ATTACHMENT A

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

Organization name: Kitsap Public Health District

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

Please Check One ☐ **New Grant Proposal** ☒ **Continuation Grant Proposal**

Please check which area of the Continuum this project addresses:

☐ **Prevention, Early Intervention and Training**	☐ **Medical and Sub-Acute Detoxification**
☒ **Crisis Intervention**	☐ **Acute Inpatient Care**
☐ **Outpatient treatment**	☐ **Recovery Support Services**

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

Requested Funds Amount: $ 450,510.50

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

Street Address: 345 6th Street, Suite 300 City: Bremerton State: WA Zip: 98337

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

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

Federal Tax ID Number: 42-1689063

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

[signature] ADMINISTRATOR 7/28/17

Signature Title Date

KITSAP PUBLIC
HEALTH DISTRICT

345 6th Street, Suite 300
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360-728-2235

2017 KITSAP PUBLIC HEALTH BOARD OFFICERS

Chair: Commissioner Ed Wolfe
Vice Chair: Mayor Patty Lent

2017 KITSAP PUBLIC HEALTH BOARD COMMITTEE ASSIGNMENTS

Finance & Operations	Mayor Becky Erickson Commissioner Charlotte Garrido Mayor Patty Lent
Policy	Mayor Becky Erickson Commissioner Rob Gelder Mayor Rob Putaansuu
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Attachment C

1. Current Project Summary

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

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

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

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

2. Accomplishments to Date

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

Kitsap Connect has successfully addressed the 2014 Behavioral Health Strategic Planning goals, or gaps, #1, 2, 3 as follows:
Gap #1: Behavioral Health Prevention, Early Intervention, and Training
Kitsap Connect has created shared planning through ongoing collaboration and increased care coordination among mental health, substance abuse, health, and justice stakeholders.
Gap #2: Crisis Intervention/Triage Services
Kitsap Connect has established a Mobile Crisis Team and infrastructure to handle attempts by law enforcement or mental health outreach teams to preempt entry into the legal system, jail or the hospital and has established specialized homeless outreach services.
Gap #3: Outpatient Care – Psychiatry, Medical and Medication Management, Counseling Services
Kitsap Connect has enhanced linkage to comprehensive services including care coordination, access to medication, prompt access to benefits, health care, housing with/without supportive services, and mental health & substance abuse treatment.

In addition, we have accomplished the successful reaching of the Kitsap Connect goals and objectives initially called out on our 2016-2017 grant application.
Goal A- Improve the mental and physical health and well-being of highly vulnerable clients: To date, sixty identified potential high-utilizer clients with mental health and/or chemical dependency conditions have been screened for eligibility. Twenty-four clients are currently enrolled in Kitsap Connect services, with another six clients pending admission; the current client caseload is twenty-four clients, with length of service engagement an average of 7.2 months. 100% of engaged Kitsap Connect clients (3 months of engagement or longer), have tailored care plans,100% of clients report at least moderate improvement in well-being as evidenced by self-report at time of quarterly and exit of program surveys.
Goal B- Reduce usage of costly health, social, and public services resulting in cost savings: Since January 2017 (beginning of data sharing availability), specific client encounters with the CHI/Harrison Hospital Emergency Department, Fire Department (county-wide) 911/EMS, Kitsap County Jail, and Law enforcement, are being tracked. Usage data is being compiled from the nine-month period prior to service engagement. Data collected is used as a client baseline to compare to client encounters during the nine-month period of service engagement in Kitsap Connect. We anticipate that we will

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

B. Barriers to Implementation

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

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

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

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

C. Kitsap Connect Outreach Plan

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

D. Integration & Collective Impact

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

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

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

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

E. Key Accomplishments

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

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

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

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

3. <u>Budget Narrative</u>

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

<u>Personnel</u>
Manager and Staff (Program Related) = $159,713.88
Fringe Benefits = $49,877.65
SUBTOTAL = $209,591.53

<u>Supplies and Equipment</u>
Equipment = $1,911.92
Office Supplies = $1,732.69
Computer/Software = $5796.54
SUBTOTAL = $9,441.15

<u>Administration</u>
Communication = $2,009.62
Training/Travel/Transportation = $3,410.63
% Indirect = $26,764.43
Client Incidentals = $3,032.33
Subcontracts: KMHS, KCR = $40,158.89
SUBTOTAL = $75,375.90

TOTAL EXPENDED FUNDS = $294,408.58

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

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

B. Funding Request

For 2018, we are requesting the Citizens Advisory Board consider increasing the annual support to our program. This increased request is related to the following:
-Original projections for hiring of a Program Coordinator of Kitsap Connect were low. Finding the right person for the position required increasing the salary allocation towards that position.
-We underestimated how substantial the physical needs of Kitsap Connect clients would be, and did not initially include subcontracted funds to PCHS to help coordinate medical care for these clients. We have included a request to fund 0.25 FTE of a PCHS health care specialist for this purpose. PCHS would like to develop a mobile primary care team, and if they are successful in this, the cost of the HCS may be reduced.
-KMHS had matching Medicaid funding the pilot year of Kitsap Connect, but the change in the health care landscape has eliminated that funding as a matching option. Their subcontract request has therefore increased.
-KCR has slightly higher program management costs for 2018. Salary and benefit cost increases for all participating agencies are projected.

<u>Personnel</u>
<u>Managers:</u>
0.06 FTE of Assistant Director of Health X 12 months = $7565
1.0 FTE Program Coordinator X 12 months = $92,893

<u>Staff:</u>
.5 FTE Public Health Nurse X 12 months = $40,679
.5 FTE Public Health Nurse X 12 months = $38,755
Total Benefits (taxes, benefits, retirement) = $63,256
SUBTOTAL = $243,147

<u>Supplies and Equipment</u>
Office supplies - $50 per month X 12 months = $600
SUBTOTAL = $600

<u>Administration</u>
Communication: 4 cell phones at $50/ month X 12 months = $2,400
Client incidentals: $3,000 over a 12-month period to pay for items needed by clients to improve chance of successful engagement in services, including bus vouchers, medical equipment and supplies, clothing & shoes, phone minutes, hygiene items, bedding, etc.

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

Other: Professional Services/Sub Contractors
Subcontract to KMHS: 1.0 FTE Behavioral Health Specialist = $88,161 for 12 months
Subcontract to KCR: 1.0 FTE Housing Outreach and Stabilization Coordinator = $51,048 for 12 months
Subcontract to PCHS: .25 FTE Health Care Specialist = $17,199 for 12 months

SUBTOTAL = $206,763.50

TOTAL REQUESTED FUNDS = $450,510.50

C. Funding Modifications

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

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

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

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

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

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

4. <u>Sustainability</u>

A. Sustainability Plan

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

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

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

A. Leveraged Funds

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

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

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

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

EVALUATION WORKSHEET

INSTRUCTIONS:

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

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

DEFINITIONS:

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

ATTACHMENT D

EVALUATION WORKSHEET

PROJECT NAME: Kitsap Connect

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

ATTACHMENT D

EVALUATION WORKSHEET

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

ATTACHMENT D

EVALUATION WORKSHEET

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

ATTACHMENT D

EVALUATION WORKSHEET

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

Kitsap Public Health District
OPERATING BUDGET WITH ACTUALS

REVENUES		UNAUDITED ACTUAL 2016		BUDGET 2017		BUDGET 2018
Contracts & Grants	$	5,246,053	$	3,691,840	$	3,991,840
Fees		5,553,245		5,531,518		5,531,518
Local Government Contributions		2,466,371		2,459,645		2,459,645
Local Government NDGC Mortgage		60,150		62,250		62,250
Miscellaneous Income		28,714		21,541		21,541
TOTAL REVENUES	**$**	**13,354,533**	**$**	**11,766,794**	**$**	**12,066,794**

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

* Includes use and reserve of designated and reserved funds.