, food, and small articles of clothing, i.e. socks, underwear, in order to facilitate communication with the homeless population. The PATH case manager is aware of gathering points of homeless individuals and will make stops in these locations. The PATH case manager is the only dedicated outreach case manager in Portsmouth. As such other agencies provide information when they are approached by or notice a PATH eligible individual.
e. Indicate whether your organization provides, pays for, or otherwise supports evidence-based practices and other training for local PATH-funded staff, including training and activities to support migration of PATH data into HMIS. PATH funds pay for 1 full time case manager. This PATH case manager has set days and times at Oasis Outreach Ministries, Portsmouth Public Library, and Third Avenue Baptist Church. The PATH case manager will carry bottled water, food, and small articles of clothing, i.e. socks, underwear, in order to facilitate communication with the homeless population. The PATH case manager is aware of gathering points of homeless individuals and will make stops in these locations. The PATH case manager is the only dedicated outreach case manager in Portsmouth. As such other agencies provide information when they are approached by or notice a PATH eligible individual.
f. Describe gaps in the current service system and how PATH will assist consumers in addressing those gaps. Locally, lack of housing continues to be the major barrier for the PATH identified consumers. There is not enough affordable and/or subsidized housing for low income individuals. Portsmouth is no longer issuing Section 8 vouchers and the wait list for low income housing is long. The Shelter Plus Care Program is currently at capacity. Additionally, many PATH clients have histories of legal problems, outstanding utility bills, and poor credit which are barriers to accessing housing. If background checks of past living arrangements and/or housekeeping skills are not satisfactory, clients are often denied housing. Although the jail system is improving with placements of individuals leaving the penal system, there continues to be a gap in services for these individuals when they return to Portsmouth. Often, in addition to the above, the consumer's legal issues and inconsistent employment history make placements difficult. The PATH case manager continues to submit letters and advocate for reasonable accommodations on behalf of hard to place individuals. DBHS is identifying and removing barriers by developing relationships with landlords and providing supportive services that assist consumers.
g. Describe services available for consumers who have both serious mental illness and substance use disorder. Consumers presenting with mental illness or co-occurring disorders go through PDBHS Central Intake where they receive assessment and are referred to need based, appropriate services. The PDBHS Intake staff is licensed and experienced in working with individuals with

mental health/co-occurring disorders. Case reviews, involving all programs at PDBHS, are held weekly so that appropriate treatment for all consumers is monitored. The PATH case manager attends this meeting and has input regarding PATH suitable individuals. PDBHS staff receives training in evidence based best practices and other training that will provide them with up to date information. PDBHS offers a Women's Program, HIV/AIDS information and Recovery Houses for women with co-occurring disorders.

h. Describe strategies for making suitable housing available to PATH consumers (e.g., indicate the type of housing usually provide and the name of the agency that provides such housing).). The PATH Case Manager is on location (as cited in 5d) in order to assist with referrals and linking the homeless with resources and information. Assistance is provided with placement in local housing programs (as cited in 1f).

i. If you plan to implement one or more Virginia PATH Innovative Practices, indicate which one(s) and describe the implementation plan:

j. Briefly describe your plan for providing the following PATH-allowable services:

Outreach: Outreach: The full time PATH case manager will continue to provide outreach and assessment at various locations around the city where homeless individuals congregate in order to offer services and distribute information regarding homeless services and activities such as Homeless Connect, which the PATH case manager participates in. Pamphlets have been created and are distributed to various locations where homeless congregate.

Screening and Diagnostic Treatment: PDBHS offers screening and assessment services for PATH consumers to determine the clinical and service needs of the individual. All persons are triaged in Central Intake, which is the starting point for services with PDBHS. No appointment is required; Central Intake is available Monday – Friday, 8 a.m. to 5 p.m.

Habilitation and Rehabilitation: Path consumers may be referred to one or more services, which are designed to promote recovery, independence, maximum functioning and a sense of well being. Opportunity House, a psychosocial day program for adults with mental illness or co-occurring disorders serves more than 60 individuals and is open Monday through Friday. The Women's Center provides numerous services for women experiencing substance use or co-occurring conditions.

Community Mental Health Services: The PATH case manager will refer most PATH clients who are eligible for services to PDBHS for assessment and evaluation. Services can include case management, medication management, individual therapy, co-occurring services and/or psychosocial rehabilitation, PACT, Department of Aging and Rehabilitative Services or HIV/AIDS education. If PATH clients have health insurance Path case manager will assist clients with finding an outside provider if that is the client's preference.

Alcohol or Drug Treatment Services: The PATH case manager makes referrals to Substance Abuse Outpatient Treatment Services. The referrals for services are presented at the

multidisciplinary intensive treatment team meeting (ITT) for the appropriate levels of care.
Staff Training: The PATH case manager will provide in-service training and educational materials to the business associations, shelter volunteers, civic leagues, property managers, and the faith based community to address issues and concerns related to the homeless population. The PATH staff receive training through the COC, PDBHS, HUD, SAMSHA, Relias and state sources.
Case Management: The PATH case manager utilizes person-centered approach to treatment planning. Treatment plans address housing, entitlements, medical, food, shelter, clothing, budget and additional service needs. All service options or identified needs are documented in progress notes.
Supportive and Supervisory Services in Residential Settings: Eligible PATH consumers who are placed in transitional housing may receive Mental Health Case Management and/or Mental Health Skillbuilding Services (MHSS). Persons placed in permanent housing through Shelter Plus Care also receive supportive case management through the supportive service portion of the S+C grant and PACT services.
Minor Renovation: NA
Planning of Housing: PDBHS Transitional Housing.
Technical Assistance in Applying for Housing: The PATH case manager makes referrals to housing for eligible PATH clients, assists in filling out the application paperwork and assists them with finding housing.
Improving the Coordination of Housing Services: NA
Security Deposits: Eligible consumers are assisted on a limited as needed basis.
Costs Associated with Matching Eligible Homeless Individuals with Appropriate Housing Situations: For PATH eligible consumers, financial assistance may be provided in a limited basis to cover the cost of moving expenses, furniture or to satisfy outstanding consumer debt that is identified in the credit check. Cost to obtain identification may be covered.
One-time Rental Payments to Prevent Eviction: This funding will provide assistance to PATH eligible consumers who are at eminent risk of becoming homeless by definition. The PATH case manager will assess the risk for homelessness to determine if the person(s) meet the criteria for this one time assistance to prevent eviction.
Referrals for Primary Health Services, Job Training, Education Services and Relevant Housing Services: PATH refers to DARS, Goodwill Job Training Center, Oasis Occupational Center and VEC for job training, Maryview Foundation and Hampton Roads Community Health Center for health, and PARC, 2nd Chances, IMPAC, PCOM, PHRA, VHS and S+C for housing.

6. HMIS Data Integration: Describe your HMIS transition plan, with accompanying timeline, to begin using HMIS to collect and report PATH data in HMIS by July 1, 2016. If you are fully utilizing HMIS for PATH services, please describe plans for continued training and how you will support new staff. Indicate any technical assistance needs you may have in meeting the HMIS data requirements. The Portsmouth PATH program has been utilizing HMIS for the last 18 months. The PATH/Credible users group is developing forms and working on how to migrate information that prevents duplication of data input. Portsmouth CoC uses and supports HMIS, it is administered by the PARC program and Supportive Housing Program case managers use and are familiar with HMIS. The HMIS administrator for Portsmouth's CoC has been very supportive with training and technical advice. PDBHS already holds 4 licenses for HMIS use. Portsmouth is currently merging its' HMIS system with Norfolk/ Virginia Beach HMIS systems for a regional approach for tracking and ending homelessness.

7. SSI/SSDI Outreach, Access, Recovery (SOAR): Describe your plan to train PATH staff on SOAR. Indicate the number of PATH staff trained in SOAR and the number of PATH-enrolled consumers assisted through SOAR during State Fiscal Year 2013, and the approximate number of staff to be trained in SOAR for State Fiscal Year 2015.
The PATH case manager received SOAR training in November of 2014. There were no clients assisted through SOAR in 2013 as Portsmouth did not yet have an active SOAR program. There is one now. The state SOAR coordinator holds quarterly meetings with Portsmouth case managers who are SOAR trained.

8. Program demographics and cultural competency: Describe the following.

a. The demographics of the target population. The targeted population is single adults with mental illness. Per the 2010 census the Portsmouth population is made up of 51% African Americans, 45% Caucasians, 4% Other. The PATH case manager attends cultural competency workshops offered through City of Portsmouth/PDBHS and has worked with a diverse population for many years. The 2015 PIT count was 184 with 49 of those were identified as having mental health issues.

b. The demographics of the staff serving PATH consumers. The PATH case manager position is currently open.

c. How staff providing services to the target population will be sensitive to age, gender and racial/ethnic differences of consumers. The PATH case manager receives training available in motivational interviewing techniques, cultural sensitivity and diversity, aging and ethical issues encountered in dealing with the homeless populations. The PATH case manager's ability to work with a diverse population is displayed through respect for differences, empathy and knowledge of available resources to meet specific needs and/or interests.

d. The extent to which PATH staff receive training in cultural competence. Path staff receive training, as available, on cultural diversity through City of Portsmouth/DPHS, fair housing and other training resources.
Path staff receive training, as available, on cultural diversity through City of Portsmouth/DPHS, fair housing and other training resources.

e. The extent to which the organization adheres to the Culturally and Linguistically Competent

(CLAS) Standards. The CLAS standards can be accessed at http://www.ThinkCulturalHealth.hhs.gov.
PDBHS has a clearly stated policy on cultural and linguistic standards that adhere to the Virginia Department of Behavioral Healthcare and Developmental Services' (DBHDS) vision for culturally and linguistic competent care. Interpreters can be arranged for if/when needed.

9. Consumer and Family Involvement: Describe how individuals who are homeless and have serious mental illnesses, and family members will be involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards. (See attached Appendix I – Guidelines for Consumer and Family Participation.) Currently there is one consumer serving on PDBHS Advisory Board. There are also two formerly homeless consumers on the S+C board. One of our S+ C consumers, who was once in PATH, has volunteered to work with PATH program for outreach to homeless individuals. The Department of Behavioral Healthcare Services is in the process of re-establishing involvement with NAMI and previous PATH consumers are also involved in that organization through PDBHS. DBHS also is beginning a Family and Friends Group which is open to the general public.

10. Outreach to Homeless Veterans: Describe how your PATH program identifies and outreaches to homeless veterans with SMI, and the services available to them in your catchment area. How does PATH interface with your veterans' service continuum? Portsmouth is one of three designated communities in the Commonwealth of Virginia working with the Zero:2016 campaign to end homelessness in the veteran population. The Portsmouth CoC is working with the VA and other organizations working to find homes for veterans. The PATH case manager works with, and receives referrals from, all of these agencies. The PATH case manager is finding that she is working more with the vets who do not met criteria for some of the established programs due to receiving less than honorable discharges. These are very difficult to place as they are not eligible to receive benefits but often cannot hold a job.

11. Describe your PATH program's efforts to minimize the challenges and foster support for PATH clients with a criminal history, such as collaboration with local jail diversion and/or other programs. If you can, estimate the percent of PATH clients with a criminal history. It is estimated that approximately half of PATH clients have some kind of criminal history. PDBHS has a jail diversion program that will refer to PATH if their clients fit the criteria. For the most part these are of short duration as jail diversion clients are usually fast tracked to both medication management and case management. All of the Portsmouth CoC agencies are adhering to Housing First which housing individuals regardless of criminal history. Working with criminal backgrounds can be a challenge but most agencies work with a variety of landlords many of whom will rent to those with these backgrounds depending on what the charges were for. Sex offenders continue to have the most difficult time finding housing.

PATH Site Name: City of Portsmouth Department of Behavioral Health Services					
Budget FFY 2016/SFY 2017 (2016-2017 PATH Year)			PATH Funded	Match	Match Source (Cash or In-kind)
Staff Title	***Annualized*** Salary	FTE			
Case Manager	$32,400	1.00	$32,400		
				$12,371	
Total Staff Salary					
Fringe	12,371				
Total Personnel			**$32,400**	**$12,371**	
Travel (Outreach travel, travel for training, state meetings, etc.)					
Use of Agency Vehicle				$2,000	in kind
Training Travel			$100		
Training Conference Costs			$1,000		
Total Travel Costs			**$1,100**	$2,000	
Equipment (Personal property/equipment having useful life of more than one year)					
Lapotop (new)					
Cell Phone (replacement)					
Total Equipment Costs					

Supplies (Office Supplies, Outreach Supplies, Computer Software)			
Office Supplies	1,500		
Outreach Supplies	2,500		
Supplies	2,000		
Total Supplies Costs	6,000		
Contractual			
Cell phone service fee	500		
HMIS License and tech support	470		
Total Contractual Costs	970		
Other (List and Describe Each)			
Medication Assistance	500		
Identification related purchase costs (incl. Birth certificates)	1,030		
Rental Assistance/temporary shelter	7,415		
Bus Tokens	2,000		
Staff Training (non-travel registration and costs)	300		
Administrative Costs	0	3,629	inkind
Associated Housing costs	2,000		
Total Other Costs	13,245	3,629	
Total Proposed Budget	**53,715**	**18,000**	Is match > or = to 1/3 of federal allocation? >

Virginia PATH Local Intended Use Plan, FFY 2016/SFY 2017
PATH Program Year 2016-2017

1. Description of Provider Organization:
a. Name: Prince William Community Services
b. Organization Type: Community Mental Health
c. Description of Services Provided: The Prince William County Community Services (CS) is the umbrella agency for the area PATH program. CS provides mental health, intellectual disability, substance abuse, and early intervention programs as well as emergency services for children and adults. The PATH program is placed within the organization under the MH Community Mental Health Program (CMHP). The MH CMHP provides community-based services for individuals with serious mental illness (SMI) and/or co-occurring SMI and substance use disorders (SUD). These services include outreach, active case management, support services, intensive community treatment (ICT), and supported housing.
d. Region Served: The Prince William County Community Services serves Prince William County, the Cities of Manassas and Manassas Park.
e. Provider's experience in providing services to homeless/at-risk individuals and those with SMI and/or co-occurring SUDs: The Prince William County Community Services has provided services to individuals who are homeless or at risk for homelessness and have a Serious Mental Illness and/or a co-occurring Substance Use Disorder for more than 30 years.
f. Description of housing or services that are specifically targeted to PATH-eligible consumers: The CS Community Mental Health Program provides supportive housing (either directly or through partnerships) to 74 consumers who have a serious mental illness. The housing type is varied (independent apartments, townhomes, detached homes), enabling the program to uniquely match the consumer needs with the most appropriate home setting. PATH eligible consumers are given priority in all Community Mental Health, including housing support. PATH helps to meet the affordable housing gap through its organizational connection to the Community Mental Health Program.
2. Program Budget and Federal Funds Requested: (Attach detailed budget using Excel file provided by DBHDS):
a. Amount of federal PATH funds requested: The PWC CS requests a base amount of $88,067.
b. Source and amount of Provider's minimum required 33% match funds: The PWC CS match amount will be $30,914. *Proposed match pending agency approval.
c. A brief narrative describing the items in the attached budget: • Provides for a 0.8 FTE position as PATH Therapist – East and West. This equals 30 hours per week. • Provides for 0.4 FTE position as PATH outreach Therapist(s) – East and West. Therapist(s) will serve on an as needed basis, primarily during winter months, providing outreach, early engagement and case management. • Costs for staff travel to outreach sites, trainings and meetings. • Cell phone contracts for PATH therapist. • Office supplies for PATH staff. • Costs for computer software enabling staff to access EHR from the field.

- Costs for client travel, including the purchase of bus tokens from the PRTC Transportation Service.
- Supplies to assist the homeless. This includes tents, sleeping bags, inclement weather gear and other necessities for those who are literally homeless.
- Associated housing costs related to items needed to move into housing.
- Identification related expenses. This includes fees for birth certificates, DMV ID.
- Medication assistance to pay co-pays and medication related expenses.

Costs for staff training (registrations).

3. Collaboration with Local HUD Continuum of Care (CoC): Describe the organization's participation in the HUD Continuum of Care program, other local planning activities and program coordination initiatives, such as coordinated entry and coordinated assessment activities. If you are not currently working with the CoC, briefly explain the approaches to be taken by the agency to collaborate with the local CoC.

CS was involved with the Continuum of Care (COC) prior to the inception of the PATH program in the PW area and a PATH therapist has served on the COC since 1999. The Continuum of Care Network (COCN), formally known as the Homeless Services Network Council, is the group of area agencies that the PWC Board of County Supervisors tasked with coordinating and promoting homeless services in the Prince William County Area. Many agencies such as the local emergency shelters, transitional and permanent housing programs, and emergency assistance programs are members. The Prince William Area Departments of Social Services (Prince William County, The Cities of Manassas and Manassas Park), the county Housing and Community Development Agency, and the Community Services Board all participate in COC. Currently a PATH therapist, in addition to the COC bi-monthly meeting, actively participates in various sub-committees, including the Point-In-Time (PIT), Discharge Planning and the Unsheltered Homeless committees. This PATH therapist also co-facilitates the COC's outreach efforts for the PIT count, including mapping the locations and the organizing teams to ensure all known campsites have been accessed. The PATH therapist provides training to PIT survey takers related to conducting the survey in a manner that elicits valid information and is respectful of the individual's time and living space. This PATH therapist coordinates the PIT Count for CS and reviews the completed surveys for CS.

PATH services are the only services available to be provided to the target SMI / homeless population in the PWC area. Therefore, PATH services improve the continuum of services by filling a gap which would not be filled without a PATH Program. As a result, many more consumers are connected to mental health services, mainstream resources, assisted in obtaining SSI/SSDI (through the SOAR model), medical benefits and housing than would be served without a PATH Program.

The Coordinated Intake System for the greater Prince William area is decentralized, consisting of several entry points, including three primary shelters located in Prince William County. Other homelessness partner providers such as Department of Social Services, Office of Housing and Community Development, and various transitional and/or permanent supportive housing entities are represented as well. This system has been fully operational since the Spring of 2014.

4. Collaboration with Local Community Organizations: Provide a brief description of partnerships and activities with local community organizations that provide key services (i.e., outreach teams, primary health, mental health, substance abuse, housing, employment, etc.) to PATH eligible clients, and describe coordination of activities and

policies with those organizations. Provide specific information about how coordination with other outreach teams is achieved.

The PATH staff work closely with community providers to assist consumers.

Primary Health Care:

- Local Hospitals: Sentara Northern Virginia Medical Center in Eastern PWC and Novant Health Prince William Medical Center in Western PWC (PATH eligible consumers typically access medical service through the Emergency Departments). PATH therapists work effectively with hospital medical discharge planners, especially in outreach efforts for patients leaving against medical advice (AMA).
- The PWC Health Department Free Clinics (also with sites on each side of the county) provide medical care to uninsured, indigent consumers.
- The Sentara Northern Virginia Medical Center Mobile Health Care Vans also provide indigent medical care and are located at scattered sites in the County.

- The Greater Prince William Community Health Center (GPWCHC) has expanded their facilities, providing services to the eastern and western sides of the county. Most notable in this expansion has been the decision to provide medical care for an acute medical issue that can be addressed in an outpatient setting, thus preventing a visit to the local emergency room. This service is free of charge, for individuals who are homeless, without income or insurance. PATH therapists have established and will maintain a collaborative relationship with the PWC Free Clinic and GPWCHC.

Mental Health (MH) and Substance Abuse (SA) Treatment:

- Outpatient treatment: CS provides outpatient MH and SA services. Because PATH is coordinated through the CS, referrals are easily coordinated and relationships are collaborative. PATH therapists work closely with the intake therapist, Emergency Services staff, the Adult Services staff and Adult Substance Abuse Services. The PATH therapists are able to obtain services and are well informed about the services that best suit the consumer and that are open to accepting a referral for MH or SA services.
- Rehabilitation: The Prince William County CS does not have a residential substance abuse rehabilitation program but through contracts and relationships regularly refer out to other residential substance use treatment facilities in other counties, including Boxwood Treatment Center in Culpepper, VA, Phoenix House in Arlington, VA and The Salvation Army in Annandale and Richmond, VA.
- Social detox is provided through established contacts with Fairfax County ADS and Alexandria CSB.
- Medical detox for alcohol detox only is available through Novant Health Prince William Medical Center and Haymarket Medical Center. Other medical detox services are provided at the local psychiatric unit at the Prince William Medical Center's Behavioral Health In-patient Program (BHIP) which may be willing to take the PATH consumer if they also require acute psychiatric hospitalization. Detox programs also are available in local Northern Virginia hospital units for clients with Medicare and/or Medicaid. Boxwood expanded their services to include a medical detox program in the Spring of 2014. Boxwood accepts Substance Abuse Residential Purchase of Service (SARPOS) funds for residential and detox treatment.

Detoxification Programs: There is no structured social detox program located in Prince William

County. CS has contracts with Fairfax Social Detox and Alexandria Social Detox for bed purchase. These bed purchases are available as long as the funding lasts each year. The lack of medical detox for the indigent population creates pressure on the local emergency rooms and EMS system responding to crisis situations that occur when people who are at risk detox without medical supervision. PATH addresses this gap by coordinating with Community Services Substance Abuse programs to access detoxification and rehabilitation programs. In addition, CS SA controls the funding for indigent consumers and PATH helps consumers access those funds. As previously noted, Boxwood provides medical detox and although the facility accepts SARPOS funds, the price is quite steep, approximately $220 per day. Those funds are quickly depleted.

Facilitating referrals for services requires a close relationship with these mental health and substance disorder treatment providers. If the PATH therapists do not have a direct relationship with a provider they are able to leverage their relationship with the CS provider, who in turn has a good relationship with the detox or residential treatment program.

Housing:

Housing is expensive and difficult to find in the Prince William County area.

- Shelters: Prince William County utilizes three emergency shelter facilities for the homeless (SERVE, Inc., Hilda Barg Homeless Prevention Center and Beverly Warren Emergency Homeless Shelter), an emergency domestic violence shelter, and an emergency winter shelter operating November through March. There are 48 beds available for single individuals, while 130 emergency beds are available for families at the non-winter emergency shelters. The PATH therapists work very closely with the staff at all of these shelters, providing consultation, MH services, training and as a liaison with CS. The shelter staff is more comfortable accepting consumers with mental illnesses and/or substance abuse when they have a PATH staff to follow the consumer. The PATH workers go to the shelter to see the consumer rather than requiring the consumer come to the CS office.
- Transitional Living: There are nine transitional living programs with 170 beds serving families, singles and domestic violence victims, and 17 permanent beds operated by non-profits for mothers and children.
- Permanent Supportive Housing: The CS Community Mental Health Program has multiple housing sites for CS consumers with a serious mental illness. The CS also provides on-site mental health treatment and supportive services to 20 consumers who live in the Community Apartments (previously developed by a non-profit community provider through a HUD 811 grant). The CS Community Mental Health Program also partners with The Good Shepherd Housing Foundation to provide permanent supportive housing for 15 SMI consumers, five of whom must be homeless at entry. A Housing First program, Good Shepherd Leasing Program, utilizes the partnership between Good Shepherd and Community Services. This program houses ten SMI homeless consumers. PATH staff have referred and advocated for PATH consumers (all chronic homeless) to be among those housed through this program. PSH units have increased in PWC over the past several years. Northern Virginia Family Services (NVFS) has expanded their PSH stock, offering a total of 8 beds for the chronically homeless. Streetlight Community Outreach Ministries opened a medical respite facility and housed six medically fragile, chronically homeless individuals. Pathways Homes, Inc. allocated 10 PSH slots to PWC in March 2016. PATH clients who have transitioned into

mainstream services will be referred. PATH therapists work collaboratively with the PSH programs.

Homeless Drop In Center:
The Cooperative Council of Ministries (CCOM), in partnership with Prince William County Department of Social Services, operates a year round Drop-In Center, which works with many of the chronically homeless individuals. The PATH staff work closely with the Drop-In-Center and local churches (e.g., St. Paul's United Methodist and Vineyard Christian Fellowship's Streetlight Ministries) to assist PATH consumers to use this service. PATH staff maintains an established schedule at Drop-In, providing the opportunity for direct contact between the therapist and the SMI, homeless individual on a consistent and reliable basis.

Employment:
The Department of Aging and Rehabilitative Services (DARS) in connection with the Supported Employment Program (SEP) provides employment assistance. SEP is part of CS. PATH therapists make referrals and coordinate with these programs. In addition, many of the PATH consumers work with day labor employers. The PATH therapists help with coordinating transportation, provide bus tokens (after teaching how to use local transportation), and work with the consumer on managing symptoms in various settings, including making least harmful choices about substance use. The PATH therapist disseminates information related to specific hiring events and free re-employment workshops coordinated by SkillSource, a program under Northern Virginia Workforce System, directly to PATH consumers, members of the PW COC, and staff at the Homeless Drop-In Center. The PATH therapist has provided outreach to the manager at the Prince William SkillSource Center related to barriers to employment experienced by PATH consumers. These barriers include not only homelessness and mental illness but co-existing problems such as criminal background, co-occurring medical and substance use conditions, and lack of job skills relative to the burgeoning emphasis on computer related positions. SkillSource has responded by inviting PATH clients to participate in all activities at the Center.

5. Service Provision: Describe the plan to provide coordinated and comprehensive services to eligible PATH consumers. Please address the following information.

a. Projected number of adult consumers to be contacted with PATH funds: The PWC PATH program projects to outreach at least 170 individuals during FY 2017.

b. Projected number of adult consumers to be enrolled using PATH funds: The PWC PATH program projects to enroll at least 50 individuals during FY 2017.

c. Percentage of adult consumers projected to be "Literally Homeless", and activities to maximize the use of PATH funds to serve adults who are literally homeless as a priority population: It is projected at least 98% will be "literally homeless" during the proposed grant period.

d. Strategies that will be used to target PATH funds for street outreach and case management as priority services.

The PWC PATH program will utilize both permanent PATH therapist positions (0.8 FTE) as well as part-time as-needed outreach therapists for the purpose of outreach, engagement and case management activities. For the last six years, PWC PATH was able to extend the use of part-

time, as-needed outreach therapists beyond the Winter Shelter season, reallocating the deployment to various venues within the county. The flexibility responds to multiple site issues and allows the PATH program to increase person-power as needed. This flexible staffing plan has allowed for PATH presence at multiple sites, for different days, throughout the week. The PWC PATH program will demonstrate an increased street presence, specifically targeting campsites, public libraries, municipal parks, and sandwich and coffee shop establishments. PWC PATH staff has considerable experience providing case management, therapeutic and/or emergency services. The result is a projected increase in the number of consumers outreached, engaged and targeted for case management.

e. Indicate whether your organization provides, pays for, or otherwise supports evidence-based practices and other training for local PATH-funded staff, including training and activities to support migration of PATH data into HMIS.

The PWC CS provides and supports the following evidenced-based practices and training to PATH and non-PATH staff: Cognitive-Behavioral Therapy, Supportive Employment, Motivational Interviewing, Housing First, Dialectical Behavioral Therapy, Double Trouble in Recovery, ICCD Clubhouse Model, Trauma Informed Care, Integrated Dual Disorder Treatment, Prize Incentives Contingency Management for Substance Abuse, Promoting Awareness of Motivational Incentives, and Assertive Community Treatment. PWC CS will support and participate in trainings and activities related to the migration of PATH data into HMIS. PWC CS has assessed the technical assistance necessary to meet reporting requirements for HMIS and received training on data input into HMIS. PWC CS has opted to use PATH funds to pay existing support staff to enter data into HMIS

f. Describe gaps in the current service system and how PATH will assist consumers in addressing those gaps.

Housing: The primary gap for PWC is affordable housing. PATH consumers, as well as many others in the community, have difficulty obtaining safe and affordable housing. The PWC area does not have Single Room Occupancy (SRO) facilities or Safe Havens and has a very limited number of Assisted Living Facility (ALF) auxiliary grant beds. The Housing Choice Voucher Program through the PWC Office of Housing and Community Development (OHCD) opened for applications in 2010. During the two week enrollment period, 8000 names were added to the wait list. The wait list is not expected to open again during the proposed grant year. The City of Manassas and Manassas Park opened up for Housing Choice Vouchers in the fall of 2014 for a total of 3 hours and only accepted applications online. Within that 3 hour period, 4300 applications were submitted. PATH therapists methodically identified all PATH consumers agreeing to submit an application, gathered the pertinent information and, in a coordinated effort, entered the data into the system within the first 20 minutes, important when considering the applications were being processed as “first come – first served”. As PATH therapists learned of other Housing Choice Voucher opportunities throughout the Commonwealth, this same process was replicated. At least one formerly homeless PWC individual secured a voucher and used it to secure an apartment nearly 200 miles from her former campsite. Within the last several years, as vouchers have been returned to the OHCD through the natural course of events, they often have not been reissued to individuals on the waiting list. Rising rents and decreases in voucher recipients’ incomes have resulted in an increase in the cost per voucher – without a corresponding increase in funding for vouchers. This, coupled with the effects of sequestration,

has resulted in a reduction of funds available to support vouchers. As a result, not only is the wait list not expected to open again during the proposed grant year, it is likely that vouchers will not be issued to any of the individuals on the current wait list. PATH therapists coordinate with VA outreach staff to be certain that veterans outreached or enrolled in PATH submit applications for special housing vouchers (e.g. VASH vouchers) for homeless veterans.

Entitlements: The most significant issue continues to be the length of time it takes to process applications, wait for determinations, and, at times, appeal denial determinations for entitlement programs (e.g., Supplemental Security Income, Social Security Disability Income). Most emergency shelters will not allow a three to six month stay while the consumer's application is initially reviewed. When a consumer has a serious mental illness, complicated by a medical condition that is disabling, it can be very dangerous for that person to be unsheltered. Finding housing and consistent medical support while waiting for the determination is very difficult. In addition, many consumers need to be accompanied to Social Security, Social Services, etc. to apply for benefits. PATH addresses this gap by having a near-perfect record in Social Security claims being approved based on the initial application. A normal Social Security determination can take three months to two years. PWC PATH is successful in getting most Social Security benefits approved in three to six months. PATH therapists have received extensive training in applying for Social Security benefits. One of the PATH therapists completed the training of trainers program for SOAR (SSI/SSDI Outreach, Access and Recovery) and has provided SSI/SSDI training for staff of other non-profit housing providers in the community. This therapist has built a relationship with the local Social Security Administration and Disability Determination Services.

Detoxification Programs: There is no structured social detox program located in Prince William County. CS has contracts with Fairfax Social Detox and Alexandria Social Detox for bed purchase. These bed purchases are available as long as the funding lasts each year. The lack of medical detox for the indigent population creates pressure on the local emergency rooms and EMS system responding to crisis situations that occur when people who are at risk detox without medical supervision. PATH addresses this gap by coordinating with Community Services Substance Abuse programs to access detoxification and rehabilitation programs. In addition, CS SA controls the funding for indigent consumers and PATH helps consumers access those funds. As previously noted, Boxwood provides medical detox and although the facility accepts SARPOS funds, the price is quite steep, approximately $220 per day. Those funds are quickly depleted. Transportation is coordinated through the PATH program by accessing local churches to assist with funding to transport.

Health clinics: The Prince William Area Free Clinic system is over-capacity at this time. The clinic maintains a permanent office at a site donated by a local church. Because of limited funds, the clinic at this particular site is open only three and a half days of the week. The clinic continues to provide acute medical care at one off-site location on the western side of the county one night of the week. Because the line for services at this location is long, the clinic currently uses a lottery system - not all who show up will actually receive medical treatment. As previously noted, PATH eligible consumers typically access medical service through the Emergency Departments or perhaps short term stays on an in-patient unit. When no longer meeting the criteria for in-patient care, these consumers are discharged to the street. Shelters are

ill-equipped to address the overwhelming, acute medical needs of the consumer, making it more likely for the person to remain on the street.
The PATH therapists have been able to develop relationships with health care organizations to meet the need of PATH consumers on an emergency basis. In exchange, PATH has accepted referrals from these organizations, assisting those who may not meet PATH criteria but need mental health or other pertinent referrals, provided on an as-needed basis.
In addition, there is no Veterans Administration office, clinic, or hospital in PWC. PATH addresses this gap by either physically transporting consumers to a VA clinic in another county or coordinating with local churches to assist with funding transportation or volunteers to transport.

g. Describe services available for consumers who have both serious mental illness and substance use disorder.

Services available for homeless consumers with co-occurring SMI/SUD include detox, residential treatment, outpatient group and individual treatment, and self-help groups. Detox, residential, and outpatient treatment services all can be accessed through CS. CS directly provides outpatient services for individuals with co-occurring disorders. Through CS and regional contracts, detox and residential treatment services are available to medically indigent consumers with co-occurring disorders at various sites in the region and state (e.g., Boxwood in Culpeper, Crossroads and Cornerstones in Fairfax). Individuals with Medicaid and/or Medicare who require inpatient treatment services may be linked to local hospital inpatient units including the Behavioral Health In-Patient at Novant Health Prince William Medical Center and the Virginia Hospital Center's psychiatric and addiction treatment services. PATH staff also link consumers to the Veterans Administration for residential treatment services and to AA/NA groups in the community — including several that are held at the local Hilda Barg Homeless Prevention Center. Self-help groups for individuals with co-occurring disorders (e.g., Double Trouble) are a vital part in the community and at the consumer run drop-in center (Trillium). PATH staff link to these groups as appropriate.

CS staff have received training specific to identifying and treating adults with co-occurring disorders and providing integrated treatment for this population. Staff has received at least basic skill training in motivational interviewing techniques, assessment for level of care for SUDs using ASAM criteria, and cognitive behavioral therapy. As staff members of CS, PATH staff has participated in these trainings as well as in-depth training programs in Motivational Interviewing and trainings specific to assessment and treatment of consumers who have a trauma history (a frequent issue with consumers who are homeless and particularly those who have SUDs). PATH staff members have and will continue to identify, engage, and link/transition homeless consumers to appropriate SMI/SUD treatment programs and self-help groups. The PATH staff members are particularly skilled in the use of motivational interviewing to engage consumers. Staff understands the need to address both the SMI and the SUD concurrently. PATH staff will continue to screen and assess for co-occurring SMI and SUD, engage consumers through the use of motivational interviewing methods – often building trust through assisting the consumer to meet basic survival needs – and will refer and link to appropriate co-occurring treatment programs based on level of psychiatric stability and seriousness and acuity of SUD symptoms. PATH staff will link consumers by providing information on resources, addressing questions and concerns, meeting together with the consumer and mainstream treatment provider,

and/or providing transportation to treatment.

h. Describe strategies for making suitable housing available to PATH consumers (e.g., indicate the type of housing usually provide and the name of the agency that provides such housing).

Most available housing is provided through the CSB Mental Health CMHP or Good Shepherd Housing Foundation (GSHF). The GSHF has multiple HUD grants through the Continuum of Care which include permanent supportive housing for low income and disabled and Housing First units. All case-management and supportive services are provided for GSHF housing by CS staff. As previously noted, PATH clients are on multiple waiting lists under the Housing Choice Voucher program throughout Virginia. Also noted, PSH opportunities for PATH consumers have expanded over the last year to include Northern Virginia's Family Services' PASS program, Streetlight Community Outreach Ministries communal living program for the chronically homeless, and Pathways Homes, Inc. Consumers also seek housing in Oxford Houses. PATH therapists search for individually rented rooms and other shared housing opportunities through known websites sites such as Craig's List or Trulia. The PATH supervisor works closely with the Continuum of Care Network to advocate for and obtain more affordable housing for the chronically homeless. The PWC Continuum of Care 10 Year Plan to End Homelessness includes Affordable Housing Strategies as one of the four areas addressed in the plan. Both an increase in Affordable Dwelling Units (ADU) and Housing First units are identified strategies in the plan. The PATH staff support and coordinate with other homeless services programs, emergency shelters, Drop-In-Center, and churches. At various times all of the homeless service providers are involved with referrals, often through word of mouth and networking. Finding financial supports for individual consumers and developing resources is a full-time task. This work is performed in coordination with the various providers – both at a programmatic and an individual case manager level. The PATH program refers, advocates and coordinates with the CS Community Mental Health Program for PATH consumers. The PATH therapists often continue to stay involved with the consumer while they develop a relationship with their Community Mental Health therapist/case manager. The PATH program proposes, and when needed, finds financial support for housing programs for people who have a serious mental illness and are homeless.

i. If you plan to implement one or more Virginia PATH Innovative Practices, indicate which one(s) and describe the implementation plan:

PWC PATH does not plan to implement a Virginia PATH Innovative Practice during FY 2017.

j. Briefly describe your plan for providing the following PATH-allowable services:

Outreach:
The Prince William County PATH Program proposes to continue providing outreach to identify and engage individuals who do not access traditional services. Staff will continue to focus on those individuals who are experiencing chronic homelessness and have an untreated mental illness/substance abuse disorder. Developing rapport, screening for PATH, CS, and Social Security eligibility, offering support with basic needs, and making appropriate referrals currently are daily occurrences for PATH therapists. PATH staff provides direct active outreach services in the local homeless drop-in-center and local church congregate meal sites, on the street, at shopping centers, at campsites, and in the woods. Some of the

outreaches provided to consumers are in-reaches at the three local emergency shelters (Hilda Barg Homeless Prevention Center (HBHPC), Beverly Warren Shelter and SERVE), the Hypothermia shelter, the winter overflow portion of the HBHPC emergency shelter, and domestic violence shelters. During the past six Winter Shelter seasons, PWC PATH utilized part-time outreach therapists, accounting for 0.4 FTE. This flexible staffing plan allowed for PATH presence at multiple sites, for different days, throughout the week. The flexibility not only responds to multiple site issues but also allows the PATH program to increase hours during the busier winter months. The result is a projected increase in the number of consumers outreached and engaged. Many consumer outreaches begin with providing supplies to meet basic needs (e.g., bus tokens, sleeping bags, tents). This proposal includes continued funding for these outreach supplies.
Screening and Diagnostic Treatment: Services provided by the PATH therapists will continue to include routine screening for PATH services, diagnosis, mental health services, co-occurring services, Social Security, Medicaid, SNAP, and Medicare Part D, as well as comprehensive assessments such as those required for a disability determination report. More detailed screenings are conducted for specific programs such as the CS Community Mental Health Housing Program.
Habilitation and Rehabilitation: The PATH therapists assess consumers to determine their needs and discuss consumer preferences in obtaining resources to meet those needs. Therapists work with the consumers to increase functioning through the development of a supportive relationship and education on healthy ways to meet their needs. Prince William CS and PATH staff has adopted a mental health recovery model that promotes maximum functioning, a sense of well-being and increased independence.
Community Mental Health Services: Services provided by the PATH therapists include (1) accessing appropriate CS programs and supportive linking to the treating therapist and psychiatrist; (2) educating consumers on symptom management and about their illness; (3) coaching consumers on making positive life choices congruent with their personal goals; (4) obtaining emergency care; and (5) completing referrals for Community Mental Health Housing Program. Motivational Interviewing is frequently used to assist consumers based on their relevant "stage of change."
Alcohol or Drug Treatment Services: The PATH therapists provide alcohol and drug treatment as a service to PATH eligible consumers. The PATH therapists link consumers in need of mainstream substance treatment within CS and to other providers. They follow up, monitor, and support the consumer's substance abuse treatment plan. As with mental health services, Motivational Interviewing methods frequently are used to address consumer motivation related to alcohol and/or drug use.
Staff Training: The PATH therapists provide training and consultation to volunteers and paraprofessionals who serve the homeless in Prince William County. The training includes formal sessions, (e.g., a yearly training program for the Winter Shelter/Hypothermia Shelter staff, as-needed training to staff at a local emergency shelter, training for the Point-In-Time survey as it relates to strategies for outreach and engagement) as well as ongoing consultation for homeless service providers. PATH staff participates in the semi-annual PWC Crisis

Intervention Team (CIT) training that includes police patrol officers and jail staff, specifically related to engaging individuals with a serious mental illness and who are homeless. Consultation is provided on accessing available community resources, benefits, the mental health system, treatment options for consumers, and boundary issues between worker and consumers. PATH provides trainings at CS to educate CS staff about PATH and the resources available to homeless consumers and to educate staff on obtaining Social Security benefits using the SOAR model. PATH staff will continue to be involved in training local law enforcement officers and provide consultation to peer staff in consumer operated programs (e.g., Trillium, the consumer-run drop in center) on issues related to individuals who are homeless and SMI. PATH staff also provides consultation to local community groups (e.g. local town council, civic associations, and faith-based groups) to address issues related to homelessness.
Case Management: Case management services provided by the PATH therapists include directly assessing and linking to community services (mental health, benefits, medical and dental services), coordinating the delivery of services, collaborating with other service providers, following-up to determine if the consumer accessed the needed service, monitoring progress and advocating for the consumer's needs. PATH therapists work collaboratively with consumers to define their needs and develop a case plan for accessing and linking to community services. The case management plan always begins with what the consumer wants. Mental health may not be the consumer's priority but can be worked on as basic needs are beginning to be met. Case management activities include: linking to the mainstream CS; accessing Social Security entitlements, Medicaid, SNAP benefits; linking to Brain Injury Services, linking to medical health services, assisting to obtain identification, accessing reduced fare transportation services, and linking to employment services.
Supportive and Supervisory Services in Residential Settings: The PATH therapists provide support to consumers in their transition into mainstream services. This includes adjusting to shelters and residential placements. For example, PATH therapists provide outreach at all of the emergency shelters in PWC, the domestic violence shelters and occasionally in transitional living programs when homelessness is imminent. PATH therapists often meet consumers for the first time at a shelter or PATH therapists sometimes are instrumental in getting consumers into shelters and provide ongoing support while there. PATH therapists also provide support as consumers transition from PATH to mainstream mental health and substance abuse services, including residential placements.
Minor Renovation: The PWC PATH program does not provide funds for minor renovation. PATH does connect consumers to local organizations, such as Project Mend-A-House, an organization of volunteers assisting seniors, disabled, and low-income residents of Prince William County with basic home repairs, including modifications for wheelchair accessibility.
Planning of Housing: The PWC PATH program is both directly and indirectly involved in the planning of housing. PATH staff has direct input to CS plans related to supported housing. For example, a PATH therapist also serves in a supervisor role with the Community Mental Health Program. The PATH therapist / supervisor can make direct referrals to the program, provide guidance and shepherd referrals through the process. The majority of the part-time PATH therapists work with SMI clients in the community in various residential settings, e.g. communal living

arrangements and permanent supported housing in independent apartments. For that reason, PATH therapists are in a unique position to identify the type of housing within the CS Community Mental Health residential program needed for PATH clients Additionally, a member of the PATH staff serves as the CS representative to the Prince William Continuum of Care and is directly involved in the development of the communities HUD required 10 Year Plan to End Homelessness.
Technical Assistance in Applying for Housing: The PATH therapists accompany the consumer to fill out application forms for the Housing Choice Voucher program, complete applications for supportive residential services through CS or non-profit community housing providers, and assist the consumer in applying for commercially leased apartments or rooms in the community. The PATH therapists also provide information to consumers on availability and safety of the neighborhood where housing is located. In addition, the PATH therapists advocate with housing providers and landlords for PATH consumers.
Improving the Coordination of Housing Services: The PWC PATH program improves the coordination of housing services by serving on the local Continuum of Care. PATH staff is actively involved in Continuum of Care committees and problem-solving and collaborating with partner agencies on the Continuum of Care.
Security Deposits: The PWC PATH program does provide security deposits to PATH clients to assist them with obtaining housing.
Costs Associated with Matching Eligible Homeless Individuals with Appropriate Housing Situations: Currently the PATH program is not funding this area. The PATH therapists do match homeless individuals with appropriate housing through newspapers and housing lists.
One-time Rental Payments to Prevent Eviction: The PWC PATH program does not provide One-time Rental Payments to Prevent Eviction. PATH does connect consumers to churches and the Homeless Intervention Program to assist with security deposits and short term rental assistance.
Referrals for Primary Health Services, Job Training, Education Services and Relevant Housing Services: The PATH therapists assess consumers and, where appropriate, refer to primary health services, job training, education services, and relevant housing services. The primary health services include referrals to Northern Virginia Family Services where staff assists consumers with applying for pharmaceutical companies' patient assistance programs to obtain medications. Referrals are also made to the Health Department Free Clinic, Greater Prince William Community Health Center and the Sentara Northern Virginia Family Health Connection Mobile Health Van for medical care of indigent consumers. These programs serve those without income or insurance. PATH therapists routinely refer to job placement assistance services such as: the Virginia Employment Commission, Department of Rehabilitative Services, Supported Employment Program, and the Department of Social Services Job Center. PATH also regularly refers to income supports such as: Social Security entitlements, DSS, and the Veterans Administration as needed. Referrals to housing services include: the Community Mental Health program in CS, Office of Housing and

Community Development, and non-profit agencies. Education referrals may be made to GED programs and a local literacy volunteer program whenever needed.

6. HMIS Data Integration: Describe your HMIS transition plan, with accompanying timeline, to begin using HMIS to collect and report PATH data in HMIS by July 1, 2016. If you are fully utilizing HMIS for PATH services, please describe plans for continued training and how you will support new staff. Indicate any technical assistance needs you may have in meeting the HMIS data requirements.

- March 2016 – PWC CS PATH became an active participant in the local HMIS (Service Point by Bowman Systems). CS purchased three user licenses for the remainder of FY 2016.
- March and April 2016 – PWC CS received training from the PWC COC HMIS systems administrator that included making new clients records and adding to existing records.
- April through June 2016 – PATH data from July 1, 2015 to present will be extracted from CS electronic health record (Credible) and put into HMIS.

Seeking to minimize PATH therapists' duplication of effort resulting from using two independent record systems, CS chose to utilize existing support staff to assist the PATH therapist / coordinator and another supervisor with data input. The expense for the support staff will be identified in the proposed budget.

7. SSI/SSDI Outreach, Access, Recovery (SOAR): Describe your plan to train PATH staff on SOAR. Indicate the number of PATH staff trained in SOAR and the number of PATH-enrolled consumers assisted through SOAR during State Fiscal Year 2013, and the approximate number of staff to be trained in SOAR for State Fiscal Year 2015.

The PWC CS SOAR trainer completed an intense SOAR Train the Trainers program. SOAR based trainings have been provided to CS clinicians as well as community partners, such as emergency shelter case managers, non-profit housing providers and crisis stabilization clinicians on an annual basis for the last seven years. To date, 240 individuals have been trained. It is estimated at least 30 staff will be trained in FY 2017. Trainings will continue on an annual basis. At this point, seven PATH staff has been trained using the SOAR model. PATH clinicians have assisted 8 consumers with SSI/SSDI applications using the SOAR model through three quarters of FY 2016.

8. Program demographics and cultural competency: Describe the following.

a. The demographics of the target population.

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PATH Race/Ethnicity Categories	% Target Population
American Indian or Alaska Native:	2%
Asian:	0%
Black or African American:	36%

Gender	% Target Population
Male	57%
Female	43%

Hispanic or Latino:	6%
Native Hawaiian or Other Pacific Islander:	0%
White:	37%
Two or more races:	19%

Age Parameters	% Target Population
17 under	0%
18-23	7%
24-30	14%
31-50	40%
51-61	31%
62+	7%

b. The demographics of the staff serving PATH consumers.

PATH Race/Ethnicity Categories	% PATH Staff
American Indian or Alaska Native:	0%
Asian:	0%
Black or African American:	60%
Hispanic or Latino:	0%
Native Hawaiian or Other Pacific Islander:	0%
White:	30%
Two or more races:	10%

Gender	% PATH Staff
Male	10%
Female	90%

Age Parameters	% PATH Staff
18-34	60%
35-49	30%
50-64	10%

c. How staff providing services to the target population will be sensitive to age, gender and racial/ethnic differences of consumers.

The PATH therapists have a long history in treating people with Serious Mental Illness with a variety of backgrounds, races, ages and disabilities. PATH staff, through a CS contract with Language Learning Enterprises (LLE), has access to face-to-face and telephonic translation, for consumers who are hearing impaired, or whose primary language is something other than English. PATH therapists have completed graduate level courses in Assessment and Treatment of Diverse Populations; Multicultural Counseling; Counseling Diverse Populations; Clinical Social Work in Relation to Chronic Mental Illness with a focus on the interplay between diversity and serious mental illness; Mental Health and Social Policy with a focus on systemic discrimination; and Planning of Health Education Programs which addressed designing culturally appropriate intervention strategies. Post graduate trainings include Broaching Race in Counseling; Culture and Its Effect on Communication; Cultural Awareness in Therapeutic

Settings: How Oppression Impacts the Recovery Process in Mental Health and Substance Abuse; and Mental Health: Culture, Race and Ethnicity.

CS staff in general exemplifies diversity relative to their work, extending beyond race and gender. Though staff members are not required to disclose personal mental health diagnoses, a number do have mental health diagnoses. In addition, CS Community Mental Health has a designated Peer Specialist with a SMI diagnosis working on the Community Mental Health's Program for Assertive Community Treatment (PACT) team.

d. The extent to which PATH staff receive training in cultural competence.

For a comprehensive list of courses and trainings PATH staff has had relative to cultural competence, note the information as stated above (8.c.). PWC University provides classroom and online training opportunities to all CS staff on multiple subjects, including Cultural Diversity. Additionally PATH staff participates in online and classroom trainings designed to provide quality services for special populations beyond the general areas of race and ethnicity. This includes trauma survivors, military veterans, individuals with an Intellectual or Developmental Disability, individuals adjudicated Not Guilty by Reason of Insanity (NGRI) and those experiencing generational poverty.

e. The extent to which the organization adheres to the Culturally and Linguistically Competent (CLAS) Standards. The CLAS standards can be accessed at http://www.ThinkCulturalHealth.hhs.gov.

The PWC CS works to ensure that consumers receive from all staff members' effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language. As previously noted, the PWC CS provides language assistance services, including bilingual staff and interpreter services, at no cost, to consumers with limited English proficiency. Individuals or their authorized representatives receive written notice of their rights and of the appeal process at their time of admission, annually thereafter, and each time services are denied or terminated without the individual's agreement. If an individual is unable to read the written notice or is non-English speaking or deaf, the notice is read to or translated for the individual in a language or sign language understandable to him or her. All reasonable efforts are made to ensure that individuals understand their rights. Such activity is noted in the client record.

9. Consumer and Family Involvement: Describe how individuals who are homeless and have serious mental illnesses, and family members will be involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards. (See attached Appendix I – Guidelines for Consumer and Family Participation.)

The PWC CS has a proven track record of involving mental health consumers and their family members in program administration, planning, implementation, and evaluation. The PWC CS involves and solicits input from consumers and their family members through both formal and informal processes. For example, consumers and/or their family members have and do serve as members of the Community Services Board directing the mental health, intellectual disability, and substance abuse services for Prince William County. PATH, as a program of the CS,

receives oversight from this same Board. Additionally, in recent years Prince William County has been fortunate to see an increase in consumer advocacy and consumer-run services and to have established processes for collaboration and communication. For example, quarterly meetings are held with professional and community stakeholders including 1) representatives of consumer organizations (e.g., Trillium – a consumer run drop in center), 2) the president of the local chapter of the National Alliance for the Mentally Ill, 3) CSB Executive Director and, 5) managers from CS Emergency Services, Adult Services, Community Mental Health, and Vocational Service programs. The purpose of these meetings is to share information, seek input, and facilitate overall collaboration between consumers and provider programs within the CS. Because of the level of need and numbers of homeless encountered through programs such as Trillium consumer input and collaboration with PATH is frequent. Issues specific to serving individuals who are homeless and have an SMI and/or co-occurring SMI/SUD are frequent topics. Consumer input also is obtained through surveys throughout the year. CS is committed to maintaining and further developing formal and informal processes to receive input from its consumers and to use the information to inform continuing service improvements.

10. Outreach to Homeless Veterans: Describe how your PATH program identifies and outreaches to homeless veterans with SMI, and the services available to them in your catchment area. How does PATH interface with your veteran's service continuum?

PATH staff provides direct active outreach services to veterans in the local homeless drop-in-center and local church congregate meal sites, on the street, at campsites, and in the woods. PATH therapists receive referrals from other homeless service providers or veterans volunteering their time in the community, often not part of an organization but simply as a way to help a peer. Assessment of veteran status is normally completed at the first or second contact during the outreach phase of engagement. As the veteran becomes an enrolled PATH client, an assessment is completed identifying needs, such as untreated mental illness, health issues, lack of income and housing. PATH therapists link clients directly with mainstream services for issues exposed in the needs assessment. Services available to veterans include mental health, substance abuse, primary health, case management, employment, education and housing as identified in Section four of this application. PATH therapists directly link clients with services available to only veterans, such as the US Department of Veterans Affairs (VA) Medical Center in Washington, DC; the VA Healthcare for Homeless Veterans; and the VA case manager responsible for HUD VASH vouchers. Within the last 18 months, Friendship Place and Operation Renewed Hope Foundation have begun working with the PWC COC to identify veterans for housing opportunities. As the VA is designed to provide housing for honorably discharged veterans only, Friendship Place and Operation Renewed Hope Foundation can house veterans under any discharge status that is not dishonorable, thus opening the door for more overall veteran eligibility. In keeping with the emphasis to house all veterans by the end of 2015, PWC placed great emphasis on outreaching to the unsheltered homeless population to identify veterans to begin the process of securing housing. PWC PATH was represented on the veterans workgroup subcommittee under the PWC COC, formed to identify all known campsites, coordinated with the "leadership" of each site and establish a process of not only identify the veterans of that area for targeted services but also the needs and preferences of the group at large. A total of 44 formerly homeless veterans in PWC have been housed through this collaborative effort during the first three quarters of FY 2016.

11. Describe your PATH program's efforts to minimize the challenges and foster support for PATH clients with a criminal history, such as collaboration with local jail diversion and/or other programs. If you can, estimate the percent of PATH clients with a criminal history.

The PWC CS PATH therapist became a member of the PWC Jail Divert Committee in September 2015. The PATH therapist is an active participant on the committee, working with fellow committee members to identify barriers associated with being homeless and having a criminal record. The PATH therapist provides information on community resources, shelter requirements and potential housing opportunities to other members. PATH staff encourages clients to sign releases of information for Office of Criminal Justice Services (OCJS), local offender Office of Probation and/or Pre-trial Services. PATH staff offers support, identify local resources, and troubleshoot barriers so that clients can better fulfill the obligations identified in the conditions of release established by OCJS. PATH therapists will coordinate with clients' attorneys, usually appointed by the court, in matters related to arrests that can be directly or indirectly linked to the client's homeless status or mental illness. The PATH therapist has maintained a list of local and national businesses that agree to hire individuals with felony records. PATH therapists link clients with Prince William SkillSource, offering free workforce resources including resume writing and interviewing techniques. The PATH therapist has contacted the PWC SkillSource director for matters directly related to the barriers facing PATH clients with criminal histories. All have been encouraged to attend the SkillSource Center, regardless of history.

PATH Site Name: Prince William County Community Services Board					
Budget FFY 2016/SFY 2017 (2016-2017 PATH Year)					
Staff Title	***Annualized*** Salary	FTE	PATH Funded	Match	Match Source (Cash or In-kind)
PATH Therapist	$86,191	0.80	$45,953	$22,976	cash
PT Time as Needed Outreach	$54,697	0.35	$12,763	$6,381	cash
PT Time Support Staff @ 1.5	$47,372	0.05	$2,429	$1,215	cash
Total Staff Salary	$188,260	1.2	$59,931	$30,572	
Fringe	$23,872		$23,872		
Total Personnel			**$83,803**	**$30,572**	

Travel (Outreach travel, travel for training, state meetings, etc.)				
Outreach travel		$300		
Training Travel		$100		
Total Travel Costs		**$400**	**$0**	

Equipment (Personal property/equipment having useful life of more than one year)				
Total Equipment Costs		0		

Supplies (Office Supplies, Outreach Supplies, Computer Software)				
Office Supplies		100	$100	
Outreach Supplies		939	$60	
Micro computer Software Pkg		800		
Total Supplies Costs		**1,839**	**$160**	

Contractual				
Cell phone services		125		
Total Contractual Costs		**125**	**0**	

Other (List and Describe Each)				
Medication Assistance		100	140	
Identification related purchase costs (incl. Birth certificates)		150		
Housing Move-In Associated Costs (e.g., linens, dishes)		250		
Rental Assistance		400	42	
Bus Tokens		200		
Staff Training (non-travel registration and costs)		200		
Cab Vouchers		600		
Administrative Costs				
Total Other Costs		**1,900**	**182**	
Total Proposed Budget		**$88,067**	**$30,914**	Is match > or = to 1/3 of federal allocation?Yes

Virginia PATH Local Intended Use Plan, FFY 2016/SFY 2017
PATH Program Year 2016-2017

1. Description of Provider Organization:

a. Name:
Rappahannock Area Community Services Board (RACSB)

b. Organization Type:
Community Mental Health (RACSB is the public Mental Health, Intellectual Disability and Substance Abuse Organization for the district)

c. Description of Services Provided:

RACSB is committed to improving the quality of life for people residing in Planning District 16 with mental health, intellectual disabilities and substance abuse problems and to preventing the occurrence of these conditions. We do this through an integrated community-based system of care that is responsive to consumer needs and choices. We respect and promote dignity, rights and full participation of individuals and their families.

d. Region Served:

Rappahannock Area Community Services Board (RACSB) serves Planning District 16 constituting Spotsylvania, Stafford, Caroline, and King George Counties and the City of Fredericksburg.

e. Provider's experience in providing services to homeless/at-risk individuals and those with SMI and/or co-occurring SUDs:

The special needs of homeless clients with co-occurring serious mental illness and substance use disorders will be met much better due to the RACSB PATH supported staff person. PATH staff will provide initial screening and assessment to determine general needs and mental health issues that need to be addressed. The individual will then be referred to RACSB providing an integration of mental health and substance abuse services. As appropriate, PATH staff will advocate for referral and they will aid program staff to establish better rapport. PATH staff will aggressively provide individualized support and service to improve the likelihood of follow-through by the consumer. The PATH Case Manager will assist the consumer in securing transportation resources by introducing the individual to the Fredericksburg Public Transportation System and training the individual, if needed, in the use of the system. Medicaid funded transportation services will be pursued where appropriate once Medicaid has been applied for and secured. When possible, the PATH Case Manager will coordinate transport of the individual until the individual is established in the community in permanent housing and transportation alternatives have been arranged. The PATH worker will assist Veterans with coordinating transportation to the VA clinic. PATH participants are also given information about AA and NA meetings. The PATH Case Manager encourages participation in these meetings by providing support and assistance to find transportation and contacts.

f. Description of housing or services that are specifically targeted to PATH-eligible consumers:

Using funding primarily from non-PATH sources, Micah Ministries operates a supportive housing program that targets the chronic homeless – individuals with a disability who have been homeless a year or more or more than four times in a three year period. The disability of these individuals is often mental health, thus making them PATH-eligible. Through the use of individual incomes and funds from the Department of Housing and Urban Development, Micah places qualifying homeless individuals in scattered site apartments and provides staff support that helps them maintain housing, increase skills and/or income and increase client self-determination.

2. Program Budget and Federal Funds Requested: (Attach detailed budget using Excel file provided by DBHDS):

a. Amount of federal PATH funds requested: $98,144

b. Source and amount of Provider's minimum required 33% match funds: Matching funds will be available July 1, 2016. The total program cost is $130,859. The local match from RACSB will be available at the beginning of the grant period. Micah Ecumenical Ministries is contributing $32,715 to RACSB as part of an area wide project to address the homeless.

c. A brief narrative describing the items in the attached budget: Approval of this grant will fund two staff, a PATH outreach worker and contracted SOAR Coordinator, who deliver PATH-eligible services to individuals who are homeless with a serious mental illness. The proposal also includes funds to support the travel and equipment needs of both positions, plus an allotment for basic need assistance to individuals who are PATH eligible.

3. Collaboration with Local HUD Continuum of Care (CoC): Describe the organization's participation in the HUD Continuum of Care program, other local planning activities and program coordination initiatives, such as coordinated entry and coordinated assessment activities. If you are not currently working with the CoC, briefly explain the approaches to be taken by the agency to collaborate with the local CoC.

The Rappahannock Area Community Services Board and its PATH program works closely with the Fredericksburg Regional Continuum of Care (CoC) and also with the area agencies who serve the homeless and at risk population. Information is shared through HMIS to ensure the coordination and quality of services to the individual. RACSB is an active member of the CoC, which is comprised of more than 25 agencies serving Planning District 16 (PD16). Its goal is reducing the number of people experiencing homelessness, reducing returns to homelessness, and reducing the number of people who become homeless. RACSB, including staff from PATH, Jail Diversion and residential programs, attend CoC meetings each month and collaborate with the partner agencies there to identify gaps in services which may lead to homelessness. In addition, the PATH Outreach Worker actively participates with interfaith groups and churches within the planning district by providing mental health and other referral services for individuals/families identified as resistant to access services. PATH also participates in weekly discharge planning with MH Inpatient programs such as Snowden at Fredericksburg and with the Behavioral Health Unit of

Spotsylvania Regional Hospital. In addition the Outreach Worker meets with staff and individuals at the Rappahannock Regional Jail prior to release of individuals to homelessness when they are identified as having a serious mental illness.

The Fredericksburg Area CoC provides a coordinated entry and assessment through a Central Intake program administered by the Central Virginia Housing Association. Central Intake provides families and individuals with coordinated assistance connecting them to appropriate community resources. The Central Intake program is provided for Planning District 16 only. Services are available Monday and Thursday from 8am to 11am and 2pm to 4pm. Appointments are available on Tuesday, Wednesday or Friday. The most appropriate service is determined through a common screening tool that is incorporated in each agency's intake process. EmpowerHouse serves those fleeing domestic violence; Hope House/Mary's Shelter serves women with children; Thurman Brisben shelters lower barrier singles and adults and Micah serves individuals who don't fit into another organization. People who are at risk of homelessness are referred to the Central Virginia Housing Coalition, which assesses the need and connects the household to necessary resources that will keep them from becoming homeless.

The PATH program assists the CoC in conducting the local Point-in-Time (PIT) count of the homeless of Planning District 16. Micah Ministries and RACSB are active participants in a number of current COC committees, which are working on a regional plan to address three main goals—housing, discharge planning and communications. The 2015 Point in Time count accounted for 217 (HUD-qualified) homeless individuals in Planning District 16. The PIT data shows a decrease in chronic homelessness in our community while it had been trending up over the last several years:

2010: 288 total homeless: 83 met the definition of chronic homelessness
2011: 280 total homeless: 68 met the definition of chronic homelessness
2012: 193 total homeless: 47 met the definition of chronic homelessness
2013: 189 total homeless: 51 met the definition of chronic homelessness
2014: 193 total homeless: 75 met the definition of chronic homelessness
2015: 217 total homeless: 42 met the definition of chronic homelessness

4. Collaboration with Local Community Organizations: Provide a brief description of partnerships and activities with local community organizations that provide key services (i.e., outreach teams, primary health, mental health, substance abuse, housing, employment, etc.) to PATH eligible clients, and describe coordination of activities and policies with those organizations. Provide specific information about how coordination with other outreach teams is achieved.

In our community homeless individuals and families are served by the Thurman Brisben Homeless Shelter and Micah Ecumenical Ministries. In addition, Hope House, is an emergency shelter serving women with children, who are homeless and need assistance with childcare, job training and in establishing more permanent housing. EmpowerHouse, formerly known as Rappahannock Council on Domestic Violence, sponsors a shelter for

people fleeing domestic violence. Mary's Shelter also takes women who are homeless and pregnant. All of the above shelters serve individuals who may also have a diagnosis of a serious mental illness.

The PATH Outreach team consists of one PATH Outreach Worker who leverages his resources and time by working closely with Micah and other CoC members, as well as maintaining effective communications with area hospitals, clinics, agencies and law enforcement which interact with homeless individuals and families. The PATH Outreach worker provides community presentation to staff at the Rappahannock Regional Jail, EmpowerHouse, Thurman Brisben Shelter, Caroline County Social Services, Spotswood Baptist Church Youth Group and maintains a presence at VA and VFW Stand Down where the focus is on homeless veterans.

The PATH program's relationship with Micah Ministries also positions it to influence the overall homeless service system to better serve individuals experiencing serious mental illness. Being a part of Micah gives the PATH program legitimacy as it develops working relationships in the greater community. As a result, the program has formed working relationships with 5 local Department of Social Services, three hospitals and Snowden of Fredericksburg, the Moss Free Clinic, the Central Virginia Housing Coalition, Quinn Rivers, the Salvation Army, the Veteran's Administration, Access Wireless, DMV and Fredericksburg Area HIV/AIDS Support Services (FAHASS). These relationships offer a unique opportunity to streamline access to services for many individuals who may be experiencing increased stressors, anxiety, depression or paranoia.

As part of Micah's program, the PATH Outreach Worker also has the unique ability to refer individuals into through Micah's co-located services. For example, individuals needing to enroll in Moss Clinic can complete the eligibility process while they are visiting the PATH Outreach Worker in Micah's office. PATH individuals can also access Micah's income program, which includes trial work experiences, placement in jobs within the community and access to SOAR services when employment is ruled out as an option.

The PATH Outreach Worker regularly refers individuals to area churches for assistance, such as food, clothing, shoes, sleeping bags, quilts, and various sundry items. Micah provides showers, clothes and brown-bag lunches for the street homeless, including PATH-eligible persons five days a week. Micah also supports a coordinated group of organizations in the downtown area to provide and host a free community dinner and breakfast 365 days a year, which is open and welcoming to the homeless and PATH-eligible persons.

Several churches and ministries have volunteers who deliver food and supplies to locations in the city of Fredericksburg as well as Stafford and Spotsylvania counties. The PATH Outreach Worker accompanies these volunteers and meets with individuals in non-traditional locations for the purpose of assessing need, building rapport, and providing information on resources and referrals.

Persons in need of assistance with rent or security deposits will be referred to the Central Virginia Housing Coalition, Quinn Rivers, the Salvation Army or Micah's Housing

Assistance program. ~~Center~~. Section 8 housing is included in services provided by the Housing Coalition. Individuals enrolled in Residential Services with RACSB will be offered assistance with budgeting and bill paying. RACSB or Micah will link individuals to payee services if appropriate. RACSB Case Management and Residential Services may also utilize Section 8 vouchers when appropriate.

5. Service Provision: Describe the plan to provide coordinated and comprehensive services to eligible PATH consumers. Please address the following information.

a. Projected number of adult consumers to be contacted with PATH funds: 270

b. Projected number of adult consumers to be enrolled using PATH funds: 130

c. Percentage of adult consumers projected to be "Literally Homeless", and activities to maximize the use of PATH funds to serve adults who are literally homeless as a priority population: 85%

d. Strategies that will be used to target PATH funds for street outreach and case management as priority services.

- Outreach services staff has a high degree of active outreach and in-reach. Staff conducts outreach into Thurman Brisben Homeless Shelter, EmpowerHouse, the library, area parks, free community dinners and other sites frequented by homeless people for direct, face-to-face interactions. Staff utilizes strategies aimed at engaging persons into the needed array of service, including identification of individuals in need, development of rapport, offering support and referrals to appropriate resources. This results in increased access to community services by homeless people. The PATH outreach worker also maintains an office at the Micah Ministries day center, where PATH-eligible people frequent five days per week, seeking basic needs and case management. When necessary, the SOAR Coordinator will go to the client, particularly when they are in the hospital or jail, in order to engage them in services.
- Case Management Services: Case plans are developed for delivering services to PATH eligible individuals. Staff assists the individual in accessing needed services in accordance with the plan. The SOAR Coordinator, who works out of the Hospitality Center, develops a plan that guides assistance provided to the person during their disability application process.
- Screening and Diagnostic Treatment Brief screenings to determine need for referral to comprehensive clerical assessments are conducted. Coordination with mental health and health care providers, such as the hospital and mental hospital give some pre-determined screening and diagnosis to those accessing the SOAR coordinator. It also improves discharge planning, ensuring those with a diagnosis are sent most directly to a person that can begin a process for SSI/SSDI. The SOAR Coordinator uses RACSB staff, the Moss Free Clinic, Department of Rehabilitative Services and other relevant providers to develop current medical/mental health diagnostic records determine eligibility for disability. The success of SOAR is providing timely and comprehensive medical documentation to support a claim for disability. One of the major challenges of

the Severely Mentally Ill Chronic Homeless is the lack of current medical documentation. While free and subsidized medical services are available in the community, they are often lagged down with waiting lists months behind and stringent eligibility requirements. As a last resort a pool of money targeted to providing medical (vision, neurological, etc.) testing and exams would negate the need for DDS sponsored Consultative Exam, increase approval rates for SSI/SSDI claims and decrease DDS's decision time.

- Community Mental Health Staff helps the client access mental health services, educating them about mental health and co-occurring disorders, assisting with obtaining emergency or clinic care and acquiring resources to obtain medications. In addition staff provides supportive counseling and referrals to therapy.
- Staff Training (training of others): Staff informally work with individuals from the Thurman Brisben Shelter regarding the PATH program and service delivery strategies to promote effective services. A brochure is provided to increase the knowledge of the PATH program and staff's involvement with the program. The SOAR Coordinator spends time each week educating community partners about the program—how it can help both the client and the partner.
- Referrals for primary health services, job training, educational services, and relevant housing services
- Staff continues to provide valuable referrals linking persons to Medicaid, Fredericksburg Area Food Bank, various Housing Resources and meeting primary health needs at clinics. Referrals are made to RACSB which provides MHIDSA emergency services, case management and other services.

e. Indicate whether your organization provides, pays for, or otherwise supports evidence-based practices and other training for local PATH-funded staff, including training and activities to support migration of PATH data into HMIS.

RACSB offers, pays for and supports evidence-based practices or other trainings for local PATH-funded staff. Trainings this past year for staff have included Human Rights, Health and Safety, Blood Borne Pathogens, Residential Competencies, Therapeutic Options, CPR/First Aid, Stepping Stones to Recovery, Frontline Diversity Training, Cultural Diversity Training, Positive and Productive Meetings, The Impact of Co-occurring Mental Health and Substance Abuse Disorders on Homelessness. PATH staff also participate in HMIS and related training through Micah as the primary homeless service provider in the partnership. PATH/SOAR staff, as a part of Micah, are also heavily immersed in training and front line discussion about the national shift to rapid re-housing and housing first models.

f. Describe gaps in the current service system and how PATH will assist consumers in addressing those gaps.

Gaps in service delivery include:

- Noticeable Trends
    - the PATH worker notes an increase or trend in the number of unaccompanied

young adult and female homeless individuals
    - the PATH worker notes these individuals report the economy and the inability to find employment as a key factor in their becoming homeless
- Overcoming an individual's lack of trust with necessary and knowledgeable staff
    - *the* PATH worker establishes rapport with individuals over an extended period of time creating an atmosphere of mutual and respect
    - the PATH worker builds upon this rapport to assists individuals in linking successfully to RACSB staff and other providers in the community
- Growing Lack of transportation
    - the PATH worker provides referrals to Micah, Food Pantries, Moss Clinic, Goodwill and other community based resources.
    - the PATH worker provides direct assistance to individuals with FRED bus tokens
- Lack of communication or poor contact opportunities
    - the PATH worker provides referrals to available cellular telephone assistance programs
    - the PATH worker provides direct assistance to individuals needing assistance completing applications
    - the PATH worker provides direct assistance in obtaining free prepaid wireless telephones
- Insufficient Funds and coordination to access medications
    - the PATH worker refers individuals to the Moss Clinic for free medical care and medications
    - the PATH worker provides referrals to Micah's Journey Program, the Salvation army, St. Jude and pharmaceutical programs to with assist with prescription costs
- Difficulty in securing affordable housing
    - the PATH worker provides individuals with referrals to affordable landlords, income based housing and subsidized housing assistance within the community, and Section 8 outside of the area.
    - the PATH worker provides individuals with referrals to housing assistance programs such as the rapid re-housing program which assists with security deposits and the first month's rent
- Lack of temporary housing
    - the PATH worker advocates for and assists in an individual's application for placement in the Thurman Brisben Center, Hope House or at Micah Respite
- Difficulty in securing managing, and budgeting resources.
    - the PATH worker provides individuals with referrals to available resources in the community such as payee services, financial support services and personal banking
- Difficulty accessing mental health and substance abuse services due to limited resources and the special needs of homeless clients with co-occurring serious mental illness and SA disorders

The PATH worker provides individuals with referrals to RACSB for screenings with emergency services and substance abuse programs which schedule mental health and SA

intakes. The PATH worker provides direct assistance to individuals by reminding them of their appointment and also assists them in completing paperwork prior to appointments.

g. Describe services available for consumers who have both serious mental illness and substance use disorder.

PATH staff will provide initial screening and assessment to determine general needs and mental health and co-occurring issues that need to be addressed. The individual will then be referred to RACSB's substance abuse therapist for evaluation and treatment. As appropriate, RACSB uses multiple statewide inpatient treatment centers, but no PATH funds are used for this purpose. PATH program participants are encouraged to follow up with outpatient treatment, Specialized Substance Abuse Services for Women and supported with transportation assistance and sundry items, as incentives for following up. Information about AA and NA meetings in the local community is also provided.

h. Describe strategies for making suitable housing available to PATH consumers (e.g., indicate the type of housing usually provide and the name of the agency that provides such housing).

Once an individual is identified as PATH-eligible, he/she is assisted in obtaining an intake appointment with an RACSB therapist, if agreeable. Concurrently, the individual's immediate mainstream needs are assessed and the PATH worker initiates referrals for services, such as food stamps, medical care, shelter, and immediate psychiatric screenings, in cases of crisis. As the person works with the PATH outreach worker, the individual is identified to Micah's re-housing staff who initiates efforts to place the person in permanent housing with grant funds, including PATH funds when no other funds are available and the financial need requires just one-time assistance. Sometimes the system works through multiple step downs. For example, a person may start at local in-patient MH services, discharge to RACSB's Crisis Stabilization program and transition to Micah's Residential Recovery Program. From there, individuals either enroll in Thurman Brisben's longer-term program, or Micah assists them with re-housing. As an integrated part of Micah's services, the PATH program is embedded in the community's housing first approach. More than $700,000 from state and federal sources comes into the Fredericksburg region specifically for housing activities. As a vulnerable population, PATH clients receive a high priority in accessing those resources and receiving housing placement.

i. If you plan to implement one or more Virginia PATH Innovative Practices, indicate which one(s) and describe the implementation plan:

RACSB has elected to implement and continues to provide the SSI/SSDI Outreach, Access and Recovery (SOAR) initiative that provides assistance to homeless individuals with SMI to apply for, acquire, and maintain SSI and SSDI benefits to PATH consumers. While remaining responsible for meeting all terms of the PATH grant, RACSB has subcontracted a part of the PATH program to Micah Ecumenical Ministries. Micah is a local not-for-profit

organization dedicated to reducing, alleviating and preventing the causes of homelessness and its impact on Planning District 16 citizens. In coordination with the Social Security Administration, social services, area hospitals and free clinics, RACSB, Micah and a multitude of other agencies have worked for the last year to establish a program to offer significant SSI/SSDI application assistance as a targeted service of the PATH program. The PATH program in Planning District 16 has been well established for several years and is successful. It is outstanding in its outreach and recruitment activities. This is demonstrated in the results of our outcome measurements and incentive grant awards. Continuing on this foundation SOAR services have provided substantially more assistance to our homeless population as they enroll in PATH services.

As a result of this grant, the PATH program will continue to:

- Provide full assistance in the application for SSI/SSDI
- Develop and maintain a relationship with the local offices of DDS and SSA in order to expedite application processing for homeless individuals
- Continue to develop relationships with practitioners willing to perform consultative exams
- Provide data to the department of Behavioral Health and Development Services on SSI/SSDI application activity as an attachment to quarterly reports

The PATH program is further enhanced by the relationship of the PATH Outreach Worker and Micah Ministries' ongoing partnerships with area hospitals, emergency rooms and community based services. Staff regularly attends meetings of the downtown merchants and the Continuum of Care, and convenes with city leaders on homeless related issues. In addition, Micah continues to operate its Residential Recovery Program, providing a temporary place for homeless individuals to stay after being discharged from the hospital, or other treatment center as a means to further their ongoing treatment plan.

j. Briefly describe your plan for providing the following PATH-allowable services:

Outreach:

Staff has a high degree of active outreach and in-reach. Staff continues to maintain office hours at Micah's Hospitality Center and conducts outreach and in-reach at area hospitals and behavioral health units, Thurman Brisben Homeless Shelter, Salvation Army, N/A and AA meetings, the library, Hurkamp Park, free community dinners and other sites frequented by homeless people for direct, face-to-face interactions. Staff utilizes strategies aimed at engaging persons into the needed array of services, including identification of individuals in need, screening, development of rapport, offering support and referrals to appropriate resources. This has resulted in increased access to and utilization of community services by homeless people.

Screening and Diagnostic Treatment:

Brief screenings to determine need for referral to comprehensive clerical assessments are

conducted. In addition, following PATH intake, clients can be referred to RACSB for further assessments and treatment.
Habilitation and Rehabilitation: N/A
Community Mental Health Services: Staff provides assistance to individuals seeking access to mental health services, educating them about mental health and co-occurring disorders, assisting with obtaining emergency or clinic care, and acquiring resources to obtain medications. In addition staff provides supportive counseling and referrals to therapy.
Alcohol or Drug Treatment Services: Staff provide referrals to SA treatment services and community based therapy
Staff Training: Staff work informally with individuals from Micah Ministries, Thurman Brisben Shelter, and other community providers regarding the PATH program and service delivery strategies to promote effective services. A brochure is provided to increase the knowledge of the PATH program and staff's involvement with the program. RACSB also offers basic training in medication management, human rights, and Ther-ops to Micah staff.
Case Management: Case plans are developed for delivering services to PATH eligible individuals. Staff assists the individual in accessing needed services in accordance with the plan.
Supportive and Supervisory Services in Residential Settings: N/A
Minor Renovation: N/A
Planning of Housing: N/A
Technical Assistance in Applying for Housing: The PATH Case Manager helps PATH consumers to obtain housing, including housing resources, assistance with completing applications for housing, and other housing related activities that traditional housing services do not typically deliver.

Improving the Coordination of Housing Services: RACSB participates in the local Continuum of Care Committee and other homeless services coordinating groups in an on-going effort to improve housing services in the community.
Security Deposits: When relevant, the program supports security deposits and first month rent for enrolled PATH consumers moving off the street or out of shelters. This removes a major barrier that often delays client ability to move quickly and successfully into housing.
Costs Associated with Matching Eligible Homeless Individuals with Appropriate Housing Situations: N/A
One-time Rental Payments to Prevent Eviction: When relevant, the program supports rental payments for enrolled PATH consumers who have moved off the street or out of shelters, but face eviction without intervention.
Referrals for Primary Health Services, Job Training, Education Services and Relevant Housing Services: Staff continues to provide referrals linking individuals to community health services, DSS Medicaid, Fredericksburg Area Food Bank, various Housing Resources and employment assistance programs. Referrals are made to RACSB, which provides MHIDSA emergency services, case management and other services.

6. HMIS Data Integration: Describe your HMIS transition plan, with accompanying timeline, to begin using HMIS to collect and report PATH data in HMIS by July 1, 2016. If you are fully utilizing HMIS for PATH services, please describe plans for continued training and how you will support new staff. Indicate any technical assistance needs you may have in meeting the HMIS data requirements.

PATH and Micah are fully compliant and have transitioned into HMIS Data Integration. All agencies within the CoC of Planning District 16 are utilizing HMIS/Service Source. As a participant in HMIS, the RACSB PATH/SOAR staff can use what has already been entered into the system by each of the providers, rather than start from scratch. RACSB completed its integration of Electronic Health Records 2014

The Commonwealth of Virginia continues to require RACSB to use two systems with duplicating information requiring double entry of data. Entry into Avatar our EHR and CCS information systems is required by the Commonwealth in addition the state requires use of the HMIS system. This redundancy needs to be addressed.

7. SSI/SSDI Outreach, Access, Recovery (SOAR): Describe your plan to train PATH staff on SOAR. Indicate the number of PATH staff trained in SOAR and the number of PATH-enrolled consumers assisted through SOAR during State Fiscal Year 2013, and the approximate number of staff to be trained in SOAR for State Fiscal Year 2015.

Micah, through RASCB and PATH funding, employs a SOAR coordinator as well as a SOAR Trainer. Micah-PATH provided SOAR training to 6 individuals in 2015 from Fredericksburg, Spotsylvania and Stafford DSS offices, the Disability Resource Center and FAHASS. Micah with assistance from the state SOAR coordinator continues to develop a local SOAR team among partnering agencies in the CoC, who work with the homeless and should be equipped to assist their clients in accessing disability benefits. Additional training session are in the planning for 2016-2017

SOAR cases from July 01, 2014 to March 30, 2016 were as follows:

- 34completed applications
- 26 received approvals (initially or following appeal)
- 2 denials
- 4 incomplete due to loss of contact, client withdraws or death of client
- 6 cases were pending

8. Program demographics and cultural competency: Describe the following.

The demographics of the target population.

PATH Race/Ethnicity	**Community: 336,229 people**	**RACSB: 450 staff**
American Indian	0.3%	0.5%
Asian	2.3%	1.0%
Black or African American	17.5%	27.9%
Native Hawaiian or Other Pacific Islander	0.1%	-
White	68.9%	66.3%
Hispanic	7.8%	2.9%
Two or more races	2.8%	1.4%
Other	0.3%	-
PATH Gender	**Community: 336,229 people**	**RACSB: 450 staff**
Male	49.4%	20.6%
Female	50.6%	79.4%
PATH/ AGES	**Community 336,229 people**	**RACSB: 450 staff**
18-29	27%	13%
30-39	24%	24%
40-49	20%	25%
50-59	15%	27%
60-69	6%	10%
70+	5%	1%

b. The demographics of the staff serving PATH consumers.

PATH Race/Ethnicity	**% PATH Staff**	**% of people served**
American Indian		.01%
Asian	33%	.01%
Black or African American		26%
Native Hawaiian or Other Pacific Islander		–
White	66%	65%
Two or more races		.05%
PATH /Gender	**% PATH Staff**	**% of people served**
Female	50%	34%
Male	50%	66%
PATH/ Ages	**PATH Staff**	**People Served**
18-29		13%
30-39		24%
40-49	100%	25%
50-59		27%
60-69		10%
70+		1%

c. How staff providing services to the target population will be sensitive to age, gender and racial/ethnic differences of consumers.

RACSB PATH funded staff providing services to the target population will be sensitive to age, gender and racial/ethnic difference. As part of a CARF accredited case management system, all staff are required to have training at least annually in the issues of cultural diversity. Staff are also responsible for demonstrating this competency in service planning and service delivery. In addition, PATH staff will be given the opportunity to attend training provided by or recommended by the state PATH program.

d. The extent to which PATH staff receive training in cultural competence.

RACSB has 40+ years demonstrating cultural competencies sensitive to individuals with serious mental illness who are homeless. Through PATH funding we have expanded services to serious mentally ill persons for more than a decade. Attention is placed on staffing the individual with people familiar with the population and community. Material and products such as audio/visual materials, PSA's are gender/age/culturally appropriate and consistent with the population served. Annual updates in cultural diversity/sensitivity training are provided and required by the agency.

e. The extent to which the organization adheres to the Culturally and Linguistically Competent (CLAS) Standards. The CLAS standards can be accessed at http://www.ThinkCulturalHealth.hhs.gov.

RACSB offers translation and interpretation through a telephone service. RACSB has a

signing-therapist for individuals with hearing difficulties and several bilingual staff members that assist translation.

PATH through its relationship with Micah Ministries and Step Forward has access to volunteer, non-family member interpreters from multiple language groups throughout Planning District 16 including but not limited to: Spanish, Kirundi, Swahili, Tigrean, French/Creole, Portuguese, Russian, Farsi, Urdu, Hindi, Amharic, Thai, Laotian, Cambodian and Vietnamese.

9. Consumer and Family Involvement: Describe how individuals who are homeless and have serious mental illnesses, and family members will be involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards. (See attached Appendix I – Guidelines for Consumer and Family Participation.)

Micah employs multiple formerly homeless persons on its staff. These individuals range from the Housing Coordinator, Office Manager, Respite House Staff and Cold Weather Shelter Staff. They provide perspective which might otherwise be overlooked in the planning, implementation and evaluation process of its programming. Additionally Micah employees through the Rappahannock Area Agency on Aging 2 PATH-eligible or previously PATH-eligible individuals. Micah sponsors a "Giving back" program, where guests are encouraged to volunteer in exchange for various incentives—bus tickets, meal cards, laundry privileges, etc. Once housed, PATH-eligible individuals also have the opportunity to serve in regular volunteer positions within agency programs.

Micah's Residential Recovery Program is supervised by a Health Services Advisory Committee, which invites a PATH-eligible homeless client to participate in each meeting. Additionally, Micah and PATH staff conduct quarterly meetings with the general homeless population to capture input into services provided and areas of improvement. When necessary, Micah and PATH staff will also serve as intermediary between families who wish to help PATH-eligible consumers—financially or emotionally—but cannot be directly involved in the individual's care.

10. Outreach to Homeless Veterans: Describe how your PATH program identifies and outreaches to homeless veterans with SMI, and the services available to them in your catchment area. How does PATH interface with your veterans' service continuum?

Through outreach and in-reach during community breakfast and dinner hosted by the Veterans of Foreign Wars and their veteran Stand Down Events the PATH Outreach Worker has multiple referral and outreach opportunities. The CoC has for the last year a by-name list of all veterans who are currently homeless. Individuals are then fed into the list via homeless service providers such as Micah and PATH. Discussions at these meetings set in place action plans which include housing and other veteran related support services. Additionally the

PATH Outreach Worker is in regular contact with the staff and leadership of the Wounded Warrior Program, based at RACSB and through Quinn Rivers and the Micah Hospitality Center, the PATH Outreach Worker meets weekly with the VA Representative.

11. Describe your PATH program's efforts to minimize the challenges and foster support for PATH clients with a criminal history, such as collaboration with local jail diversion and/or other programs. If you can, estimate the percent of PATH clients with a criminal history.

The Fredericksburg CoC has partnered with Virginia Housing Alliance, formerly Virginia Coalition to End Homelessness, and Corporation for Supportive Housing to launch a Frequent User System Engagement Model (FUSE). FUSE is a project used across the country to study how much the homeless population is costing public systems. Through data analysis with hospitals, jails and homeless service providers the project identifies those who are costing communities the most about of money, houses a pilot group and studies the effect that housing and support has on their continued use of public systems. When implemented in other communities, FUSE has demonstrated that individuals who are housed and supported only cost the community $16,000 per year compared with those who remain homeless and costing $63,000 per year.

In December 2015, a stakeholders group was convened to begin implementation of the FUSE process. Participants included representatives from the hospitals, police, jails, political leadership, courts, homeless services, University of Mary Washington, RACSB, as well as local funders. Memo Of Understandings (MOU) for data sharing recently signed and the jail is working to pull the first sampling of data for this process. By late summer/early fall, the group hopes to have an initial cost analysis of how people who are homeless interact with the jail and identify approximately seven people to be housed as part of the target group. It is very likely that the individuals identified will also be PATH clients. RACSB will be launching its first PACT team in June 2016, and they will likely work heavily with this pilot group.

Separately, the PATH Outreach Worker and Micah staff continues to work closely with RACSB staff at the jail, who typically provide most discharge planning for mentally ill homeless individuals exiting the jail. Oftentimes, they will submit a referral to Micah's Residential Recovery Program and connect to the PATH outreach worker who monitors their follow-up after release.

PATH Site Name: RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD					
Budget FFY 2016/SFY 2017 (2016-2017 PATH Year)					Match Source
Staff Title	***Annualized*** Salary	FTE	PATH Funded	Match	(Cash or In-kind)
CASE MANAGER	$49,645	1.00	$35,615	$14,030	
Total Staff Salary	$49,645	1			
Fringe	$13,568		$13,568		
	Total Personnel		**$49,183**	**$14,030**	
Travel (Outreach travel, travel for training, state meetings, etc.)					
Use of Agency Vehicle					
Training Travel			$500		
Training Conference Costs			$400		
Staff Mileage			$1,500		
	Total Travel Costs		**$2,400**		
Equipment (Personal property/equipment having useful life of more than one year)					
	Total Equipment Costs		0		
Supplies (Office Supplies, Outreach Supplies, Computer Software)					
Office Supplies			300		
Outreach Supplies					
Supplies					
	Total Supplies Costs		300		
Contractual					
Cell phone service fee (2)			$ 1,900		
MICAH CONTRACT			$ 41,754	$ 18,685	
	Total Contractual Costs		$ 43,654	$ 18,685	
Other (List and Describe Each)					
Medication Assistance			$ 2,107		
Identification related purchase costs (incl. Birth certificates)					
Rental Assistance					
Bus Tokens					
Staff Training (non-travel registration and costs)					
Administrative Costs					
Medical Consultant			$ 500		
	Total Other Costs		$ 2,607	0	
	Total Proposed Budget		**98,144**	**$ 32,715**	Is match > or = to 1/3 of federal allocation? YES $130,859

PATH Site Name: Rappahannock Area CSB - Subcontractor Budget for Micah Ecumenical Ministries					
Budget FFY 2016/SFY 2017 (2016-2017 PATH Year)					Match Source (Cash or In-kind)
Staff Title	***Annualized*** Salary	FTE	PATH Funded	Match	
SOAR COORDINATOR	$35,438	0.87	$29,750	$1,081	
Total Staff Salary	$ 35,438				
Fringe	$ 10,154		$7,500	$64	
	Total Personnel		**$37,250**	**$1,145**	
Travel (Outreach travel, travel for training, state meetings, etc.)					
Use of Agency Vehicle					
Training Travel			$1,200		
Training Conference Costs					
	Total Travel Costs		**$1,200**		
Equipment (Personal property/equipment having useful life of more than one year)					
	Total Equipment Costs		0		
Supplies (Office Supplies, Outreach Supplies, Computer Software)					
Office Supplies			$ 500		
Outreach Supplies					
Supplies					
	Total Supplies Costs		$ 500		
Contractual					
	Total Contractual Costs		0		
Other (List and Describe Each)					
Identification related purchase costs (incl. Birth certificates)					
Rental Assistance			$ 2,000	$ 8,000	
Bus Tokens			$ 566	$ 5,942	
Staff Training (non-travel registration and costs)			$ 238	$ 3,598	
Administrative Costs					
	Total Other Costs		2,804	$ 17,540	
	Total Proposed Budget		**41,754**	**$ 18,685**	Is match > or = to 1/3 of federal allocation?

Virginia PATH Local Intended Use Plan, FFY 2016/SFY 2017
PATH Program Year 2016-2017

1. Description of Provider Organization:
a. Name: Region Ten Community Services Board
b. Organization Type: CSB
c. Description of Services Provided: Region Ten CSB is a public provider of mental health, intellectual disabilities and substance abuse services within the community providing a wide array of outpatient and residential services.
d. Region Served: Thomas Jefferson Planning District, which includes the City of Charlottesville and Albemarle, Louisa, Greene, Nelson and Fluvanna counties.
e. Provider's experience in providing services to homeless/at-risk individuals and those with SMI and/or co-occurring SUDs: Region Ten has a long history of providing comprehensive Mental Health and Substance abuse treatment services to homeless/at risk individuals. We continue to work closely with community partners in creating housing opportunities within the city of Charlottesville for housing combined with comprehensive supports and services
f. Description of housing or services that are specifically targeted to PATH-eligible consumers: Region Ten has two HUD grants that target housing subsidies and support for homeless individuals. We have a Shelter Plus Care grant that currently provides rental subsidies to a number of previously homeless individuals. In addition we have a HUD Supportive Housing grant that provides housing and supervision for up to 20 men enrolled in an intensive Dual Recovery Program. We also have the Mohr Center public inebriate facility that provides an alternative to jail for individuals who are picked up by the police for alcohol intoxication in public.
2. Program Budget and Federal Funds Requested: (Attach detailed budget using Excel file provided by DBHDS):
a. Amount of federal PATH funds requested: $64, 952
b. Source and amount of Provider's minimum required 33% match funds: $22,113
c. A brief narrative describing the items in the attached budget: The attached budget reflects $39,000 PATH funds for salary expenditures for a PATH Case Manager who devotes 95% to this project and his supervisor (5%) for his programmatic and clinical supervision. He has experience working and providing outreach, engagement and referrals for services to recipients in the community. In addition, the budget reflects a purchase of service by contract with On Our Own of Charlottesville to provide PATH outreach services to eligible participants. This contract totals $24,000 for an 80% PATH worker in the Recovery Support center and their supervision.
3. Collaboration with Local HUD Continuum of Care (CoC): Describe the organization's

participation in the HUD Continuum of Care program, other local planning activities and program coordination initiatives, such as coordinated entry and coordinated assessment activities. If you are not currently working with the CoC, briefly explain the approaches to be taken by the agency to collaborate with the local CoC.

PATH on July 1st will be completing coordinated entry on clients daily into HMIS. Coordinated assessments are happening as we speak. Clients are encouraged to complete as soon as possible to score chronic and vulnerability.

4. Collaboration with Local Community Organizations: Provide a brief description of partnerships and activities with local community organizations that provide key services (i.e., outreach teams, primary health, mental health, substance abuse, housing, employment, etc.) to PATH eligible clients, and describe coordination of activities and policies with those organizations. Provide specific information about how coordination with other outreach teams is achieved.

The PATH Case Manager is active in the collaboration effort. Currently he attends the Service Providers Council for the Thomas Jefferson Coalition of The Homeless. TJACH organization has been collaborating more with agencies sharing more information. There is now a community case review monthly that the PATH Case Manager attends on the 1st, 3rd and 5th Wednesday's of the month. This is collaboration with the City of Charlottesville, PACEM, seasonal shelter, OOO, Haven as well as other agencies involved with the consumer. Diane Gordon Senior Director and Robert Johnson Executive Director are and have been members of the TJACH Board. He attends CIP meetings. Meets weekly with The Crossings staff.

5. Service Provision: Describe the plan to provide coordinated and comprehensive services to eligible PATH consumers. Please address the following information.

a. Projected number of adult consumers to be contacted with PATH funds: 220 adult consumers

b. Projected number of adult consumers to be enrolled using PATH funds: 175 adults consumers

c. Percentage of adult consumers projected to be "Literally Homeless", and activities to maximize the use of PATH funds to serve adults who are literally homeless as a priority population: These 100 clients are in PACEM, Salvation Army as well as literally on the streets and at soup kitchens daily. These clients get bus passes, job training, gifts churches, program recruitment, substance abuse help, mental health help. These clients are truly in the CoC. PATH works as the method of getting an adult consumer from point A to point B for a client to render hope in finally getting housed.

d. Strategies that will be used to target PATH funds for street outreach and case management as priority services.

The PATH Case Manager and On Our Own PATH worker do mostly all of our work in the street. The PATH Case Manager for Region Ten has been doing weekly intake with the seasonal shelter PACEM two times per week. Mostly daily outreach to the Haven a shelter, downtown library and lunch at the Soup Kitchens. The PATH Case Manager and On Our Own PATH attempt to engage and follow up with all consumers "street case management". PATH CM is

seen as “your Social Worker on the Street that comes to you.”

e. Indicate whether your organization provides, pays for, or otherwise supports evidence-based practices and other training for local PATH-funded staff, including training and activities to support migration of PATH data into HMIS.

f. Describe gaps in the current service system and how PATH will assist consumers in addressing those gaps.

We continue to struggle to find: Affordable Housing options: Even with the array of housing options available, need outstrips supply as in most communities. PATH staff and other agency staff have set continuing goals each year to increase the supply and type of affordable housing for homeless persons. Three initiatives are identified: 1) Advocate with TJACH to target rent and security funds in area applications for Federal Reinvestment and Recovery Act funds, 2) Continued work with Virginia Supportive Housing Program who has opened a 60 room SRO, 30 of which are eligible to homeless adults. 3) Rapid Rehousing Program. Low or non-existent income: Clearly, major challenges face staff in assisting consumers who experience indigence. Most are without earned income, limited work histories, and yet frequently ineligible for Social Security benefits. PATH is able to assist each PATH eligible person to apply for SSI and SSDI. Employment Support: Employment for PATH eligible consumers has been a challenge, often restricted by the high number of felony convictions in the population, making them ineligible for many service jobs. PATH staff is exploring new possibilities in state regulations that potentially relax some of these obstacles. PATH staff work to refer persons (and assist them in follow-through) to Employers, VEC Workforce, and have helped with consumers sharpen their resumes.

PATH staff identifies an ongoing need to prioritize the mental health recovery philosophy and principles throughout the service system and the community. The joining of the PATH effort with On Our Own will assist in this effort. The agency, including especially PATH, will find ways to successfully incorporate WRAP and other recovery-oriented strategies in its tool-bag for promoting hope on the part of indigent, homeless person.

g. Describe services available for consumers who have both serious mental illness and substance use disorder.

PATH staff assesses for emergent needs for public inebriate shelter or social detox and assist the consumer’s movement to Mohr Center residential services or Recovery Support services.
PATH staff assesses and refer dually diagnosed homeless clients to appropriate services at Region Ten CSB. The PATH staff provides direct assistance to PATH clients to make and keep Intake appointments with agency ACCESS staff. Staff links the client to mainstream SA services through Region Ten CSB. Staff support attendance; consult with facilitators, and provide follow-up to the PATH client to reinforce participation with available care: case management, psychiatric evaluation, medication, Dual-Recovery Center services, Mohr Center services; specialized MICA group treatments, etc. Staff assist in identifying appropriate Community meetings as well. Inebriate shelter.

h. Describe strategies for making suitable housing available to PATH consumers (e.g., indicate the type of housing usually provide and the name of the agency that provides such housing).

Though not nearly sufficient to address the need, Region Ten and other community partners have strived to develop a wide range of affordable, supportive housing for persons with disabilities, including especially persons targeted by PATH services. Region Ten CSB serves seriously mentally ill individuals including those who are homeless using an array of funding sources and housing types. The agency is an agent for VHDA's Housing Choice Voucher rental subsidy program and maintains collaborative relationships with more than 30 local landlords. The agency developed its own spin-off housing developer corporation more than ten years ago, which today owns and rents affordable apartments to persons served by the agency. The agency has been successful with HUD Continuum of Care grants: Shelter Plus Care and Supported Housing Programs for chronically homeless persons. In the past, the agency successfully obtained city funds to pilot a Housing-First project (Step-Up) which served 12 chronically homeless men and women. With the recent opening of an SRO in Charlottesville by Virginia Supportive Housing and additional 30 beds have been made available to our homeless population. The agency has creatively extended Medicaid Mental Health Rehabilitation funding to field in-home support staff for more than 250 adults with serious mental illness. In sum, the agency is committed to expanding appropriate, affordable, and supportive housing opportunities for persons at-risk or literally homeless. PATH staff uses some of the following strategies to assure that PATH eligible persons gain access to these needed resources. PATH staff are in continuous planning with PACEM seasonal shelter, First St. Church Day Haven, and occasionally The Salvation Army for persons eligible for PATH services.

Agency PATH staff work with On Our Own and the MOHR Center to make effective use of public inebriate and transitional beds, assuring that PATH clients gain access. PATH staff identifies potential PATH clients for the agency's Shelter Plus Care funds.
PATH staff works with local churches and organizations i.e.: MACAA/CARES, PACEM, and LOVE INC. to assist people with housing finances and deposit.

i. If you plan to implement one or more Virginia PATH Innovative Practices, indicate which one(s) and describe the implementation plan:
The agency does not identify its efforts as an innovative practice. However, practices which appear to have a positive significant evidence base to them characterize this PATH project. The biggest of which is the use of peers and formerly homeless persons where possible in the engagement process.

j. Briefly describe your plan for providing the following PATH-allowable services:

Outreach:
PATH Case Manager and the On Our Own Path worker provide Outreach services to the streets, to homeless shelters, and to local Soup Kitchens. PATH staff assures that local merchants on the downtown mall and local police department and CIT staff are aware of services through PATH and enlist their support in making PATH Outreach visible. PATH staff outreach at "The Haven" (http://www.thehavenatfirstandmarket.org/the-haven/). In addition, the agency will distribute the Coalition for the Homeless' "Street Sheet" and other educational flyers on PATH services, to include information on the location of and contacts for the team to businesses, health providers, security staff, police, human services providers,

and parks and recreation facilities. During the winter months, the PATH team will provide on-site outreach to assist PACEM (People and Congregations Engaged in Ministry), the area's seasonal shelter program. The PATH staff will generally meet alongside PACEM two times per week and to the streets and Army Shelter as needed. The On Our Own PATH worker in continuous collaboration with the Case Manager will outreach to PACEM and to the "The Haven". The full PATH effort is enhanced by daily in-reach to potential PATH-eligible homeless persons at On Our Own as well. The PATH Case Manager will assure that outreach is effective and that correct eligibility requirements are applied. PATH staff provide Acudetox and WRAP at the HAVEN one time per week.

Screening and Diagnostic Treatment:
Screening and Diagnostic Treatment: PATH staff arrange meetings with potential PATH recipients in the field, evaluate for need of PATH services, enroll as needed, and proceed with direct assistance and referral for needed treatments and supports. Brief screening for need of clinical and psychiatric care is completed with appointments arranged and facilitated. For homeless persons with co-occurring disorders, this means referral for substance addictions treatments as well.

Habilitation and Rehabilitation:
PATH staff will spend most of their time on the streets, in homeless shelters, and in community locations with strong engagement efforts with homeless persons with mental illness. The Region Ten PATH case manager and the Peer PATH worker from On Our Own will seek to engage the person's interest in support. The aim is the promotion of recovery-thinking on the part of homeless persons from the outset of engagement. This will include a number of strategies or resources. Staff will:

- Build relationships of trust with homeless persons.
- Provide immediate amenities and direct assistance and ready information about accessing shelter, or identifying housing resources.
- Assist with identifying needs and inventorying skills and interests.
- Use an Intentional Peer Supports approach as developed by Sherry Mead. • Provide WRAP (Wellness Recovery Action Planning) classes at On Our Own and at the agency's psychosocial rehabilitation Blue Ridge Clubhouse.
- Develop action steps focused on the immediate quality of life issues as perceived by the homeless person. (A Personal Recovery Plan)

Assist the person with appointments to community resources. (SSI, General Relief; Shelter, housing opportunities; Employment supports)

Community Mental Health Services:
The PATH case manager and PATH worker will develop long-term helping relationships with homeless, mentally ill persons in their outreach efforts. They will maintain support to PATH-eligible persons for as long as it takes to help them navigate entry and stability with the community's mainstream resources and services. PATH staff will provide informal education to consumers about a wide variety of mental health issues. The Case Manager may introduce the PATH-eligible person to On Our Own Recovery Center in order to provide immediate quality of life amenities and social supports, as well as Peer provided Recovery groups, while seeking to engage the person in more formal, needed mental health treatments.

The PATH case manager may tour the PATH participant through the agency's psychosocial rehabilitation clubhouse program, and introduce him/her to the Supported Employment staff as well.

Alcohol or Drug Treatment Services:
PATH staff assist by referral to Substance Addictions treatment services at Region Ten CSB. As needed, referral to the MOHR Center public inebriate shelter and transitional residential substance addiction service is made. Both Region Ten and On Our Own promote Community Services groups in-house.

Staff Training:
PATH Staff regularly address information and training needs to a variety of community providers. Examples include: a) information to Shelter staff and PACEM (a local seasonal homeless shelter service) concerning access procedures to mental health and dual-diagnosis services; b) education of TJACH (area homeless coalition) members on the numbers and treatment/housing needs of homeless mentally ill consumers; and c) training of mental health agency case managers and access staff concerning strategies for active engagement with this population. PATH staff attended the PATH conference in Richmond. We have attended numerous Webinars.

Case Management:
All eligible PATH participants receive active, ongoing PATH case management necessary to engage and hold them in service until they are enrolled and stabilized in other formal mainstream agency and community treatments and program resources. From the outset, the PATH Case Manager and PATH workers:

- Evaluate for PATH service eligibility,
- Determine the nature and acuity of mental health needs,
- Assist persons to better understand their problems and the potential resources and supports in the community to alleviate these problems,
- Help persons to set goals and steps for movement from homelessness and hopelessness,
- Link PATH participants to community resources--- mainstream and otherwise--- and to housing,
- Monitor their progress and evaluate for a need for PATH staff to provide direct personal help to assure that successes occur.
- Stay engaged with the PATH participants until positive links are made.
- Meet with the PATH participant and community and agency representatives to assure that the homeless person is fully engaged in mutual work.

Supportive and Supervisory Services in Residential Settings:
The PATH case manager continues work with the PATH participant as he/she exits the streets and begins life in alternative supportive settings, including especially in housing and residential settings. The PATH case manager assists the person to link with agency resources, including the Housing Resource Coordinator. PATH supports will continue for up to ninety days to assure that the PATH service recipient is successfully engaged with

psychiatric services at Region Ten CSB. Likewise, if the participant enters housing with supports (HUD Shelter Plus Care or SHP residences, or any of the agency's other supportive housing programs, the PATH case manager stays connected with him/her until the Support Team concurs that he/she is stable and satisfied. The initial PATH work to assist the person's development of personal recovery goals becomes an important ingredient in the ongoing development of the person's Service Plan. PATH is going to pilot this next year ongoing case management after ninety days in PATH.
Minor Renovation: NA
Planning of Housing: The PATH case manager coordinates with the consumer and local Housing resources network to identify housing options. Examples: Region Ten Housing Coordinator, Charlottesville Housing Authority, MACAA, TJACH, Virginia Supportive Housing The Crossings, local landlords.
Technical Assistance in Applying for Housing: Direct assistance is provided where needed. The PATH worker assists the homeless person to apply for housing subsidies at the local Public Housing offices or at Region Ten's Housing Resource office if available. PATH will assist persons with applications for living arrangements, including resources all along the continuum from homeless shelter access, to housing subsidy offices, to landlords.
Improving the Coordination of Housing Services: The PATH worker will attempt to be involved with all the relevant local housing providers. PATH worker and the Housing Navigator will work in an effort to improve resources.
Security Deposits: PATH staff assist participants to apply for loans or grants to make security deposits. Love, Inc locally is the main source for such loans. PATH staff may assist persons to apply as well through MACAA (Monticello Area Community action Agency) for rental assistance.
Costs Associated with Matching Eligible Homeless Individuals with Appropriate Housing Situations: PATH staff make referrals to services identified by the consumer and identified through the needs assessment process. Efforts are made to connect consumers to mainstream services, resources, and benefits. These referrals are documented and followed through PATH files.
One-time Rental Payments to Prevent Eviction: The PATH case manager will assist PATH service recipients to apply through MACAA for one-time rental assistance to avoid evictions
Referrals for Primary Health Services, Job Training, Education Services and Relevant Housing Services: PATH staff make referrals to services identified by the consumer and identified through the needs assessment process. Efforts are made to connect consumers to mainstream services, resources, and benefits. These referrals re documented and followed through PATH files.

Region Ten CSB has at the Peterson Building an integrated care model w/Martha Jefferson Hospital, where we are able to direct our consumers w/out insurance into their services.

6. HMIS Data Integration: Describe your HMIS transition plan, with accompanying timeline, to begin using HMIS to collect and report PATH data in HMIS by July 1, 2016. If you are fully utilizing HMIS for PATH services, please describe plans for continued training and how you will support new staff. Indicate any technical assistance needs you may have in meeting the HMIS data requirements.

PATH workers have met with HMIS officials. Trainings online and PATH workers have met with officials from HMIS. Trainings online and help from super users for clarity.

7. SSI/SSDI Outreach, Access, Recovery (SOAR): Describe your plan to train PATH staff on SOAR. Indicate the number of PATH staff trained in SOAR and the number of PATH-enrolled consumers assisted through SOAR during State Fiscal Year 2013, and the approximate number of staff to be trained in SOAR for State Fiscal Year 2015. We have an

Access worker and OOO case manager that are trained in SOAR. As we speak the CoC will be hiring a full time SOAR provide for the area.

8. Program demographics and cultural competency: Describe the following.

a. The demographics of the target population.
Our target population ranges from 18-49, consisting of white and African American population. Co-occurring disorders, affective disorders, some veterans.

b. The demographics of the staff serving PATH consumers. Two African American staff; one male and one female.

c. How staff providing services to the target population will be sensitive to age, gender and racial/ethnic differences of consumers.

The agency generally and the PATH program in particular have adopted a number of practices that assure services are provided in a manner that is sensitive to age, gender, and racial/ethnic differences of the homeless population.

The PATH program at least annually evaluates its target population statistics in the domains above with analysis and review of needed changes/goals in a variety of areas in order to remain responsive.

The agency maintains a roster of staff with multi-linguistic abilities and assures that the PATH staff may access these resources for facilitating communications with PATH-eligible clients.

The PATH program staffing is comprised of staff with significant experience with the needs of the target population. Staff members have significant mental health service experience doing outreach and engagement of the chronically homeless mentally ill persons in the area.

The PATH project staff conduct informal meetings with PATH service recipients during the course of the year to ascertain feedback about a variety of project efforts.

d. The extent to which PATH staff receive training in cultural competence.

PATH staff participate in agency-sponsored cultural diversity training events at least yearly.

e. The extent to which the organization adheres to the Culturally and Linguistically Competent (CLAS) Standards. The CLAS standards can be accessed at http://www.ThinkCulturalHealth.hhs.gov.

The agency complies with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care

9. Consumer and Family Involvement: Describe how individuals who are homeless and have serious mental illnesses, and family members will be involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards. (See attached Appendix I – Guidelines for Consumer and Family Participation.)

PATH activities are reviewed weekly in a collaborative meeting with members of the On Our Own Recovery Center, who are mental health consumers themselves as well as, in many cases, formerly homeless persons themselves. These participants plan individual and general program supports and services for PATH service recipients.

The agency has an active Consumer Advocate and Consumer Advisory Committee directly accessible to consumers. The office identifies opportunities for the agency and its programs, including the PATH service to be more responsive to client needs, concerns and preferences.

The agency has a comprehensive protocol for initial and ongoing notification of consumer rights and protection of consumer information.

The agency's Board of Directors has mandated positions for at least one consumer and multiple family members. Members of the agency's Board of Directors meet regularly with homeless participants in several of the agency's service programs to this population.

The agency has a demonstrated commitment to the recruitment and hiring of consumer staff. PATH-eligible consumers are assisted to apply and sustain jobs with the agency. The housekeeping and moving service is a frequent job source for some PATH consumers. The agency's Dual- Recovery Center Supportive Housing Program actively recruits homeless or formerly homeless individuals to work as staff in this program. This Program's director, assuring even greater tie-in by PATH service recipients to program jobs, directly supervises the PATH service.

The PATH staff work daily and collaboratively with On Our Own in a number of service programs, including the mutual work in PATH activities.

Former PATH workers from On Our Own have also been homeless in their past.

10. Outreach to Homeless Veterans: Describe how your PATH program identifies and outreaches to homeless veterans with SMI, and the services available to them in your catchment area. How does PATH interface with your veterans' service continuum?

PATH workers work with the HAVEN, Virginia Wounded Warrior Program to ensure that Homeless Veterans are served through PATH. Veterans w/SMI are also served through PATH and Region Ten CSB.

11. Describe your PATH program's efforts to minimize the challenges and foster support for PATH clients with a criminal history, such as collaboration with local jail diversion and/or other programs. If you can, estimate the percent of PATH clients with a criminal history.

PATH workers work closely with OAR a re-entry program and District 9 Adult Probation. We have a Heathy Transitions program that goes into the jails and monitors or access when a client is appropriate for PATH services. Forty Five percent of PATH clients have a criminal history.

PATH Site Name: Region Ten Community Services Board with On Our Own of Charlottesillve as contractor					
Budget FFY 2016/SFY 2017 (2016-2017 PATH Year)			PATH Funded	Match	Match Source (Cash or In-kind)
Staff Title	***Annualized*** Salary	FTE			
Agency PATH case manager outreach	$39,251	1.00	$39,251		
Agency Senior Director, ACS	$8,800	0.10		$8,800	Cash
Total Staff Salary	$48,051				
Fringe	$ 7,629			$7,629	Cash
Total Personnel			**$39,251**	**$16,429**	
Travel (Outreach travel, travel for training, state meetings, etc.)					
Use of Agency Vehicle				$4,000	In Kind
Training Travel				$300	Cash
Training Conference Costs					
Total Travel Costs				$4,300	
Equipment (Personal property/equipment having useful life of more than one year)					
Laptop (new)				$1,700	In Kind
Cell Phone (replacement)				$500	In Kind
Tablets				$1,500	In Kind
Total Equipment Costs				$3,700	
Supplies (Office Supplies, Outreach Supplies, Computer Software)					
Office Supplies				$1,000	Cash
Outreach Supplies				$3,200	Cash
Supplies					
Total Supplies Costs				$4,200	
Contractual					
Cell phone service fee				$1,500	Cash
On Our Own PATH Woker .80 FTE			25,611	10889	
Total Contractual Costs			25,611	$12,389	
Other (List and Describe Each)					
Medication Assistance					
Identification related purchase costs (incl. Birth certificates)				250	
Rental Assistance				$2,000	
Bus Tokens					
Staff Training (non-travel registration and costs)				$1,100	Cash
Administrative Costs				$10,183	In Kind
Personal assistance needs					
Total Other Costs			0	$11,283	
Total Proposed Budget			**$ 64,862**	**$ 52,301**	Is match > or = to 1/3 of federal allocation?

Virginia PATH Local Intended Use Plan, FFY 2016/SFY 2017
PATH Program Year 2016-2017

1. Description of Provider Organization:

a. Name: Richmond Behavioral Health Authority

b. Organization Type: Community Mental Health Center

c. Description of Services Provided:
The Richmond Behavioral Health Authority (RBHA) is a public agency providing mental health, intellectual disability, substance abuse, prevention, and children's services. The RBHA provides the following non-exhaustive list of services either directly or through contracts with community providers: crisis intervention, crisis stabilization, psychiatric evaluations, nursing and pharmacy services, case management, in-home support services, psychiatric rehabilitation programs, youth day treatment programs, various short- and long-term residential programs, primary care, homeless services, and PACT. Services are provided to persons meeting the various admission criteria, but predominantly to those identified as Seriously Emotionally Disturbed, Seriously Mentally Ill, diagnosed with an Intellectual Disability, and/or a Substance Use or Dependence disorder.

RBHA also serves as the fiscal agent and hiring authority for the Virginia Veteran and Family Support Region IV team. Virginia Veteran and Family Support is a program of the Virginia Department of Veterans Services that monitors and coordinates behavioral health, rehabilitative and supportive services for Virginia veterans and their families. VVFS can provide care coordination services for any Virginia veteran regardless of discharge status, presence of disability, or VA eligibility. The Region IV team consists of a Regional Director and a Coordinator, and 5 veteran resource specialists (3 of which with key target services focused on families, housing, and reentry/criminal justice).

VVFS conducts community-based outreach to assist veterans and family members with navigating Federal, state, and local resources. The housing resource specialist (HRS) position for VVFS Region IV is located at RBHA and that position provides community based outreach and resource connections for at risk and homeless veterans in Central Virginia. The VVFS HRS position is collocated with the PATH team and will continue to work closely with them to serve homeless veterans. In addition, the entire Region IV team will work with the PATH team to provide regional outreach and connections to veterans experiencing homelessness.

The RBHA PATH program expanded its services to provide regional veteran specific outreach and services connections to homeless veterans in partnership with Virginia Veteran and Family Support (VVFS), Region IV through the services of the PATH-Vet Case Manager. The PATH-Vet Case Manager focuses more on Metro Richmond and Petersburg, where most of the known homeless veterans are concentrated.

d. Region Served:
The PATH and SOAR workers target clients in the City of Richmond, VA.
The PATH-Vet position covers all of health planning Region IV (including the cities of Richmond, Petersburg, Hopewell, Charles City, and Colonial Heights as well as the counties of Chesterfield, Hanover, Henrico, New Kent, Surry, Prince George, Goochland, Powhatan, Amelia, Cumberland, Buckingham, Prince Edward, Nottoway, Dinwiddie, Sussex, Southampton, Emporia, Greenville, Brunswick, Lunenburg, Charlotte, Halifax, and Mecklenburg. Region IV conducts intensive outreach to

homeless veterans in Metro Richmond and Petersburg.

e. Provider's experience in providing services to homeless/at-risk individuals and those with SMI and/or co-occurring SUDs:
RBHA has been providing outreach, case management, and crisis intervention services to homeless and at-risk individuals even prior to its establishment as an Authority in 1996. For over two decades, services have been provided to this population via multiple channels, including: PATH, Community Development Block Grant (CDBG) funding, and the US HUD Shelter Plus Care permanent supportive housing program. Mental health individuals at all levels of care, but especially those receiving intensive case management and PACT-level services, are also at-risk and frequently experience homelessness. In September 2015, RBHA received funding from the Office of Substance Abuse Services to hire an SUD peer. The SUD peer provides peer support services to individuals with substance use disorders experiencing homelessness to assist them in moving into and maintaining stable and suitable housing and address substance use disorders.

In all, RBHA's Adult Mental Health Division, under which the Homeless Services Team operates, manages a variety of programs, grant-funded projects, and other initiatives. The RBHA manages a wide array of services and programs, including regional programs, via a complex variety of funding sources and currently has an operating budget exceeding $40 million annually.

The Virginia Veteran and Family Support program (VVFS) has been providing outreach and supportive service linkages to all Virginia veterans and family members since 2009. Region IV staff began providing targeted outreach and care coordination services to homeless veterans in 2010 and recently added a housing resource specialist position to expand and sustain this critical services line in December 2013.

f. Description of housing or services that are specifically targeted to PATH-eligible consumers:

- Maintain a service-rich program by continuing to staff the program with 3.0 FTE PATH Case Managers, who are Qualified Mental Health Professionals ;(This includes the PATH-Vet Case Manager who serves homeless veterans regionally)
- Focus service delivery on comprehensive community outreach in those places where homeless individuals are known to live or congregate; intensive case management for PATH-enrolled consumers; collaboration and follow-through with a wide variety of providers, stakeholders, businesses; providing SOAR services;
- Utilize limited funding to purchase goods and services that incentivize PATH-eligible individuals to engage in services; to assist in accessing birth certificates, photo identification cards, prescription medications; to support best practices around rapid re-housing by providing limited funding for security deposits, first month rent payments, and furniture vouchers; and,
- Serve in both supportive and leadership roles in the community around finding solutions to end homelessness.

2. Program Budget and Federal Funds Requested: (Attach detailed budget using Excel file provided by DBHDS):

a. Amount of federal PATH funds requested: $186,499

b. Source and amount of Provider's minimum required 33% match funds:

The total match funds for FY 2016-17 will be $75,210. RBHA and VVFS will provide match funds as cash, in-kind services and supports.

c. A brief narrative describing the items in the attached budget:
The attached Budget Form details the planned program expenditures and the changes in how the funds will be distributed for the coming year. All match funds, totaling $75,210 will be made available on July 1, 2016.
RBHA in partnership with the VVFS Region IV provides regional veteran specific outreach and services connections to homeless veterans. The budget reflects the addition of 1 FTE (PATH-Vet) who joined the team in November 2014 and provides outreach to Health Planning Region IV, with particular focus on Metro Richmond and Petersburg.

RBHA proposes to continue allocating the majority of PATH funds for direct staff salaries and fringe benefits. Of the remaining funds, $400 will be reserved for costs associated with conference training and travel; $200 will be used to keep the outreach supply closet stocked with necessary items; and, $50 will be utilized to purchase bus tickets (GRTC and Greyhound) for program enrollees. To address an identified gap, $50 will be made available to PATH clients needing funds to pay for birth certificates and identification cards and $98 will be made available to assist clients with purchasing prescription medications.

The RBHA PATH program will continue to provide funding for security deposits, housing start-up and furniture assistance. This totals $1,700 of the expected funding from the state.

RBHA will provide cash and in-kind match funding totaling $56,946 for the balance of personnel costs, the use of agency vehicle(s), additional costs for conferences/other program training, costs for agency-related trainings, cell phone replacement and service fees, office supplies, HMIS service fee, CARITAS furniture bank partnership fee, monthly employee parking, MIS support/data entry/EMR transition, and general overhead and administrative support and supervision. The Virginia Veteran and Family Support (VVFS) will provide cash and in-kind funding totaling $16,264 for the use of agency vehicle, quarterly consortium meetings, cell phone service fees, medical assistance and identification related purchase costs for consumers, bus tickets for homeless veterans.

3. Collaboration with Local HUD Continuum of Care (CoC): Describe the organization's participation in the HUD Continuum of Care program, other local planning activities and program coordination initiatives, such as coordinated entry and coordinated assessment activities. If you are not currently working with the CoC, briefly explain the approaches to be taken by the agency to collaborate with the local CoC.
RBHA staff at all levels participates in HUD CoC and community planning groups. The Adult Mental Health Director is a member of the CoC/Homeward Executive Directors' committee; the PATH supervisor participates in CoC general meetings and is a member of the operational team of the Enhanced Outreach Committee of the Richmond Collaborative to End Chronic Homelessness, an effort which was supported by SAMHSA funds through the Cooperative Agreements to Benefit Homeless Individuals (CABHI) grant. Although the CABHI grant has ended, the Enhanced Outreach Committee of the Richmond Collaborative to End Chronic Homelessness still remains. PATH workers serve on the direct service portion of this Committee and are members of the Singles Housing Team who complete

the Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT) to determine the best course of action for homeless individuals that complete the assessment. The Mental Health Director serves on the board of the GRCoC. The Adult Mental Health Director is the Housing Sub-Committee Chair for the Region IV Recovery Action Focus Team (RAFT). Finally, RBHA/PATH staff is actively participating in efforts to develop the Richmond SOAR Initiative.

RBHA staff is also regularly present at the McKinney-Vento Homeless Education meetings, active with the community rapid re-housing initiative, and an advisory council member for a city public housing program. Finally, Homeless Services staff consistently provides support with the biannual point-in-time count and the annual Project Homeless Connect event, taking the lead in coordinating the mental health/substance abuse triage area.

The existing RBHA homeless services team is gradually enhancing their Richmond CoC involvement even further with the addition of the PATH-Vet case manager. The Richmond CoC conducts monthly veteran sub-group meetings focused on ending veteran homelessness. The meetings focus on veteran specific resources such as the Dept. of Veterans Affairs homeless programs and bridging veteran access to mainstream homeless services. The PATH-Vet Case Manager participates regularly in the veteran sub-group meetings. In addition, VVFS Region IV regularly participates in Richmond and Petersburg CoC meetings. The VVFS housing resource specialist (HRS) is part of a veteran taskforce called Vet Help Link (in collaboration with the McGuire VA Healthcare for Homeless Veterans program, Virginia Supportive Housing (VA Supportive Services for Veteran Families grantee) that provides targeted outreach at the Richmond Homeless Point of Entry. At the Executive Team level of VVFS, there are two positions dedicated to services coordination and housing development (HD) for veterans statewide. The HD positions work with CoCs, VA Medical Centers and other housing and supportive services stakeholders to coordinate a system of care to end veteran homelessness and support the overall affordable and accessible needs of Virginia veterans. The PATH-Vet Case Manager and the VVFS HRS participate in regular planning calls with the VVFS Housing Development staff to get best practices information and updates on state-level homeless initiatives.

4. Collaboration with Local Community Organizations: Provide a brief description of partnerships and activities with local community organizations that provide key services (i.e., outreach teams, primary health, mental health, substance abuse, housing, employment, etc.) to PATH eligible clients, and describe coordination of activities and policies with those organizations. Provide specific information about how coordination with other outreach teams is achieved.

RBHA's three PATH workers diligently address clients' immediate and long-term needs in the most comprehensive manner possible, given available resources. The PATH team maintains a solid presence in the community, strengthening and expanding the scope of services and supports available to the vulnerable population they serve. They work to address the clients' comprehensive needs to include mental health and/or substance abuse services, shelter/housing, medical, clothing and food, job development/training services, and assistance with obtaining benefits. Some of the most effective collaborative relationships include: the Daily Planet, Homeless Point of Entry, the Richmond Police Department, Virginia Supportive Housing, and the Richmond Department of Social Services. The PATH-Vet Case Manager is strengthening partnerships with veteran specific providers such as VVFS, Department of Veterans Affairs, and the Homeless Veteran Reintegration Program as well as solidifies the bridge to mainstream resources for non-VA-eligible veterans experiencing homelessness.

In May of 2015, Homeward's Coordinated Access Committee came together with leadership in community agencies to form a community housing team for single adults. The Single Adults Housing Team is made up of direct staff and modeled after the coordinated entry pilot with veterans experiencing homelessness to prioritize individuals for housing based on their needs and vulnerability. The team meets every Tuesday to prioritize and match individuals to housing based on their length of homelessness, VI-SPDAT scores and the program's eligibility criteria.

PATH workers are members of the Outreach Team which includes the Daily Planet, Virginia Supportive Housing, Department of Social Services, and the Richmond Police Department. The Outreach Team meets twice a month to coordinate outreach and discuss new/existing camp sites. This team also discusses cases appropriate for the Single Adults Housing Team.

PATH workers refer individuals that require mental health and or substance abuse services to RBHA's rapid access program where individuals are assessed and appropriately assigned to needed services. The rapid access program takes walk-in appointments between the hours of 8:00AM and 11:00AM. Individuals not meeting RBHA's criteria are referred to the Daily Planet for services. The Richmond Integrated Community Health (RICH) Clinic housed at RBHA provides primary medical care to individuals enrolled in the PATH program regardless of their benefit status. This grant funded program enables individuals to receive both behavioral care and medical care at RBHA. This one-stop shop has proven to be very valuable in the provision of services. PATH workers report that individuals are more willing to receive primary medical services provided in the on-site clinic.

The following table lists community organizations that the PATH staff has utilized regularly. Please note that the list is not exhaustive.

Agency Name	Service(s) Provided	Referral Process
Richmond Behavioral Health Authority	mental health, substance abuse, crisis services, crisis stabilization, CIT, medical clinic	triage appointment followed by regular intake/assessment process
Richmond City Jail	temporary detainment	worker accepts referrals, identifies service needs, coordinates care
Rubicon	inpatient substance abuse treatment, outpatient	worker completes referral
Homeless Point of Entry	access to all shelter services	worker provides referral and linkage
Assisted Living Facilities	24/7 board and care	Worker completes UAI
Daily Planet	shelter, medical, dental and mental health care, case management	referral from worker for clinic; for all services, must complete agency intake; employment services, SOAR partner
CARITAS Furniture Bank	furniture/household goods	worker assists with referral process, "shopping" for furniture, and loading/moving
Petersburg Freedom Support Center	Veteran One Stop resource center serving Tri-Cities	Path-Vet will link to onsite VA/VVFS homeless services, medical and other supports.
Community Emergency Shelters	Shelter (temporary, emergency).	referral from worker and assistance with linkage
Virginia Supportive Housing	SRO housing, HIV/AIDS	Worker assists with referral,

	house, Housing First program	completing applications, supports in program interviews for veterans, the PATH-Vet position will make referrals into the Supportive Services for Veteran Families program for temporary financial assistance and case management when appropriate.
Department of Social Services	food stamps, Medicaid, General Relief, outreach partner	worker assists with applications; links with DSS workers
Richmond Police Department HOPE Unit	law enforcement, specialized outreach, linkage with community providers	workers respond to requests for help with potential PATH clients; collaborative outreach
Offender Aid and Restoration	services for ex-offenders	staff assists with referral and linkage
2nd Presbyterian, St. Peter's, United Centenary, AME Bethel	daily meals programs	worker outreaches at various locations
River City Comprehensive Counseling	Homeless Veteran Reintegration Program (HVRP) from the Dept of Labor, provides employment case management for homeless veterans.	PATH-Vet will provide linkages to HVRP employment supports for homeless veterans when appropriate.
Virginia Employment Commission Region IV	Employment supports for all Virginians. For veterans, the Disabled Veteran Outreach Program (DVOP) representatives also provide intensive case management for veteran's homeless or disabled veterans.	PATH- Vet will provide linkages to DVOPs for homeless veterans when appropriate.
St. Paul's Church	meal program, financial assistance for security deposits, utilities, etc.	worker outreaches at lunch site; assists with direct referral for financial support
Social Security Administration	SSI/DI, social security cards	staff assists with accessing services, applying for benefits
Hilltop Promises	Clothing, mailing address, computer access, staff support	worker completes referral
Virginia Wounded Warrior Program	veteran's services (for VA and non-VA eligible)	worker collaborates with onsite staff (including housing resource

	–mental health and substance abuse treatment linkage, support groups, and veteran specific homeless and housing services linkages	specialist) and makes appropriate referrals
Veterans Administration	medical and behavioral health services	Worker assists with linkage, collaborates with treatment team. In addition, the Path-Vet will work specifically with the Healthcare for Homeless Veterans and HUD VASH programs.
Va. Dept of Veterans Services	VA benefits assistance, and employment and transition assistance for Virginia Veterans.	PATH-Vet will provide linkage to VVFS (a program of DVS) and additional DVS support services as needed.
Hospitals (MCV, Tucker's, St. Mary's, RCH, CSH)	medical and psychiatric care (acute care and long-term)	worker accepts referrals from hospitals; links clients to hospital, facilitates admission and discharge
Crossroads	payee services	staff assists with referral
Jenkins, Block & Associates; Krumbein & Associates	legal services, advocacy, representation at ALJ hearings	worker links client to attorney and coordinates all appointments, provides support for hearing
Department of Corrections	Probation and parole	Worker accepts referrals and coordinates care
Fan Free Clinic	Specialized medical care and limited case management services.	Worker accepts referrals
Senior Connections	Provides community resources for seniors	Worker accepts and provides services for referrals

5. Service Provision: Describe the plan to provide coordinated and comprehensive services to eligible PATH consumers. Please address the following information.

a. Projected number of adult consumers to be contacted with PATH funds: 575

b. Projected number of adult consumers to be enrolled using PATH funds: 200

c. Percentage of adult consumers projected to be "Literally Homeless", and activities to maximize the use of PATH funds to serve adults who are literally homeless as a priority population:

Based on activity in recent years, the RBHA PATH program will aim to serve at least 50% of persons who are "literally homeless". PATH activities are described below under case management and outreach.

d. Strategies that will be used to target PATH funds for street outreach and case management as priority services.

Strategies to ensure PATH funds are used for these purposes include the following:

- Designating 95% of the PATH funding allocation for direct service staff. 3.0 FTE Case Manager positions will be maintained with this funding. Staff will aim to achieve and, if appropriate, exceed the target of enrolling and providing active case management to at least 200 PATH-eligible consumers annually. Staff are credentialed as Qualified Mental Health Professionals, so they carry the KSAs required to work with the target population.
- Setting aside funds for client supports, so that PATH can further facilitate the acquisition of birth certificates and DMV identification cards; cover prescription co-payments at local pharmacies; and, maintain a well-stocked outreach supply closet.
- Providing limited funding for security deposits, one-time rental payments, and furniture bank vouchers to be targeted for those individuals who lack the resources to manage these expenses on their own when a permanent housing option becomes open for them.
- Partnership with VVFS increased direct services funding availability for homeless veterans.

e. Indicate whether your organization provides, pays for, or otherwise supports evidence-based practices and other training for local PATH-funded staff, including training and activities to support migration of PATH data into HMIS.

The following non-exhaustive list of evidenced-based practices and programs are supported by the RBHA:

- In the Adult Mental Health Division, a strengths-based case management approach is used. Strategies to continue training on person-centered planning are underway. PACT services are provided. Staff have received periodic training on Motivational Interviewing, and there has been a pilot underway to utilize Feedback Informed Treatment. This PATH program has a SOAR program with a designated SOAR worker. The PATH-Vet CM designated to serve veterans is also SOAR trained and able to assist homeless veterans with SMI in securing SSI/SSDI benefits.
- The Prevention and Substance Abuse Division staff utilizes a wide variety of EBPs with youth in schools and adults in recovery, including peer recovery supports.
- Best practices are utilized in the Crisis Stabilization Unit, including WRAP planning. RBHA supports the local and regional CIT initiative.

Throughout the project year, Homeward provided training on the use of the community's HMIS system, ServicePoint. Program staff and the supervisor worked with Homeward staff to learn the system. While capturing some required PATH data within the system has proven difficult, the supervisor and Homeward staff are committed to tailoring the system to meet the reporting and tracking needs of PATH. Staff have been entering client data and regularly utilizing the system's reports.

f. Describe gaps in the current service system and how PATH will assist consumers in addressing those gaps.

While there has been some progress with addressing some of the community's gaps through regional planning and efforts around the 10-year plan to end and prevent homelessness, many remain. Key among these are: a lack of affordable housing, a lack of specialized housing for unique populations, overtaxed public support systems (behavioral health, social services), limited employment options and a

challenging job market, limited options for youth aging out of foster care, few options for medical care, inadequate public transportation, duplication of services and/or poor collaboration among providers.

Further, homeless individuals bring challenges that must be addressed, like: limited income, criminal histories, lack of identification and birth certificates, poor credit, histories of poor adherence to behavioral health treatment, limited or non-existent family support.

PATH staff work consistently and tirelessly to address many of these, both on a case-by-case basis and at the community planning level. Specifically, PATH:

- Conducts a comprehensive assessment with each enrolled client and, as the individual allows, collaborates with all providers involved in the care of the individual;
- Provides intensive case management to enrolled clients, which may include transportation to and from appointments, and hands-on assistance with accessing mainstream services;
- Enrolls PATH clients in SOAR services to obtain benefits and/or links with employment services;
- Maintains funding for and offers assistance with accessing birth certificates in Virginia and out-of-state and DMV identification cards;
- Follows up on all legitimate housing opportunities in the community;
- Persistently advocates for PATH clients to be able to access limited permanent supportive housing in the community;
- Involves the family or friends of PATH clients, as allowed and appropriate; and,
- Facilitates discharge for clients from jails, hospitals, crisis stabilization, medical respite, and inpatient substance abuse programs.
- PATH-Vet CM and partnership with VVFS ensures that homeless veterans (regardless of VA eligibility) receive care coordination and linkage to permanent housing, VA and community supports.

g. Describe services available for consumers who have both serious mental illness and substance use disorder.

PATH clients who have not yet completed the intake process at RBHA can immediately access the agency's Motivational Enhancement Therapy (MET) groups. Active MET participants may be eligible for referral to inpatient programs. Clients enrolled in RBHA for services have access to and are encouraged to participate in Dual Recovery Program groups. The Daily Planet also offers its own co-occurring disorders group, led weekly by a staff clinician. The VVFS Region IV team also offers a veteran peer support group for veterans in mental health recovery that will be open to veterans identified by the PATH program. Homeless veterans with SMI have access to clinical assessment through the VA or community treatment options.

PATH clients may also access or come in contact with the jail team liaison, crisis stabilization, and/or the medical clinic for persons who are uninsured or underinsured.

PATH staff assists clients with the referral, triage, and intake process for these programs. With the close partnership between the Daily Planet, PATH staff is able to complete the intake paperwork and make direct referrals to the various programs, helping individuals by-pass some of the initial intake processes.

h. Describe strategies for making suitable housing available to PATH consumers (e.g., indicate the type of housing usually provide and the name of the agency that provides such housing).
RBHA PATH staff are very involved in the community's efforts to improve and increase housing options for persons who are homeless. Examples of this and of housing referral sources include the following:

- Homeless Point of Entry remains the first point of contact for persons in crisis to seek emergency shelter and limited transitional housing. PATH staff works with the established system, although many homeless clients do not wish to utilize and/or are banned from the shelters. The PATH-Vet CM works with the Vet Help Link outreach team at HPE in collaboration with VVFS Region IV, Department of Veterans Affairs, and Virginia Supportive Housing. If identified veterans are eligible for VA Grant and Per Diem transitional housing, the PATH-Vet CM coordinates with HPE and McGuire VA Medical Center to facilitate access.

- PATH workers assess an individual's financial resources and discuss available and appropriate housing options, including private landlords, rooming houses, assisted living facilities, and Section 8 subsidized housing. PATH staff has continued to develop relationships with landlords and housing managers, especially with those who are willing to be flexible with their acceptance criteria. PATH staff regularly assists clients with identifying choices, making contacts, completing housing applications, locating furnishings, and managing the move process.
- Virginia Supportive Housing (VSH) is one such agency and is a regular collaborative partner with the RBHA in meeting the needs of this population. Since VSH opened the doors to its Housing First program, A Place to Start (APTS), in late 2007 PATH workers have been referring and placing eligible clients. For Veterans, VSH has the VA Supportive Services for Veteran Families grant that may be able to provide temporary financial assistance and case management for homeless veterans.

- PATH staff worker actively participates in the outreach worker team Enhanced Outreach Committee of the Richmond Collaborative to End Chronic Homelessness. This multi-agency partnership is headed by VSH and has provided permanent supportive housing to several PATH enrolled individuals. The PATH-Vet CM participates regularly in the veteran sub-group of the Richmond CoC focused on outreaching and identifying the most vulnerable homeless veterans in Metro Richmond.
- The PATH-Vet CM specifically works with the McGuire VA Medical Center HUD VASH program to increase access to the veteran specific Section 8 vouchers for identified disabled and homeless veterans.

i. If you plan to implement one or more Virginia PATH Innovative Practices, indicate which one(s) and describe the implementation plan:
This site will continue providing SSI/DI Outreach Services (SOAR) to PATH clients in the next project year. Through this program and others, RBHA has maintained its partnership with the Daily Planet. One FTE PATH staff, the SOAR worker, has an office at the Daily Planet and RBHA and divides her time providing direct services between both locations. Because of this arrangement, the worker outreaches and receives referrals for eligible persons visiting the agency and conducts additional outreach to clients participating in the Daily Planet's Safe Havens and Medical Respite programs. At any given time, the SOAR worker is managing 25-35 active cases in various stages of the SSI/DI

application and appeals processes.

The SOAR worker utilizes the Daily Planet's psychiatric and medical staff, facilitating treatment for and required documentation of an individual's disability for the purposes of submitting SSI/DI applications to SSA. RBHA and Daily Planet staff meets monthly to collaborate on the project, review cases, and problem solve areas of difficulty with specific client cases. During 2015, the SOAR program documented 8 SSI/DI approvals. SOAR resources are increasingly spent on difficult reconsideration cases, with staff time being consumed by researching the case history and collaborating with legal counsel, SSA, DDS, and a variety of treating professionals.

RBHA PATH staff has continued collaborating with Homeward, which has taken the lead with implementing a community-wide process among providers from key homeless services agencies, DDS, and SSA staff, with the common goal of expanding SOAR capacity in the Greater Richmond area and capturing and reporting accurate community data around SOAR activities.

j. Briefly describe your plan for providing the following PATH-allowable services:

Outreach:

Outreach remains a core service of RBHA's PATH program. On a weekly basis, PATH staff outreach at any of the following locations: RBHA crisis and crisis stabilization units, Daily Planet, Homeless Point of Entry, emergency shelters, overflow shelter (seasonal), the Department of Social Services, churches and other meal sites, Medical Respite, and various parks and other sites frequented by homeless individuals. The PATH-Vet CM also conducts outreach weekly and as needed at the locations referenced above and at the Petersburg Freedom Support Center (veteran one stop resource center) in partnership with VVFS Region IV, and the McGuire VA Medical Center. The PATH-Vet CM works closely with the VWWP Region IV team members located in Chesterfield and Henrico to ensure outreach coverage in suburban areas as needed.

Periodically, city officials and concerned members of the community will call RBHA for immediate assistance outreaching a homeless individual who is displaying bizarre behaviors. PATH responds immediately in these cases to identify, assess, and offer services to the identified individual. PATH also outreaches with the Richmond Police Department's HOPE unit on at least a weekly basis, shadowing during evening patrols. With the PATH-Vet CM this option also exists for officials and community members that have identified a homeless person in need in Metro Richmond (including surrounding counties) and Petersburg.

Finally, PATH has been at the table organizing meetings among community outreach workers, so that regular information sharing and communication takes place to best serve homeless individuals on the streets. Participation with the Enhanced Outreach Committee of the Richmond Collaborative to End Chronic Homelessness has facilitated numerous placements for chronically homeless individuals. The PATH-Vet CM participates regularly in the veteran sub-group of the Richmond CoC focused on outreaching and identifying the most vulnerable homeless veterans in Metro Richmond and links them to the HUD VASH program and other veteran specific and mainstream housing options.

Screening and Diagnostic Treatment:

The PATH workers conduct a basic mental status exam for all outreached individuals to assess for immediate needs. If persons are presenting in an agitated, suicidal, homicidal, or otherwise decompensative state, then the PATH worker, a certified pre-screener, may initiate a Temporary Detention Order. Staff continues to access RBHA Crisis Services for assistance. The PATH-Vet CM also links to D19 Community Services Board crisis resources (or additional Region IV CSB crisis resources in the proximity), the VA veteran crisis line, and the McGuire VAMC Mental Health and emergency room as needed for veterans in crisis.

When individuals express a willingness to be assisted through the program, PATH staff will conduct a face-to-face interview utilizing a simple diagnostic tool, the "Street Sheet", to document a client's basic demographics and requested services. The Street Sheet asks about basic PATH program eligibility; current housing situation and homeless history; behavioral and medical health treatment and information; benefits and other sources of income and support; and other pertinent information shared during the interview. The Street Sheet becomes a part of the PATH record. The Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT) is an additional tool being used by PATH staff to prescreen single adults. PATH staff together with other community partners (VSH, VA, VVFS, Daily Planet) who are part of the Coordinated Assessment Team utilize this tool in prioritizing who gets housed first depending on the scores retrieved from the VI-SPDAT at their bi-monthly meetings.

PATH staff also regularly completes triage and intake/assessment forms for mental health and substance abuse services at RBHA and the Daily Planet, for Crisis Stabilization Unit services, and Assisted Living Facility placements. In addition, the PATH-Vet CM assists with any eligibility and treatment information needed for D19 CSB resources (or additional Region IV CSB resources in the proximity), the VA veteran crisis line, and the McGuire VA Medical center services.

Habilitation and Rehabilitation:
The PATH workers provide supportive counseling and assist clients with problem-solving with the goal of helping program participants reach their maximum level of independence in a community-based setting. Because PATH staff works under the same service umbrella as the Mental Health Support Services team, there has been an opportunity to support referrals and linkage to this service once clients have been formally opened to agency services. The PATH-Vet CM assists with access to additional Region IV CSB services in partnership with VVFS Region IV staff members (staff are located in the following CSBs: RBHA, D19 (Petersburg and Emporia offices), Southside, and Henrico. In addition, the VVFS Region IV team collaborates with all CSBs in Health Planning Region IV.

Community Mental Health Services:
Individuals presenting in a psychiatrically distressed state are immediately referred to Crisis Services, including Crisis Stabilization, at the RBHA and assisted through the prescreening process by the PATH worker. The PATH worker collaborates with the Crisis/Intake team and the Case Management units to provide background and supporting documentation that may help determine the best course of treatment for the client. Other community mental health resources accessed by the PATH workers include the Daily Planet Clinic, the Virginia

Commonwealth University Medical Center, VSH's APTS/Housing First intensive community treatment team, and private MHSS providers. The PATH-Vet CM assists with access to additional Region IV CSB services in partnership with VVFS Region IV staff members (staff are located in the following CSBs: RBHA, D19 (Petersburg and Emporia offices), Southside, and Henrico. In addition, the VVFS Region IV team collaborates with all CSBs in Health Planning Region IV. The PATH-Vet CM also works with the mental health division of McGuire VA Medical Center and the VA Community Based Outreach Clinic in Emporia for VA eligible veterans.

Alcohol or Drug Treatment Services:
Individuals presenting with substance use issues are encouraged to participate in treatment. The PATH workers assist clients with referrals to RBHA, The Healing Place, Rubicon, the Salvation Army, the Daily Planet's co-occurring disorders group, and community AA/NA meetings, as appropriate. In addition, the VVFS Region IV team collaborates with all CSBs in Health Planning Region IV. The PATH-Vet CM also works with the mental health division of McGuire VA Medical Center and the VA Community Based Outreach Clinic in Emporia for VA eligible veterans.

Staff Training:
PATH staff continues to be available on a formal and informal basis to provide training to RBHA case managers and area providers with learning about and accessing resources for their clients. More formal settings include sharing among community providers and with various RBHA teams. Most information-sharing occurs informally through collaboration with hospitals, social services, veteran's services, jails, shelters, landlords, service agencies for offenders and the like. The PATH-Vet CM has access to all VVFS statewide trainings that range in topic areas (military culture, post combat and military transition issues and resources, PTSD/TBI characteristics and treatment options), behavioral health and housing best practices etc.). Trainings occur quarterly with the VVFS statewide consortia and are usually 1 day in length.

The PATH Outreach Worker has been a member of the community's Crisis Intervention Team, a model program that trains police officers how to recognize, support, and respond appropriately to persons who may be having a behavioral health crisis. The PATH-Vet CM collaborates with the VVFS Region IV team in CIT trainings that are specific to working with veterans.

Case Management:
PATH staff is actively engaged in providing traditional and non-traditional case management services to enrolled clients. Staff assesses client needs, refers clients to a variety of services including social services, employment services, medical and behavioral health care, and actively links clients to shelter placements, permanent housing, doctor appointments, intake appointments and more as they seek to provide opportunities for clients to make a more stable life for themselves. Clients receiving SOAR services are also supported at appointments with attorneys, during CE's, and at SSA hearings.

Staff goes above and beyond their case management duties by helping clients develop resumes, finding employment resources, working with shelter providers to extend shelter

days, escorting clients to the emergency room for treatment, and collaborating with the local jail. They are regularly seen dressing for the day to move a truckload of furniture into a client's new home. The PATH workers provide brief follow-along services to clients placed in transitional and permanent housing and assist them with maintaining contact with mainstream services. The workers document progress via informal service plans and case notes for each enrolled PATH client.
Supportive and Supervisory Services in Residential Settings: PATH workers provide support in a number of ways. They may problem-solve with a client and housing provider to prevent a pending eviction; mediate a roommate conflict; collaborate with medical and behavioral health staff while a client is housed in short- and long-term shelter, medical respite, inpatient substance abuse treatment, crisis stabilization and similar. Staff also takes an active role in supporting clients through the process of enrolling in various housing programs, including Section 8, SRO housing, APTS/Housing First. Support may include helping clients with service referrals, with completing forms and applications, and meeting with staff at other provider agencies.
Minor Renovation: N/A
Planning of Housing: Homeless services staff, supervisors, and agency leaders regularly participate in a variety of housing planning activities. More current examples of this include participating in the implementation of a local rapid re-housing program, ongoing collaboration with Virginia Supportive Housing (VSH), and partnering with the local Housing Authority to prioritize housing for homeless families. Informally, staff works diligently to seek out new and work with existing private housing providers, discussing the unique needs of this population regarding housing and services to encourage them to be creative with their housing options. The PATH-Vet CM works specifically with the McGuire VA Medical Center HUD VASH program to increase access to the veteran specific Section 8 vouchers for identified disabled and homeless veterans.
Technical Assistance in Applying for Housing: The PATH workers assist clients with applying for private sector housing (i.e. rooming houses, apartment complexes, recovery houses, and subsidized housing). The workers also help clients get their names on housing waiting lists and monitor the referrals. Often, clients are limited by their income and/or waiting on their entitlements to start. Staff typically starts by helping clients identify their ideal living situation and location, reviewing housing options, and identifying sites to visit. The case managers then provide technical assistance with completing housing applications, submitting them, and following up with the housing provider(s) as to the status of the client's application or waitlist status. Affordable housing continues to be a community gap, and it can take months with consistent searching and follow-up to help a client obtain decent, affordable housing.
Improving the Coordination of Housing Services: PATH participants are given the opportunity to have the workers accompany them during a housing interview or intake process, gather supporting documents in applying for housing,

and assist individuals through a formal housing appeal process (for public housing). PATH staff continues to develop relationships with landlords, some of whom have been willing to prioritize persons with special needs and/or allow creative solutions for clients to more readily access their housing units. PATH staff continues to identify and refer all appropriate individuals to the array of housing at VSH and/or through the HUD VASH program (tenant based and project based vouchers in metro Richmond) for VA eligible veterans.

Security Deposits:
PATH staff assists clients with accessing funds for security deposits and other initial housing expenses via community partners, as resources are available. This is an invaluable resource that is always in short supply and high demand and, as such, the RBHA PATH program will again propose to devote a portion of program funding to support PATH clients with security deposits and housing start-up for the 2016-17 program year. In partnership with VVFS Region IV, the PATH program will be able to increase the availability of these funds for homeless veterans.

Costs Associated with Matching Eligible Homeless Individuals with Appropriate Housing Situations:
PATH staff evaluates an individual's financial resources, his/her housing wants and needs, and available housing-related resources in the community as a part of the services offered through the existing PATH program. The PATH program's partnership with the CARITAS furniture bank has been a successful one, again with a high demand. Since accessing affordable household furnishings is identified as a service gap, the PATH program again proposes to utilize a portion of its funding to assist a limited number of clients with purchasing furniture vouchers.

One-time Rental Payments to Prevent Eviction: N/A

Referrals for Primary Health Services, Job Training, Education Services and Relevant Housing Services:
Numerous formal and informal referrals are made on behalf of clients seeking any of the above services. Staff is constantly seeking new and creative resources to meet the many needs of this population. Primary referral sources for these services include the RBHA, Daily Planet, and Virginia Supportive Housing. A sample list of area agencies providing such services is included above in item 4. In partnership with VVFS, the list of partners will increase further to include regional veteran services organizations and other veteran specific providers.

6. HMIS Data Integration: Describe your HMIS transition plan, with accompanying timeline, to begin using HMIS to collect and report PATH data in HMIS by July 1, 2016. If you are fully utilizing HMIS for PATH services, please describe plans for continued training and how you will support new staff. Indicate any technical assistance needs you may have in meeting the HMIS data requirements.

RBHA PATH has begun integrating data into the local HMIS system as follows:

- PATH staff has been entering new PATH enrollees into HMIS beginning in October 2011.
- May 2012: SOAR worker begins entering SOAR data into HMIS.

- August 2012 – January 2013: Staff continued entering data for enrolled PATH participants in HMIS; preliminary reports done; generating list of missing elements that will impede full system use for purpose of regular PATH reporting to DBHDS and SAMHSA.
- February 2014: PATH/SOAR staff gets trained on the use of HMIS.
- March 2015: PATH-Vet staff gets trained on the use of HMIS
- Currently PATH staff use HMIS to complete the VI-SPDAT and to research other services/agencies that client has been connected with. PATH workers have entered data into HMIS in order to be fully prepared by June 2016. However, workers have encountered some difficulty in the effective use of HMIS. PATH workers continue to work with HMIS Trainer and Support Manager with Homeward to develop new forms for HMIS to generate the needed reports such as quarterly and annual reports for both PATH and SOAR.

Ongoing technical assistance is needed to ensure success with data entry, as follows:

- Ongoing training from Homeward to ensure proper use of HMIS; training on report writing; assistance modifying PATH pages to ensure data captured meets all stakeholder requirements.
- Support from DBHDS with regard to assistance working with Homeward on writing PATH-specific reports.

Support collaborative efforts between Homeward and HMIS users, especially outreach workers, as they determine the best way to capture all street homeless individuals, who may not be willing to be engaged in any services, in HMIS.

7. SSI/SSDI Outreach, Access, Recovery (SOAR): Describe your plan to train PATH staff on SOAR. Indicate the number of PATH staff trained in SOAR and the number of PATH-enrolled consumers assisted through SOAR during State Fiscal Year 2013, and the approximate number of staff to be trained in SOAR for State Fiscal Year 2015.

At this time, one of our PATH staff is SOAR trained and regularly completes applications for enrolled individuals to obtain benefits utilizing the SOAR process. The PATH-Vet CM is SOAR trained and assists in completing applications for homeless veterans.

8. Program demographics and cultural competency: Describe the following.

a. The demographics of the target population.

The January 2016 point in time count of people experiencing homelessness reported by Homeward for Metro Richmond include:

762 total homeless individuals were counted; there was a 6.8% decrease from 818 in 2015. Of the total homeless individuals, 70 were reported as unsheltered. This is a decrease from the 86 individuals reported in 2015. 74 children were reported as homeless. This is a decrease from 88 in 2015. 118 were reported as veterans in January 2016 compared to the 121 reported in 2015. These initial counts suggest that between 2015 and 2016 there was a minimal decrease in homelessness among veterans in Metro Richmond.

Source: January 2016 Point in Time Count, Homeless Management Information System (HMIS) data from emergency shelter and transitional housing, Homeward.

b. The demographics of the staff serving PATH consumers.

There are 3.0 FTE PATH staff, one of whom focuses primarily on SOAR activities. The SOAR worker who began working at RBHA in February 2014 is a Caucasian female and has a bachelor's degree in criminal justice with a concentration in psychology. She worked as an Outreach and Tracking Caseworker with the Key Program in Providence, Rhode Island for two years. She also worked in

Taunton, MA for the Community Counseling of Bristol County-Progressive Assertive Community Treatment Program (PACT) as a Housing Specialist for a year. She continued to work with the SMI population in Colonial Heights, VA where she worked as a Mental Health Support Specialist for over two years with Good Neighbor Counseling.
The outreach worker is male and identifies as African American. He has a bachelor's in psychology with 38 years of extensive experience working with the homeless population. He worked with the Emergency Shelters Incorporated which is now Home Again for 6 years and also with the Telman Corporation where he facilitated job training and development for the homeless in Richmond, VA. Prior to joining the RBHA team, he worked as a PATH case manager in D19 (Petersburg, VA) for 22 years.
The PATH-Vet CM is a Latina female and has a bachelor's degree in psychology. She worked for four years at Good Neighbor Community Services in different roles; as a therapeutic child mentor, an intensive care coordinator, and staff mentoring program supervisor, as well as an adult behavioral specialist prior to joining the RBHA team. She has a couple of uncles that have served in the US Army and is very resourceful.

c. How staff providing services to the target population will be sensitive to age, gender and racial/ethnic differences of consumers.
All RBHA staff participates in a half-day diversity awareness seminar led by trained Human Resources staff. PATH staff provides person-centered services and do so in a consistently professional, respectful, and empathetic manner for some of the most difficult-to-serve persons. Both workers are "people"-persons and regularly go above and beyond for all of their clients, regardless of age, gender, race/ethnicity, or level of disability. The staff understands that it takes building a foundation of trust to develop a working relationship with most homeless persons and recognize the need to be sensitive to privacy issues, hygiene concerns, personal belongings, and readiness to accept treatment for presenting problems.

The Outreach worker has 38 years of experience in the community and with the client population. Although he mainly worked in Petersburg, he is exceptionally well-known and respected in the community among providers and very comfortable with the client population. The PATH workers have extensive clinical experience working with a population with severe symptom acuity.

d. The extent to which PATH staff receive training in cultural competence.
Staff is strongly encouraged to attend at least one cultural competence training yearly, as provided by RBHA through external trainers, its online continuing education courses, and/or as offered in the community. The SOAR and Outreach workers have participated in Motivational Interviewing training. The PATH-Vet CM is currently SOAR trained and participated in the suicide first aide training in April 2015. A sampling of trainings that staff participated in during FY 2015 includes: VI-SPDAT training at Homeward, attending national-level homeless provider conferences and the local Homeward best practices conference annually. It is anticipated that current staff will have the opportunity to participate in other trainings during FY 2016-2017. The staff also has an opportunity to work onsite with peer specialist/consumer staff in several programs. Though not formal "training", PATH staff have frequent interactions with consumer and veteran peer specialists and have the benefit of learning their perspectives first-hand.

e. The extent to which the organization adheres to the Culturally and Linguistically Competent (CLAS) Standards. The CLAS standards can be accessed at http://www.ThinkCulturalHealth.hhs.gov.
RBHA requires staff participation in diversity training and acknowledges the importance of providers developing awareness, knowledge, and skills appropriate to the consumer's culture. These trainings are

designed to increase staff awareness of the impact of culture on treatment practices. PATH staff are also educated through "RBHA University" trainings and through clinical supervision about the utilization of recovery-oriented principles which recognize that recovery is a unique experience and culture must be effectively acknowledged and addressed throughout treatment.

RBHA is committed to providing consumers with language assistance services (bilingual staff) when available. Our agency Consumer and Family Affairs Coordinator also ensures individuals have access to patient-related material that is easily understood.

RBHA's recent transition to electronic health records (EHR) ensures that data on consumer's race, ethnicity, and spoken and written language are accurately maintained and available to all agency staff who may be providing treatment to the individual. PATH staff are trained on the EHR and have mobile capabilities (laptop, air card) to access the system while conducting outreach in the field.

9. Consumer and Family Involvement: Describe how individuals who are homeless and have serious mental illnesses, and family members will be involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards. (See attached Appendix I – Guidelines for Consumer and Family Participation.)

There are a number of meaningful ways in which consumers and family members are involved at the RBHA. RBHA employs 15-20 self-identified consumers in support service and professional capacities. The SOAR worker consistently involves family members in a consumer's disability case, with the permission of the consumer, in order to improve outcomes. When possible, PATH staff involves family members in the treatment planning process for PATH enrollees. The PATH-Vet worker collaborates with VVFS Region IV staff to provide care coordination to veterans and their family members. VVFS Region IV hosts a veteran family support group in Petersburg that family members in that area may participate in. VVFS Region IV also hosts couples workshops (Mission Health Relationships) and family retreats (Mission Health Families) semi-annually which will be available to PATH consumers and family members as well.

The RBHA has consumer and family representation on its Board of Directors. The Adult Mental Health Division continues its efforts to transform the service delivery system into a more consumer-driven one, and has planned for staff and consumer training opportunities and employment opportunities for consumers. The division supports a growing Consumer Advisory Council that meets regularly, publishes a quarterly newsletter, and has plans for program expansion, including a warmline. Current and former PATH participants are eligible to participate on the advisory board, although none is at this time. A former consumer, who was homeless and did receive past services from the Homeless Services Team, is currently employed at the RBHA as a peer specialist and has consulted with this team.

Recovery is also supported through regularly scheduled Wellness Recovery Action Plan (WRAP) groups via the psychiatric rehabilitation programs and the crisis stabilization program. Finally, there are regular opportunities for consumers to provide feedback about existing and proposed programs and services at RBHA through a variety of surveys administered throughout the year and through suggestions boxes located in several areas of the agency.

10. Outreach to Homeless Veterans: Describe how your PATH program identifies and outreaches to homeless veterans with SMI, and the services available to them in your catchment area. How does PATH interface with your veterans' service continuum?

The RBHA PATH program currently has a PATH-Vet CM who identifies homeless veterans with SMI through multiple sources, all of which partake in the Richmond Continuum of Care (CoC). CoC partners include the local Veterans Administration Medical Center Homeless Services Team, Virginia Department of Veterans Services, Virginia Wounded Warrior Program, Virginia Supportive Housing, Homeless Point of Entry, Daily Planet, Department of Social Services, Richmond Behavioral Health Mental Health Services Division, and HOMEWARD. In addition to referrals from within the CoC, the PATH-Vet CM does independent outreach with the VVFS Homeless Resource Specialist, and the RBHA Homeless Services Team. This involves outreach in the field, at feeding sites, and any locale where homeless veterans are known to frequent. The PATH-Vet CM follows up with veterans with SMI and ensures that they receive services such as clinical assessments and linkage to other community services as needed.

The PATH-Vet CM provides short-term case management, culminating in a warm handover to the agency or organization best suited to work long term with the individual. Short term case management means connecting homeless veterans with SMI to the appropriate health care system – either through the Veterans Health Administration, or for those veterans ineligible for VHA services, to a local health care system that provides the continuity of health care services required for that individual. Short term case management includes ancillary services offered through the Virginia Wounded Warrior Program (VVFS), primarily, peer support, assistance with employment, assistance with disability income, and assistance with documents required for permanent housing. Given the regional scope of the Virginia Wounded Warrior Program (22 counties, and 5 independent cities), the PATH-Vet CM works collaboratively with VVFS case managers outside of the Greater Richmond area. Periodically, the PATH-Vet CM may have to travel to any point within the Region IV catchment area, to assist with cases involving homeless veterans with SMI. More generally, however, the PATH-Vet CM provides technical support to the VVFS case managers throughout Region IV.

11. Describe your PATH program's efforts to minimize the challenges and foster support for PATH clients with a criminal history, such as collaboration with local jail diversion and/or other programs. If you can, estimate the percent of PATH clients with a criminal history.

The RBHA PATH team constantly collaborates with the Region IV Jail Team to provide supportive services to homeless individuals with criminal histories. The Region IV Jail Team provides jail-based mental health services to individuals in three local jails—Richmond City Justice Center, Riverside Regional Jail, and Southside Regional Jail. Richmond Behavioral Health Authority acts as the Jail Team's fiscal agent. The PATH team receives referrals from the jail team when individuals being discharged from jails are identified as homeless. The Jail Team is also involved in Richmond General District Court's Mental Health Docket, and supplies a clinician to conduct all court-ordered mental health assessments for the court to determine eligibility for the Docket and other programs. When individuals enrolled in the PATH program have involvement in the criminal justice system, the PATH team collaborates with the clinician on the Mental Health Docket to divert jail time if the individual is found to be appropriate for the program. A key component of the Regional Jail Team is Re-Entry Services. According to a 2008 National survey, inmates in jail are 7.5 to 11.3 times more likely to be homeless than the general United States population (Greenburg & Rosenheck, 2008). The Regional Jail Team is often instrumental in connecting homeless inmates with mental illness with housing and other

services. This often takes the form of collaboration with other homeless support services like the PATH program through RBHA.
Connecting individuals with housing, as well as mental health services is a key component of reducing criminal recidivism.
The RBHA PATH team also works closely with the Virginia Supportive Housing FUSE program to assist individuals with a criminal history in finding suitable housing. It is estimated that about 75% of the individuals enrolled/contacted in the PATH program have some involvement in the criminal justice system.

Source: Greenberg, G.A., & Rosenheck, R.A. (2008). Jail Incarceration, Homelessness, and Mental Health: a national study. *Psychiatric Services*, 59(2), 170-177.

Budget FFY 2016/SFY 2017 (2016-2017 PATH Year)			PATH		
Staff Title	***Annualized*** Salary	FTE	Funded	Match	Match Source (Cash or In-kind)
PATH Case Manager	$47,740	1.00	$47,740		
PATH-Vet Case Manager	$43,599	1.00	$43,599		
PATH/SOAR Case Manager	$43,496	1.00	$43,496		
Program Manager	$57,680	0.20		$11,536	in-kind
VVFS Supervision/Oversight	$55,571	0.20		$11,114	in-kind
Adult MH Director	$83,711	0.05		$4,185	in-kind
Total Staff Salary	$324,169		$134,835		
Fringe (3 FTE's only)			$49,066		
Total Personnel			**$183,901**	**$26,835**	
Travel (Outreach travel, travel for training, state meetings, etc.)					
Use of Agency Vehicle				$10,000	in-kind(RBHA&VVFS-$2000)
Training Travel			$100		
Training Conference Costs			$300		
Agency-mandated training & professional development				$3,750	in-kind
Total Travel Costs			**$400**	$13,750	
Equipment (Personal property/equipment having useful life of more than one year)					
Cell Phone (replacement)				$300	in-kind (RBHA&VVFS-$100)
Laptop Electronic Health Records Compatible (replacement)				$3,000	in-kind (RBHA)
Total Equipment Costs			$0	$3,300	
Supplies (Office Supplies, Outreach Supplies, Computer Software, Office Space)					
Office Supplies				$2,000	in-kind
Outreach Supplies			$200		
Total Supplies Costs			$200	$2,000	
Contractual					
Cell phone service fee				$1,800	Cash - (RBHA & VVFS-$600)
HMIS service fee				$1,400	Cash - RBHA
CARITAS furniture bank partnership				$50	Cash - RBHA
Total Contractual Costs			$0	$3,250	
Other (List and Describe Each)					
Medication Assistance			$98	$200	Cash - VVFS
Identification related purchase costs (incl. Birth certificates)			$50	$100	Cash - VVFS
Rental Assistance & Security Deposit Assistance			$1,700	$2,000	Cash - VVFS
Bus Tickets			$50	$150	Cash - VVFS
Associated housing costs (furniture bank fees)			$100		
Administrative Costs (HR, Fiscal, Office Space, MIS, etc.)				$21,625	in-kind - RBHA
Total Other Costs			$1,998	$24,075	
Total Proposed Budget			**$186,499**	**$73,210**	Is match > or = to 1/3 of federal allocation? **YES**

Virginia PATH Local Intended Use Plan, FFY 2016/SFY 2017
PATH Program Year 2016-2017

1. Description of Provider Organization:
a. Name: Valley Community Services Board
b. Organization Type: Community Mental Health Center
c. Description of Services Provided: Valley Community Services Board (VCSB) provides comprehensive mental health, intellectual disability and substance abuse services through a wide array of treatment, residential and rehabilitation services. VCSB provides 24 hour emergency services, intake assessments, case management, residential, outpatient counseling and substance abuse treatment, program of assertive community treatment, psychosocial rehabilitation, children's therapeutic day treatment, juvenile detention program, jail services, ICF/ID and ID group homes, and infant/toddler services. VCSB also provides psychiatric and nursing services to children and adult populations and is the coordinator for the local Crisis Intervention Team Program for law enforcement officers.
d. Region Served: VCSB provides services to residents of Augusta and Highland Counties and the cities of Staunton and Waynesboro. VCSB operates the statewide Deaf Services Program.
e. Provider's experience in providing services to homeless/at-risk individuals and those with SMI and/or co-occurring SUDs: VCSB has been a provider of PATH services since 2004, which led to the development of separate services specifically targeted to homeless persons with SMI who were not presently receiving treatment services. VCSB was also a founding member of the Valley Continuum of Care partnership since the group was formed in 1998 by several agencies within Augusta County region that provide services to homeless persons. The services that are currently being provided by VCSB's PATH Program include outreach services, screening and assessment of mental health and substance abuse disorders, case management services, referral for alcohol or drug treatment, mental health services, income assistance programs, employment resources, and community medical services, etc. In addition, individualized support and assistance is provided to homeless persons to help them access housing by our PATH Outreach Worker. This assistance includes referral to shelters, applying for and securing affordable housing, financial assistance with application fees, security deposits, first month's rent, and moving assistance as needed. Assistance is also provided with obtaining personal identification cards or other documentation needed to apply for and secure housing, employment, and benefits. VCSB provides supportive services to three HUD-funded Permanent Supportive Housing projects, through an agreement with Waynesboro Redevelopment and Housing Authority, which provides access to these units that are specifically targeted to homeless disabled persons.
f. Description of housing or services that are specifically targeted to PATH-eligible consumers: The VCSB PATH Program specifically targets homeless individuals and families in order to assist them to access emergency/short-term shelter, transitional, and permanent housing, as well as treatment and rehabilitative services in the community. Technical assistance and referrals are provided to help client's access available subsidized and low-income units based on their needs and resources. VCSB staff also has offices located at HUD-funded Permanent Supportive

Housing apartment complex, which provides housing for homeless adults with disabilities. This partnership allows current PATH-eligible clients to be considered first when openings occur.

2. Program Budget and Federal Funds Requested: (Attach detailed budget using Excel file provided by DBHDS):

a. Amount of federal PATH funds requested: $41, 147

b. Source and amount of Provider's minimum required 33% match funds: $20,640

c. A brief narrative describing the items in the attached budget:

1**) Personnel Costs:** A 0.8 FTE PATH Outreach Worker will be the primary provider of PATH services within VCSB catchment area. The PATH Outreach Worker shall be provided with fringe benefits offered by VCSB. The Recovery and Support Services Supervisor shall provide clinical and administrative oversight of this program at 0.05 FTE.

2) **Travel Costs:** VCSB shall provide an agency vehicle to the PATH Outreach Worker to conduct PATH outreach, training, and other related job duties to ensure access to mainstream services, housing, medical care, and other community resources.

3) **Contractual:** VCSB shall provide Outreach Worker with a cell phone and laptop computer with air card.

4) **Other Expenses:** Funds shall be made available to PATH recipients to prevent evictions through a one-time payment of past-due rent; first month's rent and security deposits to access housing; utility deposits essential to access housing; fees to obtain identification cards or birth certificates; assistance with medication costs; and transportation tokens.

3. Collaboration with Local HUD Continuum of Care (CoC): Describe the organization's participation in the HUD Continuum of Care program, other local planning activities and program coordination initiatives, such as coordinated entry and coordinated assessment activities. If you are not currently working with the CoC, briefly explain the approaches to be taken by the agency to collaborate with the local CoC.

The PATH staff serves as a member of the local planning group representing our area as a part of the Balance of State Continuum of Care, which will be overseeing the coordinated assessment process with member localities. The local planning group is comprised of members from the Waynesboro Redevelopment and Housing Authority (lead agency), Department of Social Services, Salvation Army, New Directions, Valley Mission, WARM, VACSI, Blue Ridge Court Services, Habitat for Humanity, Love INC, among others. The local planning group members are now using the VI-SPDAT tool as part of our effort to advance a coordinated assessment of homeless persons. We are in the planning stages of furthering a centralized intake process for those in housing crisis. VCSB participates in the Point in Time Homelessness survey once a year and our PATH worker assists with ensuring this is captured for all VCSB consumers including those served within the PATH program. VCSB also has a representative who serves on the board of Valley Area Community Support Inc. (VACSI), a local non-profit with a mission of developing affordable and safe housing for those with mental illness and co-occurring disorders.

4. Collaboration with Local Community Organizations: Provide a brief description of partnerships and activities with local community organizations that provide key services (i.e., outreach teams, primary health, mental health, substance abuse, housing, employment, etc.) to PATH eligible clients, and describe coordination of activities and

policies with those organizations. Provide specific information about how coordination with other outreach teams is achieved.

Our PATH Outreach Worker collaborates with many local agencies which assist those with mental illness and homelessness.

- Health and Medical Services: Augusta Health hospital; University of Virginia Medical Center; Staunton and Waynesboro Public Health Departments; and Augusta Regional Clinic and Dental Clinic. PATH staff directly refers and connects PATH consumers to necessary medical/primary health services, including help with applications for financial assistance through Augusta Health and eligibility determination for the Regional Clinic.
- Mental Health Services are provided by: Valley Community Services Board; Western State Hospital; Augusta Health hospital (Crossroads Inpatient and Outpatient Behavioral Health); Valley Hope Counseling; other area private providers of psychiatric and/or counseling services. PATH staff will link consumers to these services, transport individuals as needed, provide services aimed at helping clients engage with providers, and monitor to ensure access to such services has been attained.
- Substance Abuse Treatment is available from: VCSB Outpatient Services; Augusta Health Behavioral Health/Recovery Choice. There are active chapters of Narcotics Anonymous, Alcoholics Anonymous, and Celebrate Recovery in the area. Consumers are referred to these services and assisted with transportation as needed. Referral and coordination for admission to detox programs and inpatient treatment such as Boxwood's 28-day program is provided in conjunction with VCSB Emergency Services when needed, and transportation to such programs has been provided when needed.
- Housing/Shelter services include: Valley Mission (homeless shelter); New Directions Shelter (shelter for victims of domestic violence); WARM (Waynesboro Area Refuge Ministries; Valley Area Community Support Inc.; Staunton and Waynesboro Redevelopment and Housing Authorities; as well as a range of other income-based and low-income housing providers in the community. PATH staff assists with shelter and housing referrals, linkage to affordable units, moving assistance, as well as help with security deposits and other costs associated with securing permanent housing if needed. For emergency needs, VCSB has a reduced-rate, direct-bill arrangement with a local motel where PATH clients can be temporarily housed if needed.
- Employment Services are available from: Virginia Department of Aging and Rehabilitative Services; Virginia Employment Commission; Vector, Industries; Valley Workforce Center; Goodwill Industries; and Wilson Workforce and Rehabilitation Center. Referral and linkage to these resources is provided by PATH staff.
- Soup Kitchens/Food Assistance: Trinity Episcopal Church and Valley Mission in Staunton, VA and Disciples' Kitchen in Waynesboro, VA provide free hot meals daily. PATH staff share information about these resources and PATH referrals are welcomed. The local food bank distributes to multiple food pantries in the area, mostly through participating churches and organizations. PATH staff keeps updated information on the locations and hours, and also provides transportation

to area food pantries for PATH participants. PATH also provides direct assistance to eligible clients to apply for SNAP food assistance benefits through completion of on-line application and in-person interview.

*See Attachment A for further details on local partnerships and collaborative entities.

5. Service Provision: Describe the plan to provide coordinated and comprehensive services to eligible PATH consumers. Please address the following information.

a. Projected number of adult consumers to be contacted with PATH funds: 125

b. Projected number of adult consumers to be enrolled using PATH funds: 70

c. Percentage of adult consumers projected to be "Literally Homeless", and activities to maximize the use of PATH funds to serve adults who are literally homeless as a priority population:

The estimated percentage of individuals who are expected to be "Literally Homeless" is 80% of the persons served within the PATH Program. This is due to the rural homeless phenomenon that results in persons being temporarily housed by others, even though they have no housing of their own. The activities that will be used to maximize the use of PATH funds to serve persons who are literally homeless shall include targeted outreach to locations where literally homeless persons are most prevalent; targeting funding for rent deposits and other housing related expenditures for literally homeless persons; and prioritizing PATH-enrolled clients for housing vacancies that arise in the HUD-funded apartments supported by VCSB in partnership with Waynesboro Redevelopment and Housing Authority. Part of the criteria for these units is that the person be literally homeless at time of application.

d. Strategies that will be used to target PATH funds for street outreach and case management as priority services.

The strategies that will be used to target PATH funds for street outreach and case management to ensure that the PATH Outreach Worker makes this a part of his work routine include the following: Dedicated efforts by PATH Outreach Worker to establish a community presence for outreaching and engaging people who may be homeless on the street; respecting the homeless persons' space; reading body language regarding willingness to talk or engage; meeting people "where they are;" listening to their stories and learning what their perceptions are about their situation and needs; keeping initial contacts brief and positive if person is reluctant to engage; providing basic necessities; being consistent in following through with what is agreed upon; earning trust and building rapport; and making offers and suggestions rather than being directive or authoritative. Due to the size and type of communities VCSB PATH covers, there is not a readily observable population of people living on the street in downtown areas, etc. Persons living outdoors tend to be in less frequented areas, living in tents, or living in a vehicle, abandoned buildings not suitable for habitation, etc. In terms of case management, this service will be provided if appropriate to any enrolled PATH client. Staff will engage the client in assessing needs and establishing specific goals. Staff will then make ongoing contacts (both scheduled and unscheduled) with client to work toward those goals. This focus will be reviewed within supervision and as needed to ensure the priority is met by PATH worker.

e. Indicate whether your organization provides, pays for, or otherwise supports evidence-based practices and other training for local PATH-funded staff, including training and activities to

support migration of PATH data into HMIS.
VCSB utilizes numerous evidence-based practices through the continuum of outpatient services, including among others, assertive community treatment; motivational interviewing; cognitive behavioral therapy; and wellness recovery action plans. During the past year PATH Outreach Worker has attended several offered webinars, including those pertaining to: "Spotlight on Kentucky's Housing Innovations;" "Privacy and Confidentiality in HMIS;" "Housing First for People Experiencing SMI and COD," and "How to Effectively Reach People who Experience Homelessness (and keep them engaged)." PATH Outreach Worker, PATH supervisor and clerical staff participated in training in the use of Service Point HMIS system and PATH Outreach Worker attended an additional training on this as well. PATH worker and supervisor also attended state-wide meeting, "Virginia PATH Program Participation in HMIS" held in Richmond in November 2015. PATH staff plans to attend any other scheduled PATH training conferences during the coming year and will attend additional trainings or webinars offered by SAMHSA or other entities related to evidenced-based practices in the areas of homeless outreach, housing issues, or other topics related to working with homeless individuals with mental illness.

f. Describe gaps in the current service system and how PATH will assist consumers in addressing those gaps.
There is a lack of inpatient detox and SA treatment facilities in our area. PATH staff assists clients with accessing inpatient medical detox services if needed through the local hospital facility, Augusta Health. Additionally staff will collaborate with VCSB Emergency Services staff to locate appropriate alternatives for individuals seeking SA treatment and needing detoxification from active substance use. One of the other significant gaps in local services continues to be the lack of affordable housing for many of the individuals served by PATH. Both of the local housing authorities have frequently closed waiting lists for Housing Choice Vouchers, and the availability of public housing or other income-based housing is limited and generally have wait-lists for those programs. PATH continues to address this by searching out a wide array of rental options via developing contacts and relationships with landlords and property managers. PATH staff advocates for clients to be considered for available lower rent units by landlords who may deny applications initially based on factors such as credit history, rental history, and income. PATH staff also has provided direct input to Valley Area Community Support, Inc. in their planning process for developing further affordable housing units locally for individuals with mental health and related disabilities.

g. Describe services available for consumers who have both serious mental illness and substance use disorder.
Services for individuals with co-occurring disorders: PATH staff directly assist individuals in linkage to the following services, by assisting with referral and scheduling appointments, transportation if needed, and monitoring access and follow up with such services.

Detox/Inpatient Treatment- PATH staff will link individuals with VCSB emergency services to screen for appropriate treatment options within our area.

VCSB offers a co-occurring disorders Wellness treatment group once a week.

VCSB Open Access is established to provide same-day agency intake the day services are requested.
In the event that an Open Access appointment cannot be scheduled on a given day, an appointment will be scheduled the following day for clients with co-occurring disorders, which has greatly increased VCSB's ability to respond to their needs in the most timely manner possible.

VCSB SA Outpatient-provides a wide array of services from day treatment to less intensive SA services with staff trained in Motivational Interviewing and dually-diagnosed treatment.

Augusta Health also offers inpatient services and an array of outpatient MH/SA services with co-occurring focus when indicated.

h. Describe strategies for making suitable housing available to PATH consumers (e.g., indicate the type of housing usually provide and the name of the agency that provides such housing).
VCSB has collaborated with local housing authorities, private landlords, and nonprofit agencies in order to increase accessibility to affordable housing within this area. The Waynesboro Redevelopment and Housing Authority has HUD Supportive Housing grants to provide units of housing within Staunton, VA and Waynesboro, VA. There are HUD public housing complexes provided by both Staunton Redevelopment and Housing Authority, and Waynesboro Redevelopment and Housing Authority. There are also several other HUD-subsidized housing complexes provided by Knopp Enterprises; Parkway Village; Willow View, Garber Manor; Gypsy Hill House; Craigmont; and Willow Lake. There are several low-income, tax-credit apartment complexes such as Springhill Village; Valley View; Frontier Ridge; Waterford Village, and others. Other lower-income housing providers include Mountain View; Highland Hills; Hopeman West; Augusta Farms; Quadrangle; Parkhill; Property Management, and others. VCSB collaborates and serves on the board of the Valley Area Community Support Inc., a local non-profit with a mission of developing affordable and safe housing for those with mental illness, intellectual disabilities and those recovering from substance abuse. Additionally, PATH staff maintains a thorough database of information about area housing opportunities, property managers, subsidized housing options, local area landlords, and related resources, information sources, and current housing applications. These are used in the provision of PATH services to help clients secure housing, and will be shared with partnering agencies and other individuals outreached through PATH. PATH staff will continue to work with area landlords, property managers, and subsidized/low-income housing providers, building collaborative relationships to enhance housing availability for PATH consumers.

i. If you plan to implement one or more Virginia PATH Innovative Practices, indicate which one(s) and describe the implementation plan:
VCSB PATH Outreach Worker will complete SOAR training during FY 2016-2017. This will involve completion of on-line training first followed by onsite training by state SOAR coordinator.

j. Briefly describe your plan for providing the following PATH-allowable services:

Outreach: The PATH program plans to provide both active and passive outreach services. Active outreach shall occur at the local homeless shelter (Valley Mission) where the PATH

staff provides on-site outreach at least two days per week; at the seasonal, overnight WARM shelter; at other agencies and service locations that may serve the homeless; and on the streets, at specific locations where homeless persons are known to spend time, and outlying areas. For passive outreach endeavors, the PATH program will receive referrals through VCSB emergency services program, and also assist walk-ins who learn of our program by word-of-mouth. The PATH Outreach Worker will regularly visit locations where homeless persons congregate in the area in an effort to engage them in services and to initially encourage them to accept temporary housing in a local shelter.
Screening and Diagnostic Treatment: The PATH staff shall provide brief mental health and/or co-occurring disorders screenings, and review referrals of outreached individuals to ascertain the presence of mental health and substance abuse disorders. Individuals who agree to participate in more extensive treatment services shall be offered further clinical assessments through the VCSB Access team and VCSB Medical/Psychiatric Services, or other private provider, which will be facilitated by PATH staff by assisting with referrals and providing transportation or transit tokens as needed.
Habilitation and Rehabilitation: No direct services are to be provided by PATH-funded staff. Linkage to Habilitation and Rehabilitation Services shall be offered to PATH consumers when indicated through VCSB's psychosocial rehabilitation program (Shenandoah Club) by referral from the PATH Outreach Worker or case management team.
Community Mental Health Services: No direct services are to be provided by PATH-funded staff. PATH staff shall make referrals to various mental health services including: Valley CSB MH Case Management; Outpatient Therapy; Psychiatric Medication Management; Assertive Community Treatment; Psychosocial Rehabilitation; Crisis Stabilization; Emergency Services, and inpatient treatment based on individual's needs and preferences. PATH staff shall assist in making initial appointments for intake to services, ensuring that individuals have transportation to such services, and monitoring to ensure appointments were kept or rescheduled and that client engages with providers.
Alcohol or Drug Treatment Services: No direct services are to be provided by PATH-funded staff. PATH staff shall make referrals for detox, inpatient treatment, intensive outpatient treatment, day treatment, or dual-recovery group. Information on area 12-step meetings is provided to clients interested in attending. Individuals are assisted in accessing co-occurring treatment services and can be assisted with sober living housing and further residential treatment if indicated.
Staff Training: PATH staff shall provide training of both Community Services Board and other community groups on the PATH program, issues related to homelessness, and how to access the PATH Program. PATH staff has presented information about homelessness and the PATH Program to various community groups and agencies, and flyers have been posted throughout the area included within VCSB. Crisis Intervention Team (CIT) training is provided locally by VCSB staff to area law enforcement and other interested individuals, including staff at the Valley Mission.

Case Management: PATH staff shall provide PATH case management services to enrolled individuals until they begin receiving mental health case management or similarly intensive services from VCSB, or until PATH services are discontinued. These services shall include an assessment of individual's needs and preferences, and referral and linkage to targeted services and mainstream resources that address these needs. The PATH Outreach Worker will monitor an individual's progress toward addressing their needs for housing, healthcare, mental health treatment, entitlement benefits, etc., to ensure that homeless persons have every opportunity to establish and retain housing and personal stability in the community.
Supportive and Supervisory Services in Residential Settings: PATH staff shall provide referral to supportive services such as case management, and transitional housing programs when needed. The PATH staff shall monitor and assist PATH-enrolled individuals who have accessed housing for up to 90 days as needed or until a case manager or other provider has been assigned. These services may include accessing medical and mental health care, social services, monitoring payment of rent and bills, transportation, activities related to establishing their household, etc.
Minor Renovation: The VCSB PATH Program does not directly provide minor housing renovation. However, PATH staff shall make referrals to local groups that may provide home renovations for low income persons who want to continue to maintain independent living and are in need of home renovations to safely remain in their current housing.
Planning of Housing: VCSB shall participate in the local planning group for the Continuum of Care (Balance of State) on a consistent basis and provide consultation and collaboration with other agencies to expand housing and services to the target population, as well as other related housing development activities. VCSB collaborates and serves on the board of the Valley Area Community Support Inc., a local non-profit with a mission of developing affordable and safe housing for those with mental illness, intellectual disabilities and those recovering from substance abuse, and to provide some of the special services they need to succeed in housing.
Technical Assistance in Applying for Housing: VCSB PATH Staff shall provide technical assistance to persons seeking housing, including referral, guidance, information, and assistance with application process to relevant housing opportunities. Other examples of this service could include providing consultation or direct support to assist a homeless person with various challenges including: felony convictions, an intellectual disability, head trauma, substance abuse history, prior evictions, poor credit history, etc.
Improving the Coordination of Housing Services: VCSB PATH staff shall participate in any joint efforts to increase access to and availability of affordable housing. Historically, the Valley Continuum of Care Partnership had been meeting for several years to focus on coordinating housing and support services to homeless individuals and families in our area, and in pursuing grant funding to enhance services to this client population. Currently, the Balance of State Continuum of Care helps improve the coordination of services provided by local agencies that serve homeless persons. PATH staff will participate in all local planning meetings for the CoC, as well as other groups that are working toward the goal of increased

collaboration of homeless service providers in order to avoid duplication of efforts.
Security Deposits: VCSB PATH program shall provide financial aid as needed to get access to housing, within budgeted limits. VCSB PATH program will provide financial support to PATH recipients who could not otherwise access housing without the availability of such financial aid. VCSB PATH program provides security deposit funds for PATH consumers who are unable to access other sources of funding to gain entry to housing, within budgeted amounts committed to the PATH Program. Referrals are also made to other resources when appropriate, such as Mercy House, Project Horizon, or TAP/SSVF who have funding for similar expenses.
Costs Associated with Matching Eligible Homeless Individuals with Appropriate Housing Situations: VCSB PATH program will assist with application fees, first month's rent, and linking to moving services for PATH consumers who have been approved for apartments. VCSB's PATH staff regularly assists with apartment application fees, rent deposits, and in some cases utility deposits, if necessary to access housing and other community housing resources have been exhausted. The PATH Outreach Worker reviews individual's budgets, assesses whether chosen housing is affordable given an individual's financial status, and provides financial assistance to access such housing if the individual could not otherwise obtain such housing. VCSB may also use PATH funds to make payment on prior bills owed by PATH consumers if needed in order to satisfy a debt identified in a rental application that would preclude them from securing available housing.
One-time Rental Payments to Prevent Eviction: When it is appropriate and funds permit, the VCSB PATH Program will provide financial assistance on a one-time basis to prevent eviction. These funds are normally utilized when it appears that an individual has experienced a short-term financial crisis and would definitely face homelessness if such funds were not provided. The PATH Worker and Supervisor of PATH services review such requests to ensure that funds are likely to prevent an eviction, and may include a stipulation that the recipient of such funds agree to receive budgeting assistance and/or a representative payee, if warranted. Referrals are also made to other resources when appropriate, such as Mercy House, Project Horizon, TAP/SSVF, etc.
Referrals for Primary Health Services, Job Training, Education Services and Relevant Housing Services: Referral Services shall be provided by PATH personnel, including referrals for housing, vocational training or job placement assistance, or for help with medical needs through the Regional Clinic, Augusta Health Urgent Care, Emergency Room, or clinics, Staunton/Augusta Health Department, or UVA Hospital. Referrals may be made to the local VA clinic or hospital if appropriate. The PATH Worker shall transport PATH-enrolled persons to physicians or local hospitals, as appropriate, in order to obtain necessary medical services. The Augusta Regional Clinic is a resource that is regularly utilized for persons who lack insurance, as well as UVA Hospital. The PATH staff also makes referrals to the Virginia Department of Aging and Rehabilitative Services, the Shenandoah Valley Workforce Center, and adult education/GED programs. PATH staff regularly refers PATH-eligible individuals to both the Staunton and Waynesboro Redevelopment and Housing Authorities, as well as to private housing agencies in the area that oversee HUD-subsidized

housing. PATH staff also foster working relationships with many local landlords in order to try to build and maintain a referral network to housing units that are affordable.

6. HMIS Data Integration: Describe your HMIS transition plan, with accompanying timeline, to begin using HMIS to collect and report PATH data in HMIS by July 1, 2016. If you are fully utilizing HMIS for PATH services, please describe plans for continued training and how you will support new staff. Indicate any technical assistance needs you may have in meeting the HMIS data requirements.

Currently PATH Outreach Worker and administrative support staff have completed HMIS training. PATH Outreach worker is utilizing HMIS for all PATH data collection effective 4/1/16. VCSB MIS staff are working in tandem with RBHA staff to finalize program reporting from HMIS to satisfy the DBHDS state reporting requirements. It is anticipated this phase will be finalized by 7/1/16, and it is VCSB's intention to solely utilize HMIS for all documentation and reporting by that date.

7. SSI/SSDI Outreach, Access, Recovery (SOAR): Describe your plan to train PATH staff on SOAR. Indicate the number of PATH staff trained in SOAR and the number of PATH-enrolled consumers assisted through SOAR during State Fiscal Year 2013, and the approximate number of staff to be trained in SOAR for State Fiscal Year 2015.

VCSB does not currently have any staff trained in SOAR. VCSB's one PATH Outreach Worker will complete SOAR training by 10/1/16. Through FY 2017 PATH Outreach Worker will track the number of PATH enrolled clients assisted through SOAR.

8. Program demographics and cultural competency: Describe the following.

a. The demographics of the target population.

Demographic summary of those enrolled in PATH services over the past year:

Gender Summary

Female	59%
Male	41%

Age Summary

18-23	5%
24-30	21%
31-50	47%
51-61	24%
62 and over	3%

Race Summary

African American	25%
American Indian or Alaska Native	2%
Caucasian	71%
Two or More Races	1%

Ethnicity Summary

Hispanic/Latino	0%
Non-Hispanic/Non-Latino	100%
Veteran Status	
Veteran	6%
Non-Veteran	93%
Unknown	1%

b. The demographics of the staff serving PATH consumers.
The VCSB PATH Program includes one PATH Outreach Worker, who is a white/Caucasian male, age 43.

c. How staff providing services to the target population will be sensitive to age, gender and racial/ethnic differences of consumers.
PATH staff shall have training in cultural awareness provided by VCSB as a part of their agency orientation. VCSB strives to be inclusive of all races and ethnic groups in their hiring practices. VCSB staff have considerable experience working with a wide array of ethnic groups, although this area of Virginia has limited ethnic diversity among its population.

VCSB offers cultural awareness training to all new employees, with annual updates provided. The VCSB Board of Directors has actively sought membership from various ethnic groups residing in our catchment area.

VCSB has previously sought public comments in the development of both our annual and long-term plans and encourages all local citizens to attend monthly VCSB Board meetings to express their concerns and preferences. Periodically, a survey tool is widely distributed that permits citizens to rate all services offered by VCSB and to provide recommendations for improving services. These results are incorporated into annual goals for each specific program area.

d. The extent to which PATH staff receive training in cultural competence.
All VCSB staff are required to participate in annual cultural awareness training. Staff are also encouraged any supplemental training in cultural awareness that is offered throughout the course of the year. VCSB is an equal opportunity employer.

VCSB has access to interpreter services if non-English speaking individuals seek treatment services at our agency. Since there is a school for deaf or blind students in our area, we also have a clinician who specializes in serving this client population and is certified in American Sign Language.

e. The extent to which the organization adheres to the Culturally and Linguistically Competent (CLAS) Standards. The CLAS standards can be accessed at http://www.ThinkCulturalHealth.hhs.gov.
Valley CSB meets CLAS standards by all new hires completing training in Cultural Competency and Cultural Sensitivity. We also provide within services the opportunity for more specific training through our online training system for staff who may be providing services to individuals of differing cultural backgrounds.

9. Consumer and Family Involvement: Describe how individuals who are homeless and have serious mental illnesses, and family members will be involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards. (See attached Appendix I – Guidelines for Consumer and Family Participation.)

Consumers and their family members are encouraged to be active participants in all components of VCSB service delivery in order to enhance and reinforce treatment options that are provided. VCSB has made efforts to include consumers and their family members on the Board of Directors. Consumers have been encouraged to attend VCSB Consumer Advisory Committee Meetings, the annual goal planning meetings, and to make suggestions or recommendations for additional services or improvements to treatment and rehabilitation services offered by VCSB. NAMI "We Care" Augusta is another VCSB and consumer/community meeting facilitated at the VCSB site, where consumers and their family members can attend to hear guest speakers speak on local resources; new therapies; medications; consumer needs; community supports; etc.

All VCSB staff are provided annual training on informed consent, human rights regulations, and on means of fully engaging consumers in the process of developing individualized services/treatment plans.

At the first contact with VCSB, consumers are informed of their rights and provided an orientation to VCSB, including information on filing a complaint with the regional human rights advocate.

Consumers are also informed of their rights regarding a choice of providers and are given a listing of both public and private providers of services so that they may select their preferred provider of treatment. Consumers of VCSB services have been invited to join the Board of Directors and have served as VCSB Board Members.

10. Outreach to Homeless Veterans: Describe how your PATH program identifies and outreaches to homeless veterans with SMI, and the services available to them in your catchment area. How does PATH interface with your veterans' service continuum?

Potential PATH clients are asked about their veteran status upon initial intake in order to identify homeless veterans with SMI. PATH also coordinates with local shelter programs who also gather initial information on residents' veteran status. PATH staff will work to coordinate housing resources to homeless veterans as needed. PATH staff have worked with the Supportive Services for Veteran Families via the Total Action for Progress (TAP) located in Roanoke, VA, whereby the program can provide rapid rehousing assistance for homeless veterans in the Augusta County catchment area. PATH staff also works to connect homeless veterans to the local Staunton CBOC so veterans can access medical and psychiatric care. PATH staff has also collaborated with the local veteran-specific staff at the Virginia Employment Commission in Fishersville, VA to provide employment-based and other case management-based services to local homeless veterans.

11. Describe your PATH program's efforts to minimize the challenges and foster support for PATH clients with a criminal history, such as collaboration with local jail diversion and/or other programs. If you can, estimate the percent of PATH clients with a criminal history.

It is estimated that approximately 85-90% of PATH clients have some type of criminal history,

whether a misdemeanor and/or felony record. PATH staff assist clients who are on probation with keeping the requirements of their probation, including in some cases direct coordination and communication with probation officers. PATH clients who have more recent violent or drug-related charges are excluded from applying for certain housing programs, but have the opportunity to apply if they complete a rehabilitative program such as anger management or SA treatment group. PATH staff educates clients about this and assists when needed with referrals for such groups.

Appendix A
Community Collaboration with the VCSB PATH Program

Agency	Location	Services Provided
Augusta Health	Fishersville	Hospital, Psychiatric Unit, Emergency Medical
Augusta Behavioral Health	Fishersville	Outpatient MH/SA Services
Waynesboro Redevelopment and Housing Authority	Waynesboro	Administers HUD subsidized units, and HUD Permanent Supportive Housing in Staunton and Waynesboro at 3 complexes; Homeless Prevention Program to prevent shelter stays through assistance with rent, deposits, etc.
Staunton Redevelopment and Housing Authority	Staunton	Administers HUD apartment program in Staunton.
Knopp Enterprises, Parkway Village, other private housing complexes	Staunton/Waynesboro/Augusta county	Administers HUD subsidized apartments at several complexes in Augusta County.
Augusta Regional Clinic/Dental Clinic	Fishersville	Provides medical assessments, medications and dental care.
Blue Ridge Area Food Bank, numerous affiliate food pantries	Verona/various churches in Augusta county	Provides emergency food distribution
Valley Mission	Staunton	Provides a homeless shelter, 3 meals daily, food boxes, pastoral care, on-site counseling and classes, and thrift store vouchers
Waynesboro Area Refuge Ministry	Waynesboro	Rotating seasonal thermal shelter sponsored by local churches and transitional shelter for women/children..
Salvation Army	Staunton	Provides clothing, furniture and financial aid for rent and utilization

Salvation Army	Waynesboro	Provides clothing, furniture and financial aid.
Salvation Army	Harrisonburg	Offers a Thrift Store and a homeless shelter.
Salvation Army	Charlottesville	Provides a homeless shelter.
Mercy House	Harrisonburg	Rapid re-housing/rent assistance program covering VCSB's area
Trinity Episcopal Church	Staunton	Provides a lunch-time soup kitchen M-F.
Second Presbyterian Church-Disciples Kitchen	Waynesboro	Provides a soup kitchen at lunch.
Local planning group for Balance of State CoC	Staunton/Waynesboro	Regular meeting of homeless services providers for information sharing and input with CoC activities
Shenandoah Valley Department of Social Services	Staunton/Waynesboro	Financial aid, food stamps, Medicaid, fuel/cooling assistance.
Staunton/Augusta & Waynesboro Health Departments	Staunton/Waynesboro	Provides basic health services, immunizations, TB screening and treatment etc.
Valley Community Services Board	Staunton	Provides comprehensive assessment, emergency, MH, SA, & individual treatment and rehabilitation services
Staunton/Augusta Church Relief Association	Staunton	Provides food boxes, and financial aide for medications, rent and utilities.
Virginia Employment Commission	Fishersville	Provides job search assistance and unemployment benefits.
Virginia Department of Aging and Rehabilitative Services	Fishersville	Job assessment, placement, training and job coaches.
Valley Workforce Center	Staunton	Job search resources, career counseling, job skills training.
Wilson Workforce and Rehabilitation Center	Fishersville	Brain injury, assistive technology, occupational therapy, spinal cord injury, supportive living training, and job training services.
Valley Area Community Services, Inc.	Staunton	Local non-profit which develops affordable/safe housing for those with MH, SA and ID disorders, and provides some special services such as medication assistance
Love INC (In the Name	Augusta county	Affiliation of area churches

of Christ)		providing goods and services to neighbors in need from member volunteers and donations
Comfort Care Women's Health Center	Staunton	Local health center assisting with all aspects of unplanned pregnancy: pregnancy confirmation, nurse's consultation, peer counseling, pregnancy options, STI testing
New Directions shelter	Staunton	Domestic violence shelter for women
Blue Ridge Legal Aid	Harrisonburg/Staunton	Provides free civil legal assistance to low-income residents
Virginia Regional Transit	Staunton/Waynesboro/Augusta county	Provides public transportation (PATH provides tokens, schedules, guidance for clients to use their services)
Veteran's Administration-Staunton CBOC	Staunton	Community-Based Outpatient Clinic for V.A.-administered medical/psychiatric services
Total Action for Progress	Roanoke	Administers SSVF program providing housing and case management assistance for homeless veterans
Mercy House	Harrisonburg	Provides shelter for families and also has rapid rehousing and homelessness prevention funds

PATH Site Name: Valley Community Services Board					
Budget FFY 2017 (2016-2017 PATH Year)			PATH		Match Source
Staff Title	***Annualized*** Salary	FTE	Funded	Match	(Cash or In-kind)
PATH Outreach Worker	$33,800	0.80	$31,250	$2,550	Cash
Program Manager	$3,150	0.05		$3,245	Cash
Total Staff Salary	$36,950			$5,795	
Fringe	5448		$2,935	$2,513	Cash
	Total Personnel		**$34,185**	**$8,308**	
Travel (Outreach travel, travel for training, state meetings, etc.)					
Use of Agency Vehicle			$2,463		
Vehicle Lease				$5,040	Cash
	Total Travel Costs		**$2,463**	**$5,040**	

Equipment (Personal property/equipment having useful life of more than one year)			
Lapotop (new)			
Cell Phone (replacement)			
Total Equipment Costs	0	0	

Supplies (Office Supplies, Outreach Supplies, Computer Software)			
Office Supplies	0		
Outreach Supplies	0	$500	
Supplies	0		
	0		
Total Supplies Costs	0	500	

Contractual			
Cell phone service fee	0	850	Cash
Total Contractual Costs	0	850	

Other (List and Describe Each)			
Medication Assistance	500	500	
Identification related purchase costs (incl. Birth certificates)		200	Cash
Rental Assistance	3,850	4841	Cash
Bus Tokens	149	151	Cash
HMIS License Fee		250	Cash
Total Other Costs	4,499	5,942	
Total Proposed Budget	**41,147**	**20,640**	Is match > or = to 1/3 of federal allocation?

Virginia PATH Local Intended Use Plan, FFY 2016/SFY 2017
PATH Program Year 2016-2017

1. Description of Provider Organization:
a. Name: Virginia Beach (VB) Department of Human Services, (DHS) Mental Health Substance Abuse Division (MHSA), PATH
b. Organization Type: Community Mental Health Center Substance Abuse Treatment Agency
c. Description of Services Provided: Virginia Beach Department of Human Services (DHS) is the comprehensive public human services agency for the City of Virginia Beach. The Division of Mental Health Substance Abuse (MHSA) provides a full range of services including prevention, emergency services, crisis stabilization and detoxification, medication management, case management, day treatment, psychosocial rehabilitation, mental health support services, supportive residential services, and child and youth treatment programs.
d. Region Served: Virginia Beach
e. Provider's experience in providing services to homeless/at-risk individuals and those with SMI and/or co-occurring SUDs: The Virginia Beach PATH program has two decades of experience in providing PATH outreach services to Virginia Beach homeless individuals. The PATH program added SSI/SSDI Outreach, Access and Recovery (SOAR) services in 2005. PATH manages the SA PATH Outreach services (established 2011) and SA Peer services (established 2015). These two services (SA PATH and SA Peer) target individuals with Substance Use Disorder's and assists with bridging them into services. Virginia Beach PATH utilizes Targeted Street Outreach in providing assessments and bridging individuals to mainstream services.
f. Description of housing or services that are specifically targeted to PATH-eligible individuals: Each individual and family that PATH encounters is referred to the Virginia Beach, Department of Housing and Neighborhood Preservation (DHNP) Outreach Workers (OW). The DHNP Outreach Workers administrate the VI SPDAT for referral to housing through the Coordinated Assessment. All homeless individuals and families must be screened through Coordinated Assessment and pared with available housing resources referencing the highest vulnerability status. PATH assists in the Veteran Initiative in Virginia Beach, locating homeless Veterans and submitting their names to the DHNP Outreach Workers for verification and referral to housing.
2. Program Budget and Federal Funds Requested: (Attach detailed budget using Excel file provided by DBHDS):
a. Amount of federal PATH funds requested: $126,949.00
b. Source and amount of Provider's minimum required 33% match funds: 92,434

b. A brief narrative describing the items in the attached budget: See attached budget narrative.

3. Collaboration with Local HUD Continuum of Care (CoC): Describe the organization's participation in the HUD Continuum of Care program, other local planning activities and program coordination initiatives, such as coordinated entry and coordinated assessment activities. If you are not currently working with the CoC, briefly explain the approaches to be taken by the agency to collaborate with the local CoC.

The PATH Team Leader represents the CSB as an active member of *Bringing an End to All City Homelessness* (BEACH). BEACH is an advocacy organization consisting of faith based, governmental, and nonprofit organizations. BEACH also coordinates the CoC for Virginia Beach. PATH Team Leader represents the CSB as an active participant on the Coordinated Assessment Committee. Coordinated Assessment utilizes the VI SPDAT to establish the Vulnerability Index of literally homeless families and individuals referring them to available housing according to vulnerability status.

4. Collaboration with Local Community Organizations: Provide a brief description of partnerships and activities with local community organizations that provide key services (i.e., outreach teams, primary health, mental health, substance abuse, housing, employment, etc.) to PATH eligible individuals, and describe coordination of activities and policies with those organizations. Provide specific information about how coordination with other outreach teams is achieved.

- PATH works with the DHNP Outreach Worker (OW). This provides outreaches at the Virginia Beach Boardwalk and surrounding blocks. OW and PATH outreach to all homeless individuals and families offering various services of need. The Boardwalk area is one of the primary spots for the homeless to reside during the summertime. Local business owners were contacted and encouraged to call when the homeless activity level increased. This gave outreach the opportunity to make contact with the individuals who are jeopardy of receiving citations for trespassing, open container, and a variety of other infractions. The offer of services was accepted by a large number of individuals. This prompted the business owners in supporting further intense outreach at the Boardwalk area. While working with the OW team, PATH has worked with homeless females and males with children at the Boardwalk. Communication during the outreach revealed that the families were involved with Child Welfare (CW). This prompted PATH making contact with DHS Child Welfare and was able to assist families by obtaining much needed MHSA services for adults and Child and Youth MH services for the children. PATH continues to work with Child Welfare in keeping children safe and adults connected with services. SOAR worked with 95% of adults involved with CW by completing or assisting with disability applications. The increase in outreach has also added to the number of eligible individuals for SOAR disability applications. This increase in disability applications for the Part Time SOAR position has reflected cause for the position to be considered as a Full Time position.
- PATH has ongoing relationships with various community resources. PATH connects individuals in need of medical services and assists them with making appointments with the **Virginia Beach Family Medical Center,** which is a primary health care center that has a sliding scale fee. The **Beach Health Clinic** is a free clinic for Virginia Beach

citizens. PATH provides some funding for medical services and if needed finds alternative funding resources. Proofs of residency letters are provided for PATH individuals applying for entitlements to include food stamps, disability determination, housing and health care. Transportation can be provided via a bus ticket or a city vehicle. PATH also refers individuals to **People In Need Ministries** (PIN). They have volunteer medical doctors and nurses available on Sundays at an oceanfront church. PIN has a limited amount of funds to assists homeless individuals with prescribed medications. **Medical Reserve Corps** is available for educational opportunities to the homeless population and they provide Flu and H1N1 vaccines. **Department of Human Services Prevention Services** provides HIV testing and **Virginia Beach Health Department** provides both testing and treatment for HIV/AIDS. **Veterans Administration Medical Center** and its Community Based Clinic are available for homeless veterans. In emergencies, 911 will be called and the individuals can be taken to Sentara Hospital Emergency rooms for appropriate services.

- Virginia Beach Psychiatric Center, Riverside Behavioral Health Care, and Maryview Behavioral Health Center are providers of emergency psychiatric inpatient treatment. Virginia Beach Family Medical Center has mental health counseling available if the individuals are in need of counseling.
- PATH informs individuals regarding access to emergency services. The MHSA Emergency Services Department operates 24 hours a day/7 days a week. PATH assists individuals in calling the MHSA Pre Registration number to schedule appointments for intake to MHSA services. PATH refers individuals to the Recovery Center (RC) (a sub-acute medical treatment facility) for individuals who may be withdrawing from substance abuse. RC also assists with referrals to SA residential treatment programs using SARPOS funds. The regional crisis stabilization program in Norfolk and Hampton is also utilized to provide immediate intervention for individuals with co-occurring disorders. Additionally, MHSA has a Community Based Crisis Stabilization program to prevent hospitalization by offering short term counseling to stabilize individual in the community.
- Virginia Employment Commission (VEC) provides job-seeking assistance to the homeless population. Department of Aging and Rehabilitative Services (DARS) prepare individuals for job placement. In addition, Beach House psychosocial rehabilitation program offers Transitional Employment to individuals that are expressing a desire to work. .
- Adult Outpatient Services: Treatment services provided for adults 18 and older with mental illness, substance use or co-occurring disorders include: psychiatric evaluations, medication management, individual, family, and group therapy.
- Adult Day Treatment: Day treatment services is a short term intensive five days a week program. This program offers Mental Health and Substance abuse therapy and education for individuals with moderate to severe levels of mental illness, substance use, or co-occurring disorders.
- The Harbour is an additional Psycho-social day program for individuals who may have more moderate to severe levels of mental illness, and co-occurring disorders that require medication management and psychoeducation services.
- Program of Assertive Community Treatment (PACT) – Services are correlated to the individual's assessed clinical needs, functional ability, and level of motivation. These

services are designed for those who demonstrate a higher level of supportive care, have not been successful in traditional services and require intensive wrap around services in the community to promote mental health stability.

- **Community Alternative Management Group** (CAMG) and **Virginia Beach Community Development Corporation** (VBCDC) provide subsidized transitional housing and permanent housing for individuals with mental illness, substance use and co-occurring disorders. **Virginia Beach Housing and Neighborhood Preservation** (VBHNP) offer a list of affordable housing options and is the administrator of the Virginia Beach housing vouchers. VBHNP is also the administrator of a Housing First program for individuals who are categorized as chronically homeless with a disabling condition. **Virginia Supportive Housing** (VSH) is a regional program and currently manages four SROs in Va. Beach, Norfolk, Portsmouth and Chesapeake.
- **PATH** has established an employment meeting called Next Step. It focuses on resume building, application process, interviewing, and the appropriate job for the individual. The meeting is held once a week.
- **PATH** sponsors a Self-Management and Recovery Training (SMART) Recovery meeting is held three times a week. One meeting is held at the Virginia Beach Recovery Center. SMART Recovery is a recognized resource for substance abuse and addiction recovery by the American Academy of Family Physicians, the Center for Health Care Evaluation, and The National Institute on Drug Abuse (NIDA), US Department of Health and Human Services, and the American Society of Addiction Medicine.

5. Service Provision: Describe the plan to provide coordinated and comprehensive services to eligible PATH individuals. Please address the following information.

a. Projected number of adult individuals to be contacted with PATH funds: 240

b. Projected number of adult individuals to be enrolled using PATH funds: 160

c. Percentage of adult individuals projected to be "Literally Homeless", and activities to maximize the use of PATH funds to serve adults who are literally homeless as a priority population: 95% of Virginia Beach PATH individuals are considered "literally homeless". Outreach workers make contact with homeless individuals where they sleep by going into various campsites, boardwalk area and interacting with those individual who may be panhandling. PATH services are provided routinely and check in with the local church providers. PATH also attends homeless support groups offering support and education. PATH/SOAR workers strive to obtain/build trust and good working relationships with the homeless population.

d. Strategies that will be used to target PATH funds for street outreach and case management as priority services.
Virginia Beach PATH utilizes traditional Street Outreach approach as the primary method of contact. Scheduled outreach occurs at the areas where the homeless tend to frequent. These areas include the oceanfront boardwalk, two local churches that provide resources, and other key areas throughout the city of Virginia Beach such as homeless campsites. The churches that provide resources are the Star of the Sea (SOS), Virginia Beach United Methodist Church/Potters House and People In Need Ministries (PIN). PATH responds to calls and referrals from the shelters as well as calls from concerned citizens of Virginia Beach. PATH also outreaches with the local police precincts at various times to ensure camp site safety and assists in resolving

concerns of citizens and property owners. The Virginia Beach PATH/SOAR programs utilize a person centered/recovery-oriented outreach approach. This approach places the emphasis on the individual's willingness and ability to move in a positive direction. Motivational Interviewing is the primary interviewing tool used during outreach. Each homeless individual is an active participant in their recovery path/process to non-homelessness. In-reach is utilized at the local shelters: Judeo Christian Outreach Center (JCOC) and Volunteers of America (VOA). Continuing to work with the OW team increases the ability to reach more homeless individuals who are in need of services. The OW team will assist in covering the entire area of Virginia Beach this year. PATH outreaches with the Police to homeless camp sites that are being evicted by land owners.

e. Indicate whether your organization provides, pays for, or otherwise supports evidence-based practices and other training for local PATH-funded staff, including training and activities to support migration of PATH data into HMIS.
PATH enters all individuals, services Service Point, HMIS system. This system is administered by The Planning Council. Virginia Beach Continuum of Care (CoC) requires all homeless services utilize the HMIS reporting system. A yearly user's fee is paid for each HMIS certificate to The Planning Council. PATH participates in the quarterly meetings and trainings provided by HMIS administrators.

f. Describe gaps in the current service system and how PATH will assist individuals in addressing those gaps.
Lack of affordable housing: PATH participates in the Coordinated Assessment (CA) process. CA has providers who offer affordable housing for literally homeless families and individuals in accordance with their VI SPDAT score. All individuals receiving PATH services are referred for housing through CA. Great success has occurred but the lack of affordable housing is still a great barrier for individuals with the income of SSI, SSDI, SA or no income.
Lack of supervised and supportive housing: PATH advocates at the CoC meetings to increase the number of supervised and supportive housing in VA Beach. Many in cases individuals are in need of Supervised and Supportive housing which is at a minimum.

Difficulty obtaining a replacement ID: PATH assists individuals in applying and paying for documentation needed to obtain an ID. Without an ID housing is not possible.
Lack of reduced or no fee medical treatment: PATH assists individuals with co-pays for medical services at Virginia Beach Family Medical Center providing they have a valid ID. PATH advocates for individuals at Beach Health Clinic however the individual must have a valid ID and prof of Tax payment.
Employment and income assistance: Employment programs are difficult for the homeless population to access due to transportation or the inability to maintain hygiene and clean appropriate clothing. Many have had little education and read or write well. For the same reason many are not computer savvy which is a downfall for many jobs
Transpiration assistance: PATH transports individual to the first two appointments than provides a bus pass for future appointments up to one month. Transportation via bus is a long process. Going just 30 blocks can take up to 2 hours.

g. Describe services available for individuals who have both serious mental illness and substance

use disorder.

- Case Management serves individuals with diagnoses of mental illness and/or substance use disorders who need assistance to identify and use resources that will promote their highest level of functioning. Case Management assists individuals to access needed medical, psychiatric, mental health, substance abuse, social, educational, vocational services and other supports essential to meeting basic needs and improve their quality of life.
- Project LINK is a program that provides intensive case management services to pregnant, post-partum and parenting women whose lives have been affected by substance use and/or a co-occurring disorder by reducing barriers that may prevent her from seeking appropriate treatment.
- The Harbour is a Psycho-social day program for individuals who may have more moderate to severe levels of mental illness, and co-occurring disorders that require medication management and psychoeducation services concurrently.
- Adult Day Treatment services are provided five days a week. Group therapy and education are provided for persons with moderate to severe levels of mental illness, substance use, or co-occurring disorders.
- Adult Outpatient Services – Pembroke 6 services focus on individuals with mental health and significant substance use disorders. Services include psychiatric evaluations, medication management, group therapy and limited individual and family counseling.
- Adult Outpatient Services – Magic Hollow serves individuals with serious and persistent mental health issues. Services include psychiatric evaluations, medication management, group therapy, limited individual counseling, co-occurring treatment, and advocacy services.
- Community Based Crisis Stabilization – This service provides direct mental health care to adult individuals experiencing an acute psychiatric crisis that may jeopardize their current community living situations.
- Regional Residential Crisis Stabilization Programs – There are two other programs that are utilized in Norfolk and in Hampton along with the Virginia Beach Recovery Center. These facilities are utilized to prevent further destabilization and avoid hospitalization for the PATH individuals.
- Program of Assertive Community Treatment (PACT) – Services are correlated to the individual's assessed clinical needs, functional ability, and level of motivation. These services are designed for those who demonstrate a higher level of supportive care, and would not be able to maintain their mental health stability.

h. Describe strategies for making suitable housing available to PATH individuals (e.g., indicate the type of housing usually provide and the name of the agency that provides such housing).
PATH assists individuals in contacting with Coordinated Assessment to complete a VI SPDAT for access to shelter, transitional housing, permanent supportive housing, and rapid re-housing. Coordinated Assessment has housing resources from The Planning Council, ACCESS Aids, as well as
Virginia Beach Community Alternative Management Group (CAMG) and Virginia Beach Community Development Corporation (VBCDC) provide subsidized transitional housing and also permanent housing for individuals with mental illness, substance use and co-occurring disorders. Virginia Beach Housing and Neighborhood Preservation (VBHNP) offer a list of

affordable housing options and is the administrator of housing vouchers. Virginia Supportive Housing (VSH) is a regional program and currently manages five SRO's, two in Va. Beach, Norfolk, Portsmouth and Chesapeake.

i. If you plan to implement one or more Virginia PATH Innovative Practices, indicate which one(s) and describe the implementation plan:
Targeted street outreach is the main focus with the Virginia Beach PATH program for the last 17 years. We are proactive upon first encounter and consistent in meeting at set time and places. Meeting the individuals on their own terms and turf help to build a relationship of trust and support as well as on site assessments of the individuals' needs and wants. The first task is to facilitate obtaining whatever they perceive as their first basic need. From there we work toward prioritizing an action plan for them to move from homelessness and into services.
For most a primary need is applying for disability. Social Security Benefits: Outreach, Access and Recovery (SOAR) have been part of the Virginia Beach PATH since 2005. The SOAR worker completes and submits disability applications for PATH individuals. Each applicant is assessed for prioritizing in SOAR. Once established as appropriate, the worker and individual completes a disability work sheet, and signs "appointment of representative" forms allowing the SOAR worker to represent the individual. The applicant is followed through the entire disability proceeding including the appeal process should it be required.

j. Briefly describe your plan for providing the following PATH-allowable services:

Outreach:
The outreach team offers support to disconnected homeless individuals. The PATH team gradually builds up relationships of trust, assesses the needs, and makes the appropriate referrals. Encouragement and support through the process of entry into services. The outreach takes places wherever the homeless individuals reside.

Screening and Diagnostic Treatment: N/A

Habilitation and Rehabilitation: N/A

Community Mental Health Services:
Motivational Interviewing techniques are utilized during outreach and engagement process in assessing and identifying individuals having treatment history for their mental health or co-occurring disorders. When a PATH individual is ready to receive on-going services and treatment, they are bridged over via PATH staff coordinating with MHSA Pre-Registration office and scheduling an intake appointment. Some individuals may not want VA Beach MHSA services but will opt for other mental health/substance abuse services; in this case outside resources are contacted for appointments.

Alcohol or Drug Treatment Services:
If a PATH individual is in need of stabilization due to substance abuse, the PATH worker will assist the individual in contacting the Recovery Center regarding bed availability. Arrangements are facilitated with the center for the individual to either be admitted for stabilization or placed on the wait list. The Community Based Crisis Stabilization program

and case management services also works with individuals who may be stepping down from hospitals or need intensive services to support their recovery. When a PATH individual is ready to receive on-going services, they are assisted in calling the MHS, Pre-Registration office and scheduled for an intake appointment.
Staff Training: PATH participates in training Crisis Intervention Team (CIT) officers. Information is provided on the aspects of homelessness and responds to questions from the officer. PATH staff provides information and training at the local schools, shelters, case managers, and at churches in Virginia Beach. PATH will provide this information upon request throughout the year. PATH workers have participated in the Applied Suicide Intervention Skills Training. They are also trained in Individual Centered Motivational Enhancement and the Stages of Change.
Case Management: PATH provides motivational support to individuals utilizing a person centered recovery approach. Strategies and goals are explored and discussed with individuals to help them with their decision process for recovery. Once a individual is engaged and committed to services the pre-registration office is contacted for an intake/orientation appointment. The SOAR worker assists the individuals with the application process for Social Security Disability (SSI/SSDI).
Supportive and Supervisory Services in Residential Settings: N/A
Minor Renovation: N/A
Planning of Housing: Virginia Beach PATH participates in planning activities for the development of housing by working with VBDHNP and the Virginia Beach Continuum of Care.
Technical Assistance in Applying for Housing: PATH provides guidance and assists individuals with applying for housing with private providers. The primary PATH worker is trained in Fair Housing, the American Disabilities Act, and Section 504 of the Rehabilitation Act.
Improving the Coordination of Housing Services: The PATH Team Leader is an active member of the Coordinated Assessment Committee. The Team Leader also participates in the local Continuum of Care process.
Security Deposits: PATH individuals who do not have the assets to pay for a security deposit may receive a one-time assistance for deposit or they may receive the first or last month's rent through the PATH program.
Costs Associated with Matching Eligible Homeless Individuals with Appropriate Housing Situations: N/A

One-time Rental Payments to Prevent Eviction:
One-time rental payments are available through the PATH program for individuals who are at risk of eviction. Each request is reviewed to assess if there are other resources that can be obtained prior to utilizing PATH funds. If there are not any resources available, PATH assistance can be provided.

Referrals for Primary Health Services, Job Training, Education Services and Relevant Housing Services:

- PATH assists individuals with scheduling appointments and transportation to and from the Virginia Beach Family Medical Center, Beach Health Clinic, People In Need Ministries (PIN) and the Medical Reserve Corps. The Department of Health, the Veterans Administration Medical Center and the Community Based Clinic are also used for primary health services. Sentara Hospitals provide emergency care at various locations and hospitalization when needed.
- Virginia Employment Commission (VEC) provides job-seeking assistance to the homeless population. Opportunities Inc. offer a comprehensive range of services to help find jobs. Department of Rehabilitative Services prepares individuals for job placement.
- PATH advocates through the Coordinated Assessment program for relevant and affordable housing: Community Alternative Management Group (CAMG) and the Virginia Beach Community Development Corporation (VBCDC) provide subsidized, transitional housing and permanent housing for families and individuals with mental illness, substance use and co-occurring disorders. The Virginia Beach Housing and Neighborhood Preservation (VBHNP) offer a list of affordable housing options and is the administrator of housing vouchers. VBHNP is also the administrator of Voucher Program in Virginia Beach. Virginia Supportive Housing (VSH) is a regional program and currently manages five SRO's in Va. Beach, Norfolk, Portsmouth and Chesapeake.
- Department of Aging and Rehabilitative Services (DARS) prepare individuals for job capability's and placement.

6. HMIS Data Integration: Describe your HMIS transition plan, with accompanying timeline, to begin using HMIS to collect and report PATH data in HMIS by July 1, 2016. If you are fully utilizing HMIS for PATH services, please describe plans for continued training and how you will support new staff. Indicate any technical assistance needs you may have in meeting the HMIS data requirements.

PATH utilizes the HMIS system sponsored by the Virginia Beach Continuum of Care (CoC) and managed by the Planning Council of Hampton Roads. PATH utilizes HMIS as the primary data collection system. The HMIS Administrator has designed a report that is patterned after the Quarterly and Annual report for PATH. The report is run than transferred to PDX for reporting purposes. Virginia Beach is waiting the merge with Chesapeake to be completed. When this is successful the system will be updated to the most recent version. Until the update we are entering the referrals in the services area where we can pull the numbers out of the services report. The PATH Team attends trainings and stays up to date with changes. All new PATH staff will be thoroughly trained by the Administrator before active access in system.

7. SSI/SSDI Outreach, Access, Recovery (SOAR): Describe your plan to train PATH staff on SOAR. Indicate the number of PATH staff trained in SOAR and the number of PATH-enrolled individuals assisted through SOAR during State Fiscal Year 2013, and the approximate number of staff to be trained in SOAR for State Fiscal Year 2015.

Virginia Beach PATH has two SOAR trained staff. Virginia Beach PATH is requesting the SOAR part time position become a full FT. In FY 2015, the SOAR program assisted 70 individuals with their disability applications. Virginia Beach PATH does not plan on training the third staff person in SOAR.

8. Program demographics and cultural competency: Describe the following.

a. The demographics of the target population.

American Indian	0%
Asian	3%
Black or African American	15%
Hispanic or Latino	3%
White	76%
Multi-racial	3%

b. The demographics of the staff serving PATH individuals.

Three females all white.

c. How staff providing services to the target population will be sensitive to age, gender and racial/ethnic differences of individuals.

The Department's Accessibility Plan details specific goals and objectives to ensure that appropriate services are available to all individuals regardless of age, gender, race, national origin, religion, sexual orientation, disability and/or ability to pay for services. This plan examines potential impediments to service including attitudinal, physical and communication barriers and provides steps to overcome such barriers.

d. The extent to which PATH staff receive training in cultural competence.

PATH workers receive annual cultural diversity training provided by the City of Virginia Beach. PATH complies with the City of Virginia Beach's strategic Cultural Competency and Diversity Plan. Virginia Beach MHSA has procedures for requesting a translator if needed. PATH has access to Public Service Announcements and printed material in Spanish to distribute to the Hispanic homeless population and can access translated material in other languages as needed.

e. The extent to which the organization adheres to the Culturally and Linguistically Competent (CLAS) Standards. The CLAS standards can be accessed at http://www.ThinkCulturalHealth.hhs.gov.

The city of Virginia Beach provides a language bank for translation services for citizens requesting city services. Staff is required to review CLAS standards each year during their annual review to ensure competency and services provided are within the standards. All individuals receiving city services are informed of the grievance resolution policy and individual rights policy.

- **9. Individual and Family Involvement: Describe how individuals who are homeless**

and have serious mental illnesses, and family members will be involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards. (See attached Appendix I – Guidelines for Individual and Family Participation.)

- Virginia Beach MHSA Division Mission Statement: To promote recovery for Virginia Beach citizens and their families, with or at risk of mental health, substance use or co-occurring disorders, through an array of coordinated services offering prevention, treatment and community collaboration delivered in a climate of dignity and respect.
- All PATH individuals are assessed for suitability of services. At that time, each individual is informed of individual's rights, and voluntarily sign consent forms for services and fees (based on income). Once individuals are admitted into on-going treatment, they sign other documents notifying them of their rights and choices and well as consents for medications, they are prescribed.
- The Office of Individual and Family Affairs (OCFA) provides opportunities for individuals (including PATH individuals), their families, and members of the community to participate in educational activities, learn about and be linked with community resources. They learn about how to become involved in advocacy initiatives. Programs offered include Friends and Family which is a 6 week series of classes that offers understanding and help for friends and families affected by substance use and Wellness Recovery Action Plans (WRAP) is a 9 week series of classes that help individuals learn how to write a recovery plan focused on their goals for wellness. The individuals can also attend Peer to Peer which is a 9 week class that is taught my mentors and helps individuals with severe mental illness prepare their own recovery and relapse prevention.

Currently, PATH staff do not self-identify as having mental illness or a history of homelessness, however many previous PATH individuals have volunteered to participate in the *Point in Time* count. PATH encourages individuals to support and participate in public hearings and open planning meetings.

10. Outreach to Homeless Veterans: Describe how your PATH program identifies and outreaches to homeless veterans with SMI, and the services available to them in your catchment area. How does PATH interface with your veterans' service continuum?

PATH is continuously assessing individual that are in status. If the vet is not in VA services they are assisted in registering at the Hampton VA Center. If they do not qualify for VA services the individual is assisted in contacting the MHSA Pre Registration to schedule an appointment for services. We are involved in the Virginia Beach Veterans Initiative. We are assisting Veterans that are VASH eligible by helping them become document ready for housing. We also assist in finding financial resources for those that may need help with deposit and first month rent.

11. Describe your PATH program's efforts to minimize the challenges and foster support for PATH individuals with a criminal history, such as collaboration with local jail diversion and/or other programs. If you can, estimate the percent of PATH individuals with a criminal history.

Virginia Beach PATH is in the process of meeting with the local corrections facility and the Probation Office to find out how we can provide better services to the returning citizens. An estimate of PATH individuals with criminal history is 60 percent. Virginia Beach PATH collaborates with the Adult Correctional Services department of the MHSA division. The Adult Correctional Services is curriculum-based mental health and substance abuse education, relapse prevention, re-entry planning and referrals to community resources. Includes jail diversion, forensic services, and restoration to competency, advocacy, discharge planning, and referrals for inmates with serious mental illness.

PATH Site Name Virginia Beach Department of Human Services, MH/SA Division				
Budget FFY 2015/SFY 2016(2015-2016 PATH Year)				Match Source (Cash or In-kind)
Staff Title	***Annualized*** Salary	PATH Funded	Match	
Clinician III	$59,559	$25,501	$34,058	Cash
MH/MR Assistant	$31,503	$7,067	$24,436	Cash
Clinician I	$42,635	$42,635	$0	Cash
Total Staff Salary	$133,697	$75,203	$58,494	
Fringe	$54,054	$20,114	$33,940	Cash
	Total Personnel	**$95,317**	**$92,434**	
Travel (Outreach travel, travel to training, ot travel to state meetings)				
Use of Agency Vehicle		$7,416		
Training Travel		$1,000		
Training Conference Costs		$1,500		
	Total Travel Costs	**$9,916**		
Equipment (Personal property/equipment having useful life of more than one year) NOT FEES				
	Total Equipment Costs	**0**		
Supplies (Office Supplies, Outreach Supplies, Computer Software)				
Office Supplies		$570		
Outreach Supplies		$6,296		
Medical Supplies		$4,276		
	Total Supplies Costs	**$11,142**		
Contractual				
Cell phone service fee $441.33 per yr. x 3 = $1,324		$1,324		
Chest X-rays for PATH clients		$1,500		
	Contractual Total Costs	**$2,824**		
Other (List and Describe Each)				
Identification related purchase costs (incl. Birth certificates)		$850		
Rental Assistance		$6,300		
Bus Tokens		$600		
Staff Training (non-travel registration and costs)				
	Other Total Costs	**$7,750**	**$0**	
	Total Proposed Budget	**$126,949**	**$92,434**	Is match > or = to 1/3 of federal allocation? **Yes**

PATH Site Name: **Richmond Behavioral Health Authority as SOAR Coordination Contractor**					
Budget FFY 2016/SFY 2017 (2016-2017 PATH Year)			PATH Funded	Match	Match Source (Cash or In-kind)
Staff Title	***Annualized*** Salary	FTE			
SOAR Project Director	$52,196	1	$52,196		
Total Staff Salary	$52,196				
Fringe			$11,816		
Total Personnel			**$64,012**	**$0**	
Travel (Outreach travel, travel for training, state meetings, etc.)					
SOAR Trainings - Travel and Lodging			$5,900		
Total Travel Costs			**$5,900**	**$0**	

Equipment (Personal property/equipment having useful life of more than one year)			
Total Equipment Costs			

Supplies (Office Supplies, Outreach Supplies, Computer Software)			
Office Supplies and Training Materials	$500		
Total Supplies Costs	**$500**	**$0**	

Contractual			
Cell phone service fee	$600		
Total Contractual Costs	**$600**	**$0**	

Other (List and Describe Each)			
Administrative Costs (HR, Fiscal, etc.)	$2,460		
Total Other Costs	**$2,460**	**$0**	
Total Proposed Budget	**$73,472**		

Assurances, Certifications and PATH Agreement