III. PROJECT NARRATIVE

Project Name: Benefits and Entitlement Specialist Team Plus (BEST+)

Purpose Statement- One sentence description of what will be accomplished as a result of the project: The proposed project will provide funding for the critical partnerships necessary to fully support the Benefits & Entitlement Specialist Team Plus (BEST+) program, dedicated to addressing the multi-faceted social determinant of health that is homelessness.

Amount Requested: $373,570

Project Overview:

The BEST+ Project will work to assist homeless and formerly homeless individuals in becoming self-sufficient through one of two ways, with the ultimate objective of ending the cycle of homelessness, creating healthier citizens and healthier communities in which disparities are minimized and myths about the homeless are dispelled. The BEST+ team will used evidence-based practice programming to assist those with disabilities in expedited acquisition of federal benefits and entitlements (SSI/DI and Medicaid/Medicare) so that they may access the comprehensive and specialized health and behavioral healthcare, supported housing and services needed to stabilized their conditions and ultimately lead to increased self-sufficiency. For those not disabled, the BEST+ Project will investigate models of assisting those with multiple barriers to employment (such as lengthy histories of addiction, incarceration and unemployment) in securing eventual livable wage jobs with health insurance coverage. The end result of this project will be better health maintenance, improved health outcomes and reduction in unreimbursed health care encounters to safety net clinics and hospitals. The successful outcomes generated by this project will diminish the multiple negative social determinants of health to which those with lengthy histories of homelessness succumb. Homelessness, while extremely detrimental to those impacted first hand, is also a toxic indicator of the health of the communities in which we live.

The BEST+ Project addresses health and wellbeing disparities through exploiting the innovative and necessary multiple partnerships needed to provide a full continuum of care to those served. Partners necessary to the achievements of this project include the City of Portland, JOIN, Transition Projects, Inc. and Central City Concern, the lead on this proposal. Each of these partners has committed resources to the efforts of this project. The implementation of the federally endorsed evidence based SSI/SSDI Outreach Advocacy and Recovery (SOAR) model will include staff from JOIN, TPI and CCC, including medical provider time from Old Town Clinic. The commitment of collaboration between the Social Security Administration and Oregon Disability Determination Services will be necessary for the expedited processing of and eventual awards for fully documented SSI/SSDI applications. Other federal partners necessary to meeting the objectives of this project include the Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Health Care for the Homeless Council (HCH). SAMHSA is contributing the funding for one benefits specialist on the BEST+ team while HCH has committed to the provision of technical assistance to the medical providers on the thorough documentation of disabilities that increases the rate of SSI/SSDI awards. Partnerships that will be developed to promote the self-sufficiency of those not qualified for disability benefits will include the business community so that BEST+ may create increased opportunities for eventual employment in livable wage jobs with health insurance needed to exit the cycle of homelessness.

Project Goals- Impact to be achieved:
The goal of this community partners' project is to reduce disparities, increase integration and improve access to the comprehensive services needed to promote total health and self-sufficiency amongst Portland's homeless and formerly homeless. BEST+ will do this by assisting individuals in speedy access to federal benefits and entitlements for which they are eligible using an evidence based practice model. For those who are not disabled, efforts to support securing livable wage employment with health insurance benefits will be focused upon.

Two federal initiatives focusing on increasing speed and success of SSI/SSDI (Supplemental Security Income/Social Security Disability Insurance) and Medicaid/Medicare awards have resulted from the U.S. Interagency Council on Homelessness efforts to ending homelessness. One of these was initiated by the Federal Homeless Policy Academy which brought together national experts on issues pertaining to ending homelessness. This Academy developed and launched a training curriculumm titled "SSI/SSDI Outreach Advocacy and Recovery (SOAR)" for which 10 states were selected to receive technical assistance. Oregon was one of the original states and since the documentation of efficacy, 10 new states were recently selected. One of Oregon's statewide trainers will be the Team Lead for BEST+. The other initiative was funded by the Social Security Administration in which 40 sites were awarded 3 year service grants to implement evidence base practice programming to expedite the processing of homeless SSI/Medicaid applications. SSA's dedication of these funds (the "Homeless Outreach Planning and Evaluation (HOPE)" projects) communicated publicly their acknowledgement of how difficult the process is for the most vulnerable, disorganized and marginalized: our homeless citizens. The projects proved to be so successful that SSA identified funding for a fourth year of all projects. Unfortunately, they were unable to identify funding to issue additional solicitations for future projects. Their most successful project, operated by the Colorado Coalition for the Homeless and located within their Healthcare for Homeless Stout Street Clinic, processed 1,000 SSI/SSDI Medicaid/Medicare applications in just 3 years with 70% successfully awarded. The average length of time from submission of application to award was 90 days (though one individual secured an award in only 2 weeks). The Project Director for this Providence Partners in Health grant was the Project Director for the Denver HOPE grant for the first 18 months of its operation.

It is not an overstatement to say an impact of this collaborative partnership will literally be saved lives. There are many obstacles to thoroughly documented applications. Due to the transitory nature of the homeless and the frequent cognitive impairment associated with their high incidence of mental illness and traumatic brain injuries, it is extremely unlikely that these individuals can piece together a thorough documentation of medical records that demonstrate disability. Additionally, they may not even access their local SSA offices without state-issued identification. For the few who do succeed in completing an application, only 10% are awarded on initial review. The 90% denied may choose to appeal and the court dockets for appeals hearings are currently scheduled 1-2 years out. Cases of multiple appeals have been known to last for 6 years before final award and under the costly navigation of an attorney. People die while awaiting this process. This SOAR model has a documented ability to reduce processing time to 60-120 days and a 60% rate of award at initial review. Upon award of SSI and/or SSDI comes automatic qualification for Medicaid (OHP+ and/or Medicare). The impact that this collaborative partnership will have on those served will be speedy access to comprehensive and specialty healthcare, special needs housing and the support services necessary to stabilization. An added benefit this program will have for health systems is the ultimate shift of healthcare costs from their own limited resources to the federal government. The more

individuals successfully awarded federal disability benefits and entitlements, the greater the capacity that these safety net health systems have to serve those still uninsured and at the beginning of their journey out of homelessness.

Project Objectives- Key factors or achievements necessary for success:
Key factors involved in improving access to health care, supportive services and housing necessary to promote self-sufficiency and to improve quality of health will include a variety of activities. This grant will fund a portion of the BEST team and the "Plus" component of a Self-Sufficiency Project Manager. This position will report to the existing Director of Supportive Housing and Employment and will be advised by the CCC Executive Management Team. Key factors necessary for success are:

1) **Implementation of SSI/SSDI Outreach Advocacy and Recovery (SOAR) model.** A great deal of work has gone into the plans for funding and implementing this model using the BEST team. Financial commitments have been secured through blended funding including funds from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the City of Portland, and in-kind contributions committed by Central City Concern, JOIN, Transition Projects, Inc. and the City of Portland. Additionally City Commissioner Erik Sten, Congressmen Wu and Blumenauer, Senators Smith and Wyden and the Social Security Administration Region 10 Commissioner Schoening have documented their support for this program. The Benefits and Entitlement Specialist Team (BEST) will serve between 120-200 individuals per year, assisting homeless disabled individuals in accessing SSI/DI and Medicaid/Medicare in less than 120 days through the use of the nationally recognized evidence based practice SOAR model. Critical to the success of this model is that the BEST staff focus solely on substantiating disability through the careful and thorough collection of all medical records and accompanying clients to their medical exams and appointments. That is why CCC seeks funding through this grant to support 2 Benefits and Entitlements Case Managers; one from JOIN and the other from Transition Projects, Inc. (TPI) to assist clients in getting all their other needs met, to do the outreach necessary to bring people to their appointments and to assist them in accessing existing health, mental health and treatment resources needed until their SSI/SSDI and Medicaid/Medicare awards are approved. Additionally funds are requested to cover the build out of the space required by the BEST team and funding for a portion of a medical provider who will be trained by both the Oregon Disability Determination Services office and National Healthcare for Homeless on how to document a disability.

2) **Development of Self-Sufficiency programming.** The requested funds for a Self-Sufficiency Project Manager will be used to explore a variety of models used nationally to assist homeless and formerly homeless individuals not qualified for disability benefits in securing livable wages and health insurance. These individuals often encounter multiple barriers to employment such as poor work histories, lengthy periods of active addiction and incarceration. CCC is aware of several approaches in working with those with multiple barriers in securing eventual employment. The Self-Sufficiency Project Manager will investigate these as well as research any other models that may exist across the country. Examples to be explored include a Community Service Corps which could assist those with the greatest barriers to employment to develop the work skills and habits necessary for eventual employment. The experience of volunteering in a Service Corps has also been used to build the work history necessary for a resume and reputable references. Creating supported employment programming may be another area for development. Supported employment services work to actually develop paid employment in the community and provide ongoing job coaching that assists those with

poor work histories in staying on the job. The Individual Placement and Support model is one known approach endorsed by SAMHSA as an evidence-based practice that may be considered and with which the Project Director has extensive history here in Oregon. Another possible area for exploration would be to partner with local businesses through the creation of a Business Advisory Council to create employment opportunities and/or mentor programs for those with multiple barriers**.** CCC has a reputation both locally and nationally for transforming lives through our creative interventions and being the largest employer of formerly homeless individuals in the State of Oregon. There may be opportunities to share the responsibility and privilege of those transformations with the broader business community.

Background and History of this project:
Central City Concern has been providing pathways to self-sufficiency through active interventions in poverty and homelessness since 1979. Our continuum of care serves an estimated 12,000 individuals per year through our Hooper Detoxification Center, Old Town Clinic, outpatient addiction treatment, 1,300 units of affordable housing, supportive housing case management and our WorkSource employment center. Since 2002, the Federal Interagency Council on Homelessness has made ending homelessness a national priority, promoting the adoption of 10 Year Plans to End Homelessness in 53 States and Territories and 222 communities. Portland's own 10 Year Plan, titled "Home Again," has made significant strides since adoption in 2004: however it wasn't until this year that performance measures relating to self-sufficiency and acquisition of benefits and entitlements were included. Our homeless experience multiple chronic health and mental health conditions that can lead to and result from the harsh reality of life on the streets. They are our healthcare system's highest utilizers of emergency rooms and hospitals. Those without disabilities often have extreme barriers to becoming employed (histories of incarceration and lengthy experience with addictions). This proposal would support this community's endorsement (through the Home Again SOAR workgroup) of the critically needed evidence-based SOAR model and will work to achieve similar results to the nationally recognized Denver project documented above by attaching the program to the federally funded healthcare for homeless Old Town Clinic. CCC brings 3 years of SOAR knowledge to this project through its SAMHSA funded Benefits and Entitlement Specialist Mellani Calvin, a certified State-wide SOAR Trainer and recent recipient of the State Mental Health Award of Excellence for her SOAR efforts. While her efforts have been significant, a fully funded team designed after Denver's is needed to fully optimize the model's potential and to serve the unmet need.

Rationale- Why the project is important at this time:
Approximately 17,000 individuals are estimated to be homeless in Multnomah County each year.[1] Nationally, a conservative 39% are estimated to be eligible for Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) and Medicaid based on their mental illness and 46% based on their physical health conditions, but **only 11% receive these benefits**. [2] Given the multiple chronic health conditions leading to and resulting from homelessness, acquisition of benefits and entitlements for these most vulnerable citizens is critical. It provides them access to the continuous and comprehensive healthcare and supported services needed to stabilize and improve health outcomes and promotes eventual self-sufficiency. Within just the Old Town Clinic, CCC Outpatient and Intensive Case Management services we saw 2,695 of these individuals in 43,934 encounters last

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[1] Home Again: A 10-Year Plan to End Homelessness in Portland and Multnomah County, 12/04,
[2] Government Accountability Office Study, 2000

year. Only 15% had Medicaid, Medicare or some kind of private insurance and only 23% of encounters were reimbursed through these programs. Given national estimates that 85% of these individuals could qualify for benefits, we estimate 1,947 of these clients are in need of the intensive assistance required to secure SSI/SSDI and Medicaid/Medicare. These numbers only reflect CCC. There are a number of other agencies serving this population, including TPI and JOIN, who are also serving a high percentage of uninsured clients who would qualify for benefits if a team of specialists were dedicated to the effort. Too much time has passed in addressing this disparity and the safety net clinics and hospitals have been taxed with the burden or serving these uninsured individuals with expensive and unreimbursed healthcare. Often, these clients need emergency healthcare that could have been prevented with access to the preventative and maintenance care available to those with fully covered health insurance such as OHP+. Additionally the time is right because the City of Portland has committed to funding a portion of the BEST team through funds identified in the "Fall Bump" additional City funding round. They are committing to 6 months of initial funding and ongoing funding through their next fiscal year funding cycle.

The Self-Sufficiency component designed to assist those not eligible for disability benefits and entitlements is also timely, given the recent reorganization of the CCC WorkSource One Stop Center and its placement under the Director of Supported Housing and Employment. Additionally, the City of Portland has supported this effort through funding of 2 Employment Specialists and discussions of additional funds through their Economic Opportunity grants. A recent data run found that of the 2,400 unduplicated individuals served through WorkSource last year, only 10% were individuals living in CCC's Supportive Housing programming. Additionally, only 20% of CCC's clients are estimated to be employed full time. In order to address the needs of moving people beyond CCC's four walls so that those at the front door may have access, we must work to address the multiple barriers to employment these individuals face through some of the innovative ideas discussed above in the **Project Objectives** section.

Rationale for collaboration- Why is collaboration necessary for the success of this project? Many of the individuals in need of this project are served by CCC, JOIN and TPI and are recipients of programming funded through the City of Portland. Combined CCC, JOIN and TPI have provided 82 years of services to the homeless. Each of these partners is critical to addressing the disparities that uninsured homeless and formerly homeless individuals experience as a result of their disabilities and poverty and each of these agencies serves a slightly different demographic of homeless individuals. JOIN works closely with those living under bridges and other places not meant for human habitation, those resistant to using the shelter and homeless service systems. TPI serves a population whose interest initially may only be a bunk in a shelter, providing safety at night while they remain homeless during the day. CCC serves a population typically wanting to end their homelessness through accessing our continuum of care, from Hooper detox to outpatient treatment and primary care, to clean and sober housing and sometimes to self-sufficiency through their access to employment via CCC's Business Enterprises and WorkSource employment center. There is also a great deal of overlap with individuals served by each of these agencies who have frequented the services of the other 2 agencies. This collaboration is an obvious choice given the need to coordinate total care across each other's systems and to exploit the different resources we each bring to the full continuum of care.

The city's contribution currently consists of funding multiple homeless services and housing, including the Key Not a Card (KNC) program. KNC funds housing subsidy for homeless uninsured

singles and families while they await assistance in achieving greater self-sufficiency through either disability benefits and entitlements or employment programming. These funds are limited and can only assist a finite number of people unless those currently receiving these funds "graduate" through the award of SSI/DI, insurance or a living wage. JOIN, TPI and CCC are all the recipients of these funds and this "Partners in Health" grant is the missing link necessary to all our systems to serve more homeless clients through moving more individuals from reliance on our services. No "10 Year Plan to End Homelessness" can succeed without creative partnerships and blending of services and the resources necessary to carry our efforts through beyond just stabilization, to actual self-sufficiency and graduation.

Collaboration Plan: Describe the plan and activities that will ensure agency collaboration. The City and SAMHSA funded BEST team will be supported through this grant by the addition of 2 full time case managers, one from JOIN and the other from TPI . CCC will supply its own Case Management to this project in-kind. Case management services provided by CCC, JOIN and TPI will support the efforts of the BEST team by assuring that client needs are being addressed while they participate in the SSI/SSDI, Medicaid/Medicare application appointments and award process. While some clients may receive a favorable award upon initial review, others may have to appeal a decision of denial. This is a lengthy process with cases sometimes being scheduled for hearing more than a year out. The Case Managers assigned to the BEST team will continue to serve clients until an award is made or until alternative resources are secured. In order to promote the ongoing partnership, a bi-monthly meeting of all partners will be convened to review the status of the project's implementation and evaluation findings. These meetings will be used to define quality improvement activities that will be designed to keep the project on target with its intended outcomes.

Project Activities- Activities that will be performed in order to accomplish the project objectives.

- Generate and sign MOU defining the partnership between City, CCC, TPI and JOIN
- Secure MOU between CCC, the Social Security Administration Region 10 and Oregon Disability Determination Services (who review and determine SSI/DI eligibility awards).
- Implement the SOAR model by hiring and training the BEST team
- Hire and train Self-Sufficiency Project Manager
- Convene Partners Advisory Board bi monthly
- Design and implement evaluation tracking
- Generate quarterly progress reports documenting program challenges and accomplishments
- Disseminate findings to all stakeholders

Anticipated Outcomes- What will be different as a result of this project?
The major outcomes generated by this project will be decreased processing time and increased rate of awards of disability benefits and entitlements for homeless and formerly homeless individuals. Should this approach prove to document dramatic successes, increased support of stakeholders will follow. More state, local and hospital system funds may be allocated to replicating this approach with recognition that a small investment at the front end may result in a large increase in reimbursed health encounter revenues at the middle and back end.

With SSI/SSDI comes access to more comprehensive and specialized healthcare, supported housing, services and increased self-sufficiency. This project will significantly contribute to the efforts of the federal, state and city's 10 Year Plan to End Homelessness by creating access for homeless individuals to the total continuum of resources needed to permanently address their poverty and health disparities. Those who are ineligible for the disability track will be assisted through the self-sufficiency programming resulting from this project's efforts. The research and investment of funds in creating employment programming that targets those with multiple barriers will prove to document that rehabilitation is possible and that tax users can become tax payers.

Measures of Success- Describe the measures of success.

a) 120 disabled homeless and formerly homeless individuals per year will be assisted in an expedited review of SSI/SSDI applications, with 60% securing benefits and entitlements by the end of 18 months.
b) All 120 individuals will establish a medical home through the efforts of this project.
c) 60% of those served will secure housing
d) 70% of those housed will remained housed 1 year post placement.
c) 30 disability ineligible homeless and formerly homeless individuals will have secured employment through the efforts of this project by the end of 18 months.

Sustainability Plan- Ways the grantee, community, or other beneficiary will continue to address the work after funding ends. An estimated 75% of clients served by the BEST program are anticipated to be eligible for Supplemental Security Income (SSI) and Medicaid (OHP Plus) rather than Social Security Disability Insurance (SSDI) and Medicare due to the absence of employment history that contributes to homelessness. Upon award of SSI, Medicaid can be back billed for reimbursable encounters for 90 days. Additionally, future billable encounters will generate revenue that can be used to sustain the project's efforts over time. If 72 individuals per year receive an SSI award and have on average 8 billable encounters per year, an additional $115,000 in revenue will be generated to support this program's efforts and to expand total capacity at the Old Town Clinic. This figure is based on Old Town Clinic's Federally Qualified Health Center rate of $200 per encounter. The increased revenue will also be generated through hospital systems for people who had once been uninsured but used expensive emergency care and hospital beds without any compensation. This model may prove attractive to hospital systems that choose to spend a small percentage of their funds on the front end so that they can generate revenue on the back end. The increased income resulting from the $623 monthly SSI award will also generate revenue for individuals living in CCC housing who are responsible for paying 30% of their income towards rent. Those with zero income currently pay nothing. If only 50 of the individuals served who receive an award live in CCC housing, an additional $113,760 per year will be collected in rent that can be redirected to programming. These are just some of the revenue potentials of this project. Upon documentation of program efficacy, it is also possible that this program may attract the attention of other foundations and local, state and federal grant opportunities.

Target Geographic Area- What is significant about this area?
The target geographic area of this project is Multnomah County. Given the estimated 17,000 homeless who live in this county in any given year, and given the national estimates that 85% of homeless could qualify for disability benefits and entitlements if only they had the intensive support needed to fulfill the documentation requirements for the application for SSI/SSDI, Medicaid/Medicare, the need is huge. Additionally, an estimated 80% of homeless and formerly

homeless who do not qualify for disability are unemployed and without the necessary income and health insurance necessary to both ending their cycles of homelessness and creating tax payers out of tax users.

Target Population- What is significant about this population?
The condition of homelessness often results in or is accompanied by complex and multiple chronic health conditions. End-stage liver disease, hypertension, dental disease, tuberculosis, emphysema, diabetes, vascular disease, organic brain syndrome, Hepatitis C, cancer and HIV/AIDS are just a few of the conditions prevalent and these conditions are frequently accompanied and compounded by substance abuse, mental illness, and trauma. Many of our homeless citizens qualify for disability benefits and entitlements that they do not currently have due to the unnecessarily complicated quagmire that is the Social Security Administration. The efforts of this project will create greater health equity and healthier communities.

Extended Collaborating Organizations- Other organizations you are working with on the project and the role of each.
In addition to the City, SAMHSA, JOIN and TPI, partnerships that are critical to the success of this effort include the Social Security Administration (SSA), Oregon Disability and Determination Services (DDS), National Health Care for Homeless and the Portland business community. CCC and the City have secured the support of the Social Security Administration in a letter from Commissioner Schoening stating that should funding be secured, he and Oregon DDS will cooperate fully to support the efforts of this project. Meeting with congressional staff resulted in letters of support from Congressmen Wu and Blumenauer and Senators Smith and Wyden to SSA Region 10. The National Health Care for the Homeless Council has committed to providing their training curriculum to Old Town Clinic medical providers titled "Documenting Disabilities for Substance Use Disorders and Co-Occurring Impairments: A Guide for Clinicians" to improve the quality of documentation provided to SSA and DDS. Partnership with the business community around creating employment opportunities will also be necessary to the success of self-sufficiency for those not qualified for benefits and entitlements. Given CCC's longstanding partnership with the Old Town/China Town Neighborhood Association and Visions Committee and multiple collaborations with the Portland Business Alliance, this effort should prove to be very productive. The business community has come to recognize a correlation between increased access to services and employment, and the reduction in incidences of crime and the numbers of public inebriates and homeless camping out in or near their storefronts.

Other funding sources- List all other organizations contributing to the project, including in-kind support.
As delineated in the following Project Budget, CCC, JOIN, TPI and the City of Portland will all be contributing in-kind support to this project. Both SAMHSA and the City of Portland will also be contributing funding to support this project's implementation.

Start Date: January, 2008

End Date: June, 2009

IV BUDGET NARRATIVE

PERSONNEL

Project Director @ 10 % (**in-kind 5% and 5% requested from PPH grant**) = $16,236 (annual salary of $82,000 x .10 x 1.5 years x 1.32 for fringe benefits) The Project Director role will be filled by **Rachel Post, L.C.S.W**., the Director of Supportive Housing and Employment at CCC. Ms. Post has direct experience in the focus of this project having served as the Project Director for the SSA HOPE grant awarded to the Colorado Coalition for the Homeless in 2003 which has received national recognition for its successes. Additionally, Ms. Post has over 13 years of experience, from front line social worker to administrative designer, implementer and supervisor of supported employment and intensive case management programming. While 5% of Ms. Post's time will be provided in-kind by CCC, 5% ($8,118) is requested from this PPH grant.

Old Town Clinic Director **in-kind** @ 5% FTE = $8,118 (annual salary of $82,000 x .05 x 1.5 years x 1.32) **Ted Amann, MPH, RN**, the Director of Healthcare and Improvement for Central City Concern. Mr. Amann oversees healthcare for the homeless services at Old Town Clinic and the Recuperation Care Program, and quality management for all CCC health and recovery services. Ted is recognized as an expert in the area of integrating primary care and behavioral health services, and has worked in clinical, regulatory, and managed care settings.

CCC Medical Director **in-kind** @ 5% FTE = $10,692 (annual salary of $108,000 x .05 x 1.5 years x 1.32) **Rachel Solotaroff, MD,** maintains an assistant professorship in the Division of General Internal Medicine and Geriatrics at Oregon Health and Science University, and is the co-founder of the Division's award-winning Social Medicine Curriculum, in partnership with Central City Concern.

BEST Team Leader @ 100% FTE = $83,160 (annual salary of $42,000 x 1.5 years x 1.32) **Mellani Calvin**, who currently works as a Benefits and Entitlement Specialist for CCC's Community Engagement Program has been assisting people through the SSI- SSD application process for over six years. Ms. Calvin will serve as a full time Team Lead on the BEST grant, responsible for hiring, training and supervising staff. As a Social Security Disability paralegal for three and a half years prior to her employment with CCC, Ms. Calvin worked on over 700 claims. Funding for this position is being made available through the City grant, anticipated to be awarded in January and the SAMHSA grant which has already been secured.

BEST Benefit Specialists @ 200% FTE = $134,640 (annual salaries of $34,000 x 2 staff x 1.5 years x 1.32). These positions will be recruited upon availability of the City grant which is anticipated to be awarded in January and the SAMHSA grant.

BEST Clerical/Data Specialist @ 100% FTE = $55,440 (annual salary of $28,000 x 1.5 years x 1.32) This position will be responsible for the collection of medical records and compiling all documentation for fully supported SSA applications. This position will also be responsible for data entry and management necessary to tracking total project outcomes. Funding for this position is being made available through the City grant and will be recruited upon award of those funds.

Self-Sufficiency Project Manager @ 100% FTE = $99,000 (annual salary of $50,000 x 1.5 years x 1.32) **This position will be hired should CCC receive the PPH grant award** and will be responsible for researching and strategically planning efforts to provide employment programming to those who do not qualify for disability benefits but who have multiple obstacles to employment. This position will work under the direct supervision of the Project Director and closely with the CCC executive management.

JOIN/TPI Case Managers @ 200% FTE = $150,480 (annual salary of $38,000 x 2 x 1.5 years x 1.32)

These positions will be responsible for assisting their agency clients in securing benefits and entitlements and accessing needed housing and services while they await the processing of their applications. These staff will assist clients in getting to all appointments required through the application process, including those with medical providers trained in documented disabilities. **These positions will be funded through this PPH grant and will be recruited should CCC be granted these funds.**

CCC Case Managers @ 200% FTE = $150,480 (annual salary of $38,000 x 2 x 1.5 years x 1.32)
These positions will be responsible for assisting CCC clients in securing benefits and entitlements and accessing needed housing and services while they wait the processing of their applications. These staff will assist clients in getting to all appointments required through the application process, including those with medical providers trained in documented disabilities. These positions are being provided in-kind through other sources of SAMHSA, HUD and City funds.

Medical Provider @ 55% FTE = $108,900 (annual salary of $100,000 x 55% x 1.5 years x 1.32)
This position will dedicate time to performing disability exams and narratives for the SSI/DI applications and will be trained, along with the Medical Director and other providers by Oregon DDS and the National Health Care for Homeless Council using a published curriculum. **$29,700 of this position is being requested through this PPH grant** and the rest will be provided in-kind by Old Town Clinic.

Neuropsychologist @ 30% FTE = $51,750 (annual salary of $113,850 x 30% x 1.5 years x 1.32) This position will be dedicated to working with those clients who have an extensive substance abuse history and will qualify based on their cognitive deterioration from years of abuse. Dr. Virginia Luchetti in California has been recognized for her successes in documenting disability of 50 street homeless with primary substance use disorders and has communicated interest in providing training to a local Dr. should this grant be awarded. Funds for this position are being included in the City award.

JOIN Manager **in-kind** @ 10% FTE = $9,702 (annual salary of $49,000 x 10% x 1.5 years x 1.32) This person will participate in the selection and supervision of their Case Manager and in the ongoing Advisory Board.

TPI Manager **in-kind** @ 10% FTE = $8,712 (annual salary of $43,560 x 10% x 1.5 years x 1.32) This person will participate in the selection and supervision of their Case Manager and in the ongoing Advisory Board.

City Liaison **in-kind** @ 10% FTE = $13,860 (annual salary of $70,000 x 10% x 1.5 years x 1.32) This position is being appointed by Commissioner Erik Sten and will be occupied by Marshall Runkel of the Bureau of Housing and Community Development (BHCD). In addition to the many resources and funds BHCD brings to provision of services and housing for homeless service agencies, BHCD is charged with the oversight of Portland's 10 Year Plan to End Homelessness and Marshall has been working closely with the efforts to build this project for the last several months. He will participate in the bi-monthly Advisory Board and will work closely with the Project Director on the dissemination of data and findings of this project to the larger federal, state and local stakeholder community.

A 10% indirect rate is being applied to this project with $28,729 being requested for the personnel covered by this grant with the remaining $61,388 covered by the other funding streams or in-kind.

MATERIALS & SUPPLIES
Old Town Clinic build-out funds are needed to accommodate the new BEST+ team's office space. As none of the other sources available for this program will allow for capital expenses, CCC requests

$40,000 from this grant so that we may remodel clinic space to fit these staff into it or across the street at the Central City Concern Recovery Center. Co-location of this team with medical staff is critical to the success and efficient use of time of project staff. The portion of the build-out requested is solely for the purpose of this team. The $40,000 is an educated conservative estimate provided by the Director of Housing Development who has been responsible for financing and coordinating all CCC's housing development projects, including the award winning 8 NW 8th, the home of the Old Town Clinic. The estimated $40,000 includes architecture time, materials and supplies, labor (builders, electricians, IT), licenses and other expenses to be determined based upon the design. Additionally, these funds could be used to leverage additional build out funds through a grant from Covidien and National Association of Community Health Centers that requires private match and is due on 12/31/07. These leveraged build-out funds are needed to further expand patient capacity.

Rent is calculated at $2,000 per month (including utilities). The total rent costs for this project period is $36,000. Of this, CCC requests $9,000 to be covered by this grant while the other $27,000 will be covered by the City grant.

Four computers ($1,000 each or $4,000 in total) are needed for this project (one for the Team Lead, one for the benefits specialists, one for the Self-Sufficiency Project Manager and one for the Data Specialist). The City budget includes $2,000 for 2 computers and we request another $2,000 from this grant.

A portion of the clinic's copy machine leases will be charged to this project for a total of $2,000 to be covered by City funds.

Four desks are required for the staff of this project at a cost of $300 per desk/chair. The City budget will pay for 2 of these while we ask $600 from this grant to fund the other 2.

A printer is required by this team and the City budget will allocate $1,000 for this.

TRAVEL EXPENSES

Both Benefits Specialists and the TPI and JOIN Case Managers will need to drive as a part of their job description so that they may locate their clients and transport them to various appointments so $4,320 is requested for parking. Parking is calculated at a rate of $60 per month x 4 staff x 18 months. While the City budget will pay $2,160, another $2,160 is requested through this grant.

Additionally staff will be reimbursed for mileage at the government rate of .485 cents per mile. We anticipate an average of 50 miles per week x 52 weeks x 4 staff x 1.5 years or a total of $7,566. Of this, the City budget includes $3,783 and we request the other $3,783 through this grant.

SUMMARY

The total project budget is $1,910,633. The request for PPH grant of $373,570 calculates out to 19% of the total project budget. For every $1 Providence Partners in Health spends on this project, $4 has been leveraged through federal and city funds. Of the total requested $375,351 from the City, $125,117 is committed through the Fall Bump for the next 6 months and the remaining $250,234 is intended for next year's City budget for the following 12 months. While the total revenue generated from this project is $2,125,267 and the total expenses are $1,910,633, the excess of $214,634 results from the estimated Medicaid and Rent Subsidy revenue generated over a 12 month period and resulting from SSI/DI and Medicaid/Medicare awards. These excess funds will be used to sustain the project beyond the funding cycle.

V. PROJECT TIMELINE AND KEY BENCHMARKS

	Project Manager	Team Lead	Self-Suff Program Manager	Medical Direct	OTC Dir.	Partners (DDS, SSA, JOIN, TPI, City)	Qrt 1	Qrt 2	Qrt 3	Qrt 4	Yr. 2
1. Secure Project Partnerships											
1.a Develop and sign MOU with SSA Region 10 and Oregon Disability Determination Services **!!**	P					S	**X**				
1.b Develop and sign MOU between CCC, JOIN, TPI and City	P					S	**X**				
1.c Convene project Advisory Board	P					S	**X**	x	x	x	xx
2. Implement SOAR model											
2.a Hire and train BEST team	S	P					**X**				
2.b Hire and train medical provider	S			P	A		**X**				
2.c Provide training by DDS and HCH	A	S				P	**X**				
3. Process 120 application per year by end of project											
3.a Recruit eligible applicants	A	P		S		S	**X**	x	x	x	xx
3.b BEST staff work closely with trained providers	A	S		P	S	A	**X**	x	x	x	xx
3.c Work closely with SSA and DDS on completion of application	A	P		S		S	**X**	x	x	x	xx
3.d BEST staff submit fully documented applications based on SOAR principles **!!**	A	P				S	**X**	x	x	x	xx
3.e File Medicaid/Medicare applications **!!**	A	P		S		A	**X**	x	x	x	xx
4. Implement Self Sufficiency Programming											
4.a. Hire and train Self Sufficiency Manager	P					A	**X**				
4.b. Research innovative programming used to promote access to employment for those with multiple barriers. Present findings to key stakeholders	S	P				A	**X**	x	x		
4.c. Develop strategic plan around adoption of models approved by the Executive Team **!!**	S	P				A				**X**	xx
5. Disseminate findings to the broader community.											
5.a. Track data identified in evaluation plan	S	P		S	A		**X**	x	x	x	xx
5.b Generate and disseminate quarterly and final reports documenting progress to federal, state and local stakeholders to support sustainability and expansion **!!**	P	S	S			S		**X**	x	x	xx

Key: P= Primary responsibility; S= Secondary or Shared responsibility; A= Advisory capacity	**X** = event or onset activity x= ongoing activity	**Key Benchmarks = !!**

VI. PROJECT EVALUATION PLAN AND MEASURES OF SUCCESS

BEST+ will use the same methods of evaluation used by Denver's Colorado Coalition for the Homeless and will track the following data elements:

- Demographics: Age, Gender, Race, Ethnicity, Marital Status, Language, Housing status, Disability type
- Date of enrollment
- Date "Medical Home" is established
- Date of medical documentation of disability by CCC OTC medical provider
- Date of application submission
- Date received by Disability Determination Services (DDS)
- Name of DDS analyst
- Date of decision
- Decision outcome: Approved or Denied
- Date of request for Reconsideration
- Date of decision
- Decision outcome: Approved or Denied
- Date of request for Appeal Hearing
- Date Hearing scheduled
- Hearing Decision
- Date housed and housing tenure
- Date employed and employment tenure
- Total face to face encounters
- Total collateral encounters
- Type of encounter: Medical, Application preparation, Outreach, Accompanying to appointments.

The Clerical/Data Specialist funded through this grant will maintain these data fields and data reports will be used as a feedback loop to inform quality improvement activites to both the team and the monthly Advisory Committee comprised of CCC, JOIN, TPI, the City, SSA and DDS. This information was critical to refining the process in the Denver program and will be essential to recording the efforts needed to document efficacy. Additionally this data will inform where we are with the measures of success identified in the narrative above. CCC is very fortunate to have two data bases that will be used to collect the above elements. The first is the Old Town Clinic's AcuDetox, an electronic medical record that tracks patient's encounters. The HUD mandated Homeless Management Information System "Service Point" was implemented Portland in 2005 with CCC being one of the very first providers to pilot it. We currently use HMIS to produce multiple reports to HUD, the City and the County. The City has committed their HMIS department to assuring that we may add fields needed to track the above data.

A process evaluation will be used to measure the success of the Self-Sufficiency initiative and will document the following:

- Knowledge obtained through research efforts of programs nationally
- Survey and findings of needs assessment conducted with consumers who would benefit from programming
- Stakeholders involved in reviewing and recommending areas to target
- Recommendations made for focused strategic plan
- Actions taken and results achieved through implementation of strategic plan

CCC has successfully evaluated hundreds of grant funded projects over the 30 year history of this agency and will use the expertise of partners, our IT department and the City HMIS team to assure an accurate and thorough evaluation and detailed documentation of the measures of success resulting.