

March 2011



# Integrating FQHC Health Care Services with Permanent Supportive Housing in Los Angeles



United Homeless Healthcare Partners





# Contents

4	<b>ACKNOWLEDGMENTS</b>
5	<b>PREFACE</b>
6	<b>INTRODUCTION</b>
8	<b>SETTING FOUNDATIONS: UNDERSTANDING EACH OTHER’S BUSINESS</b>
8	Defining Permanent Supportive Housing
10	Financing Permanent Supportive Housing
11	Defining Roles in Permanent Supportive Housing Developments
12	Defining Federally Qualified Health Centers
12	Financing FQHCs
15	FQHC Clinics and Satellites
19	Defining the Target Population and Understanding Their Service Needs
22	<b>THREE PROGRAM MODELS IN LOS ANGELES</b>
23	Project-based Services with On-site Satellite Clinic
29	Mobile Services
33	Off-site Clinic-based Services
37	Securing Start-up Funding
37	Evaluating Integrated Health Care Projects
38	<b>DEVELOPING SERVICE PARTNERSHIPS</b>
38	Identifying Potential Partners
39	Building a Shared Culture and Governance Structure
42	<b>“OPERATIONALIZING” IT ALL</b>
42	Planning Process
44	Feedback and Process Improvement Loop
46	<b>APPENDICES</b>
46	Appendix A: Steps to Creating an Effective Partnership
46	Appendix B: Zoning
51	Appendix C: Funding Sources
51	Sources of Capital Funding in Los Angeles, California
55	Sources of Operating Subsidies and Rental Assistance Funding in Los Angeles, California
56	Sources of Services Funding in Los Angeles, California

# Acknowledgments

**Alvaro Ballesteros**, MBA, Chief Executive Officer, JWCH Institute, Los Angeles, CA

**Joshua Bamberger**, MD, MPH, Medical Director, Housing and Urban Health, San Francisco Dept. of Public Health, San Francisco, CA

**Elizabeth Boyce**, LCSW, Homeless Coordinator Los Angeles County Chief Executive Office, Los Angeles, CA

**Peggy Edwards**, MPA, Executive Director, United Homeless Health Care Partners, Los Angeles, CA

**Elena Fiallo**, MTOM, L.Ac., Consultant United Homeless Healthcare Partners, Los Angeles, CA (*Principal Author*)

**Maria Funk**, Ph.D., Mental Health Clinical District Chief, Adult Justice, Housing, Employment & Education Services, Los Angeles, CA

**Dana Knoll**, MBA, Director Administrative Operations, Watts Healthcare Corporation, Los Angeles, CA

**Leila Towry Kumar**, MA, Project Director, San-West Health and Housing Collaborative, A Community of Friends, Los Angeles, CA

**Annie Lainer**, J.D., Staff Attorney, Public Counsel, Los Angeles, CA

**Jeanne Lam**, Chief Financial Officer, JWCH Institute, Los Angeles, CA

**James O'Connell**, M.D., President, Boston Health Care for the Homeless Program, Boston, MA

**Kathy Proctor**, MPH, MSHA, Clinic Administrator, Northeast Valley Health Corporation, San Fernando, CA

**Molly Rysman**, Director of External Affairs Skid Row Housing Trust, Los Angeles, CA

**Edward Sanders III**, Grant Development Specialist, Northeast Valley Health Corporation, San Fernando, CA

**Carol Wilkins**, MPP, Consultant, CA

**This report was produced with support from the Conrad N. Hilton Foundation and The California Endowment.**



Photography courtesy of CSH, Steve Solis, Larry Underhill.  
Pictured: Downtown Women's Center; Downtown Women's Center Housing LLC, developers  
Abbey Apartments; Skid Row Housing Trust, developer

# Preface

This guide is the result of collaborative efforts between Corporation for Supportive Housing (CSH) and United Homeless Healthcare Partners (UHHP), a network of homeless healthcare service providers; social service organizations; private health providers; professional associations; city, county, and federal officials; and other key stakeholders, whose vision is to solve the homeless healthcare crisis in Los Angeles County. CSH is a national nonprofit intermediary and community development financial institution that helps communities create permanent housing with services to prevent and end homelessness.

This guide is intended to complement and serve as a companion piece to *Defining and Funding the Support in Permanent Supportive Housing: Recommendations of Health Centers Serving Homeless People*, prepared for CSH in February 2008 by Patricia A. Post, MPA, Policy Analyst of National Health Care for the Homeless Council. The report was the product of a series of roundtable discussions with a working group comprised of Health Care for the Homeless/Community Health Centers (HCH/CHC) providers and supportive housing experts from throughout the country whose charge was to identify program models, health service delivery and financing approaches in permanent supportive housing over a 10-month period from November 2006–August 2007.

The roundtable participants were from cities throughout the country, both large and small, including one representative from Los Angeles County Community Health Clinics. At the time, there were only one HCH/CHC in Los Angeles providing services in permanent supportive housing—the newly designated Federally Qualified Health Center (FQHC), JWCH.

Building on the work of the national report, and extrapolating from our neighbors in San Francisco and Oakland, CSH committed to increasing the capacity of FQHCs participating in supportive housing in Los Angeles County.

In the summer of 2008, CSH facilitated a peer-to-peer knowledge exchange and site visit between Southern California and Northern California FQHCs and permanent supportive housing developers. With funding from The California Endowment, CSH provided planning and operating grants to participating Los Angeles clinics so they could further explore partnering with permanent supportive housing developers. UHHP received a grant to produce this how-to guide for Los Angeles-based FQHC's and permanent supportive housing developers. The guide explores funding, operational and partnership matters between permanent supportive housing developers and FQHCs in Los Angeles County. It is the intention of the collaborators of this guide to produce subsequent materials that address additional Los Angeles County-specific types of services in permanent supportive housing.



# Introduction

**P**ermanent supportive housing—permanent, affordable housing linked to health, mental health, employment and other support services—is a proven, cost-effective way to end homelessness for people who face the most complex challenges. By providing chronically homeless people with a way out of expensive emergency public services and back into their own homes and communities, supportive housing not only improves the lives of its tenants, but also generates significant public savings.

Permanent supportive housing is designed to serve those who would not be able to stay housed without a wide range of supportive services. People living in supportive housing usually have a long history of homelessness and often face persistent obstacles to maintaining housing, such as a serious mental illness, a substance use disorder or a chronic medical problem. Many tenants face more than one of these serious conditions. While services are necessary to help tenants maintain stability, being housed is an essential first step in addressing conditions that often have gone untreated for many years. Therefore, the combination of housing and supportive services creates a synergy that allows tenants to take steps toward recovery and independence.<sup>1</sup>

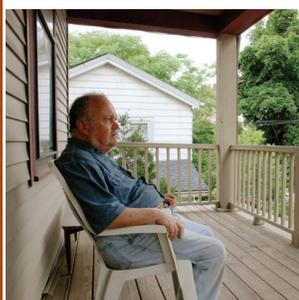
Federally Qualified Health Centers (FQHCs) are Medicaid-funded, neighborhood-based health service providers that are charged to serve underserved persons in their targeted area and must provide more than primary health care services, including behavioral health, nutritional counseling and some case management. The mission and service approach of FQHCs are similar to those of supportive housing providers, and both are usually located in the same neighborhoods. Therefore, tapping into this resource makes both economic and programmatic sense. The FQHC provides many of the additional services that high-need populations require.<sup>2</sup>

United Homeless Health Care Partners (UHHP) and Corporation for Supportive Housing (CSH) have partnered to create this how-to guide for permanent supportive housing developers and FQHCs to outline the operational considerations and implementation steps necessary for integrating health care into permanent supportive housing. The goals of the project are to (1) demonstrate that integrating FQHC primary healthcare can be a replicable and financially sustainable model for providing services to tenants of permanent supportive housing in Los Angeles County, (2) facilitate a community learning process amongst permanent supportive housing developers and FQHCs, and (3) foster the creation of new permanent supportive housing projects that are integrated with FQHC healthcare services throughout Los Angeles County.

To help demystify the complexities of integrating permanent supportive housing projects with healthcare service projects, UHHP has conducted interviews and gathered information from local projects and those around the country. Simultaneously, UHHP and CSH held quarterly meetings with representatives of organizations and government agencies in Los Angeles County, including FQHCs and permanent supportive housing developers currently planning or operating a project with integrated healthcare services, in order to identify questions that need to be addressed before

<sup>1</sup> CSH Policy Brief Supportive Housing Research FAQs: Who Lives in Supportive Housing? <http://documents.csh.org/documents/policy/FAQs/WhoLivesInSHFAQFINAL.pdf>

<sup>2</sup> Potential Opportunities for Funding Supportive Housing: FQHCs, ACT Teams and Supportive Housing Collaboration. October 2005. <http://documents.csh.org/documents/ResourceCenter/SysChgToolkit/FinancialLeverage/FQHCsACTTeamsandSH.pdf>



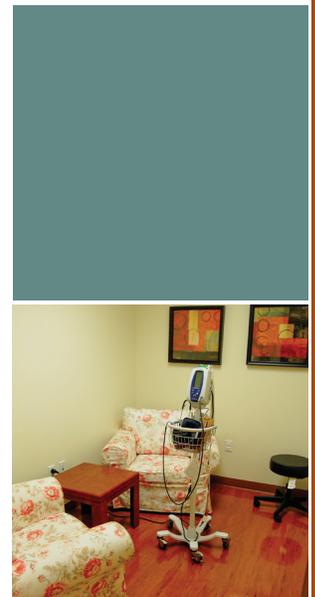
organizations can commitment to developing or partnering on a permanent supportive housing project with integrated health care. The group shared information and learning from one another in a quarterly community forum. (Note: The authors would like to acknowledge that there is continued discussion in the health and behavioral health community about defining integrated health care. For the purposes of this guide we mean health and behavioral health care services integrated into the overall services of a permanent supportive housing project.)

The objectives of the research were to understand what information organizations need before they can begin planning an integrated health care project, and to gather answers from both local and national sources to provide feedback to those questions at the quarterly forums. As we organized and categorized the questions that were raised during the forums, it became evident that understanding the operational aspects of various service models, understanding the cost of each model and forecasting potential Medi-Cal revenue were of utmost importance to the group. The research began by speaking to Dr. Jim O'Connell of Boston's Healthcare for the Homeless Program and Dr. Josh Bamberger of San Francisco's Direct Access to Housing Program to glean a basic understanding of how they have been able to ensure the financial success of their projects by off-setting large scale project budgets with Medicaid/Medi-Cal reimbursement. We also received local insight and strategy in addressing questions from the following Los Angeles County organizations and projects:

- Project 50
- Rainbow Apartments
- The Abbey Apartments
- JWCH Institute, Inc.
- San-West Collaborative
- North East Valley Community Health Corporation
- Watts Healthcare Corporation

The information gathered as part of this ongoing dialogue is by no means exhaustive and reflects the knowledge at the time it was gathered. As we speak, project leadership are fine tuning their projects, budgets and revenue projections based on the successes and shortcomings of the projects as they mature past the second operating year.

This guide presents the research and reflections of the collaborative learning process over the past two years. It is an evolving body of knowledge that changes and shifts as our existing projects mature and new projects come on line, each contributing valuable insight to the collective dialogue. While not an exhaustive operations manual, the guide provides a basic framework for creating a permanent supportive housing project integrated with health services and explores some operational considerations during the planning and implementing phase. The development of integrated projects can occur before, during or after a permanent housing development has been completed, although it is generally suggested that the planning for services occur during the initial stages of a housing development. The flow chart included as Appendix A of this guide offers a suggestion of how to think about and plan for an integrated health care project in the development of a permanent supportive housing project.



# Setting Foundations: Understanding Each Other's Business

In order to create financially sustainable and programmatically stable projects, it is important to understand the basic business operations of FQHCs and permanent supportive housing developers. Taking the time to understand how your potential project partner does business can avoid common misunderstandings and project delays. Too often we operate in service silos and forget that our business structure, daily operations, client engagement practices, treatment philosophies and community change strategies may not be shared or even known by potential community partners in another service sector. For example, while permanent supportive housing developers have been providing services to homeless and chronically homeless individuals and families as their primary target population, FQHCs may not have the same experience providing services to homeless individuals and may not understand the evidence-based practices and engagement strategies utilized to engage clients. Conversely, permanent supportive housing developers may not fully understand the scope of work and responsibilities of an FQHC or the medical interventions used to manage chronic illness. To avoid any miscommunication and/or false assumptions several years into a project, it is strongly suggested that both organizations take the time to develop a basic understanding of each other's business.

## Defining Permanent Supportive Housing

Permanent supportive housing is a successful, cost-effective combination of affordable housing with services that helps people live more stable, productive lives. The effectiveness of permanent supportive housing in ending homelessness has depended upon a willingness to take risks and experiment with new models, approaches and strategies. CSH's approach and strategies continue to evolve as we learn more about what practices are proving most effective.

CSH defines permanent supportive housing by the following elements:<sup>3</sup>

- The unit is available to and intended for a person or family whose head of household is homeless or at-risk of homelessness, and has multiple barriers to employment and housing stability, which might include mental illness, chemical dependency and/or other disabling or chronic health conditions.

---

<sup>3</sup> This definition reflects CSH's perspective that service participation should not be a condition of tenancy in supportive housing, and that harm reduction and housing first strategies have been shown to be effective approaches. CSH recognizes, however, that a variety of housing options are needed to end homelessness. Therefore, we continue to engage in, and learn from, constructive dialogues on these and other issues with our provider and advocacy partners in the housing, supportive services and disability rights communities, and with all those engaged in efforts to end homelessness.

- The tenant household ideally pays no more than 30% household income towards rent and utilities, and never pays more than 50% of income toward such housing expenses.
- The tenant household has a lease (or similar form of occupancy agreement) with no limits on length of tenancy, as long as the terms and conditions of the lease or agreement are met.
- The unit's operations are managed through an effective partnership among representatives of the project owner and/or sponsor, the property management agent, the supportive services providers, the relevant public agencies, and the tenants.
- All members of the tenant household have easy, facilitated access to a flexible and comprehensive array of supportive services designed to assist the tenants to achieve and sustain housing stability.
- Service providers proactively seek to engage tenants in on-site and community-based supportive services, but participation in such supportive services is not a condition of ongoing tenancy.
- Service and property management strategies include effective, coordinated approaches for addressing issues resulting from substance use, relapse and mental health crises, with a focus on fostering housing stability.

## A Range of Housing Models

While there may not be a single perfect model, there are a number of preferred models for permanent supportive housing. The housing setting will vary dramatically and be based on a range of factors including the tenant's preference, the type of housing stock available and the norms and history of a local community's real estate market, and might include:

- Single Site Models
  - > Apartment or single-room occupancy (SRO) buildings that exclusively house formerly homeless individuals and/or families.
  - > Apartment or SRO buildings, that mix special-needs housing with general affordable housing.

- Scattered Site Models
  - > Townhouses or single-family homes that exclusively house formerly homeless individuals and/or families.
  - > Rent-subsidized apartments leased in the open market.
  - > Long-term set-asides of units within privately owned buildings.

The housing model will influence the type of services that can most effectively and efficiently be delivered.

## Services Typically Offered in Permanent Supportive Housing

Ideally, supportive services are reflective of the tenants' needs and goals. Service programs also require adjustment as the needs and interests of the individual tenants and the larger permanent supportive housing project community evolve and change. By design, supportive housing support services are intended to help ensure stability and to maximize each tenant's ability to live independently. Support services must be easily accessible and available to tenants, and evaluation of services for effectiveness and usefulness should occur on a regular basis.<sup>4</sup> The following list of services is a sample of the types of services that can be offered in permanent supportive housing. It is also worth noting that services are entirely voluntary and therefore the housing staff plays a critical role in engaging tenants to access available services.

- Case management
- Support groups: substance use, behavioral health
- Life skills: cooking, GED preparation, money management
- Health and mental health services
- Employment services: vocational counseling, job placement
- Linkage to legal services

<sup>4</sup> Corporation for Supportive Housing. (n.d.). Understanding Permanent Supportive Housing. In *Toolkit for Developing and Operating Supportive Housing*. <http://www.csh.org/index.cfm?fuseaction=Page.ViewPage&PageID=3663>

## Financing Permanent Supportive Housing

The financing of permanent supportive housing requires three different types of funding: capital, operating and services. The capital sources are used to acquire and develop the physical structure. The operating sources are usually in the form of operating subsidies/rental assistance and are used to maintain the structure on a day-to-day basis once it is operational. Service funds provide a wide range of services to the tenants. Specific sources of each of these types of funding available to develop, operate and provide services permanent support are described in Appendix C. *To get additional details and to confirm application requirements and due dates, it is best to check the website for the funding source you are researching and to contact the appropriate department directly.*

### Capital Sources

Capital (or development) financing sources are those sources that may be used to fund the costs associated with acquiring, creating, and/or rehabilitating housing units, costs sometimes referred to as “bricks and mortar” costs. Eligible uses of these sources generally fall into two broad categories: hard costs and soft costs:

- Hard costs include such items as land acquisition, construction and rehabilitation work, and off-site improvements (such as sewers or utilities).
- Soft costs include such items as architectural services, appraisals, engineering, legal costs, fees and permits and rent-up costs.

A significant portion of capital financing originates at the level of the federal government, including funding administered by the U.S. Department of Housing and Urban Development (HUD). Other significant sources of financing for housing development that originate at the federal level include the Federal Home Loan Bank (FHLB) Affordable Housing Program (AHP), administered by FHLB District Banks; and Low Income Housing Tax Credits, primarily administered by state housing finance agencies.

In addition to administering federal block grant funds for housing development, most states have developed their own locally generated funding sources. Typically, state governments attempt to develop dedicated revenue streams to fund housing programs, rather than tapping into state general funds. The majority of state programs for housing development are accessed by developers for a specific project through competitive application processes, announced through Request for Proposals. At city and county levels, government agencies also administer a variety of capital financing programs, many of which use funding that originated at either the federal or state level. A significant number of local governments have also created local Housing Trust Funds or identified other funding streams to support housing development activities.

### Operating Sources

Operating sources are those sources that may be used to pay for the costs of operating and/or maintaining the housing or physical component of permanent supportive housing. Rent is the primary source of funds to cover the operating costs of a building. Operating costs in a project owned by a housing sponsor include all costs of maintaining the project once it is ready for occupancy, such as property management, utilities, maintenance, insurance, security, debt service or other loan payments, and operating and replacement reserves. Operating subsidies supplement the difference between what the tenant can afford to pay and the rent that could be charged under market-rate conditions.

### Service Sources

Funding for program services typically covers personnel costs associated with providing supportive services that assist tenants in maintaining their housing. These sources cover the cost of services such as case management, benefits assistance, vocational training, health care, mental health care, substance use counseling and life skills.

# Defining Roles in Permanent Supportive Housing Developments<sup>5</sup>

The successful development and operation of permanent supportive housing requires the integration of diverse skills and activities—and there are several major roles that non-profit organizations can play in the development. These roles can be described as follows:

## Owner

The owner has the ultimate long-term legal responsibility and control. The owner assumes a tremendous amount of responsibility for the long-term success of the development efforts and for the successful operation of the permanent supportive housing project. As the owner, an organization can expect:

- To have the principle long-term interest in seeing the project completed.
- To drive the planning and development process. Even if another entity is serving as the developer for the project if a development consultant is acting as project manager, the owner must be fully engaged in the development process to ensure that its long-term interests are being addressed.
- To need to dedicate in-house staff to oversee the project, even if partnering with a developer. The staffing patterns and levels required will depend upon the extent of the organization's involvement in the development process. But even when the organization is playing a relatively limited role, the need to dedicate at least one staff member working at least one-quarter to one-half time can be expected—it will not be possible for staff to perform the responsibilities simply in their spare time.

## Developer

The developer is responsible for bringing the development activities to completion, taking the permanent supportive housing project from “idea” to “ready for occupancy.” There are a variety of options for an organization to ensure that all of these responsibilities are fulfilled, including:

- Being responsible for all project development tasks and the overall management of the project in-house.
- Hiring a development consultant to manage the project based upon the organization's input.
- Partnering with a non profit developer or, in some cases, a for-profit developer, to take the lead role in developing the project, based upon the organization's input.

## Property Manager

The property manager is responsible for day-to-day operations of the project once it is completed, and is key to the financial and physical viability of the project over time. The management of the property is vital to the ongoing success of the project once it is completed. Managing a property is a complex endeavor that requires skill, experience, and familiarity with legal issues and funder requirements. It is critical that the property be managed in compliance with all local, state and federal laws that govern fair housing and the landlord-tenant relationship. Further, it is critical that the maintenance of the project will ensure its long-term viability and protect the investments that have been required to create the housing.

## Service Provider

The service provider leads the delivery of support services to residents—in effect, their work turns affordable housing into permanent supportive housing. The provision of supportive services is an essential component of any permanent supportive housing project. A single service provider may provide the majority of the services, but in most cases there will be more than one service provider to address the varied need of the residents. A lead service provider is typically needed to ensure the ongoing and effective functioning of the services program, especially if a variety of partner organizations will be involved in the delivery of services to tenants. The lead service organization should serve as the lynchpin for coordinating the delivery of services provided by other organizations, evaluating the outcomes of those services and ensuring that tenants are receiving the services necessary to achieve and maintain housing stability. Experience in providing coordinated service programs in collaboration with other organizations, and experience in case management or service coordination within housing environments will be critical to success in this role.

<sup>5</sup> Corporation for Supportive Housing, *Roles in Supportive Housing Development and Operations*. March 2006. <http://documents.csh.org/documents/ResourceCenter/DevOpsToolkit/DevRolespdf.pdf>

All four of these roles are critical to the success of a permanent supportive housing project—and all four roles are very different. In some cases a single organization may play all of these roles. More frequently, however, permanent supportive housing projects require partnerships with one or more non profit organizations and, in some cases, for-profit corporations. Supportive housing development is a complex, unpredictable and risky endeavor. An organization needs to make a careful, informed choice regarding the role(s) it will play in the ownership, development and operation of a new permanent supportive housing project. Regardless of whether it is their first or fifteenth project, all organizations should formally examine the role(s) they expect to perform within the project—even the most sophisticated organizations periodically benchmark their development activities against their mission and reevaluate how they are deploying their resources.

## Defining Federally Qualified Health Centers

An FQHC is a federal designation from the Bureau of Primary Health Care and the Center for Medicare and Medicaid Services that is assigned to private non-profit or public health care organizations that serve predominantly uninsured or medically underserved populations. An FQHC may be freestanding in a permanent location or in a mobile structure with a fixed, scheduled location. Alternately, the FQHC may be provider-based, that is, ‘an integral and established part’ of a Medicare-participating hospital, nursing facility, or home health agency operating under common licensure, governance and professional supervision.<sup>6</sup>

- FQHCs must be located in or serving a federally designated Medically Underserved Area/Population.
- All FQHCs must directly provide comprehensive primary health and directly provide or provide by arrangement with another provider oral and mental health/substance abuse services to persons of all ages.

<sup>6</sup> Texas Association of Community Health Care Centers. (n.d.). FQHC Governance Requirements. In *Section 330 Program Requirements*. [http://www.tachc.org/Community\\_Resources/Community\\_Development/Requirements.asp](http://www.tachc.org/Community_Resources/Community_Development/Requirements.asp)

- FQHCs provide their services to all persons regardless of ability to pay, and charge for services on a sliding-fee scale that is based on patients’ family income and size.
- FQHCs must comply with Public Health Service Act Section 330 program expectations/requirements and all applicable federal and state regulations.

## Medicare/Medi-Cal Certification

All FQHCs must comply with federal, state and local regulations regarding location of the center, physical environment, organizational structure, staffing requirements, provision of services, patient health records and program evaluation. If the entity provides services in multiple locations, each location must be independently certified, unless it meets the requirements of a satellite clinic as discussed below. In Los Angeles County, the Department of Health Services certifies that each site meets Medicare/Medi-Cal standards.

## Financing FQHCs

Health Centers are funded through a competitive process under Section 330 of the Public Health Service Act. Section 330 defines federal grant funding opportunities for organizations to provide care to medically underserved populations. In addition, organizations may apply for supplemental grant funds to provide service to the target populations listed below.<sup>7</sup>

- 330 (g) supplemental funding to serve migrant and seasonal agriculture workers.
- 330 (h) supplemental funding to serve homeless individuals and families.
- 330 (i) supplemental funding to serve tenants in public housing.

Some Health Centers receive supplemental funding from 330 (h) Health Care for the Homeless (HCH) grants to provide targeted health care services for homeless individuals and families. Other centers are free standing HCH programs that serve *only* homeless people. Providers are able to utilize the supplemental funding to provide services to homeless

<sup>7</sup> Rural Assistance Center. (n.d.). FQHC Frequently Asked Questions. In *What is a PHS Section 330 Grant?* [http://www.raonline.org/info\\_guides/clinics/fqhcfqa.php](http://www.raonline.org/info_guides/clinics/fqhcfqa.php)

persons after they are housed, **but generally only for 12 months**. Afterwards, they can continue to receive services from the same health center if care is funded from Medi-Cal or other funding streams.

However, in March 2009, the federal Health Resources and Service Administration (HRSA) published a Policy Information Notice (PIN 2009-05) regarding requests for a change in scope to add a new target population for special populations-only grantees.<sup>8</sup> This policy applies to HCH/330 (h) grantees. The policy acknowledges that there are often legitimate reasons for a special populations-only grantee to respond to the demand for services to other underserved populations including “emerging population groups that may need special approaches to ensure access and the appropriate level of care.” The policy requires that the grantee request prior approval to expand its target population and use grant-supported resources to provide care that is beyond the designated population for which section 330 grant funds have been awarded, “if the new population is not part of the defined target population for which section 330 funding was awarded and it is/would be a significant portion of the total health center (e.g. more than 25 percent of the total health center patients are/would be from the new target population)...” The addition of the new target population must not result in the diminution of a health center’s level of services currently provided to the existing target population.

While HRSA has not provided HCH grantees with a formal policy, informal conversations with HRSA seemed to indicate that they would consider the following interpretation of the above PIN:

- A change of scope is not required if the permanent supportive housing tenants served by the HCH are fewer than 25% of the total patients served by the HCH.
- HRSA would be receptive to change of scope requests by HCH providers who want to continue to serve homeless clients after they move into supportive housing, even if the population of supportive housing tenants exceeds 25% of the patients served by the HCH, as long as the HCH could demonstrate that services to homeless patients have not been diminished.

---

<sup>8</sup> The link to the referenced PIN can be found at <http://bphc.hrsa.gov/policy/pin0905>

As indicated, there is still ambiguity around this issue and it is advised that each HCH project contact their HRSA representative for clarification of PIN 2009-05 and how it may be applied to specific projects.

The recently enacted Patient Protection and Affordable Care Act (PPACA) authorizes an increase in funding for Community Health Centers, including FQHCs, by \$11 billion from 2011-2016.<sup>9</sup> HCH clinics will receive 8.7% of the allocation. Although some of the funds require congressional appropriation, HRSA has already released a portion of the funding through supplemental funding of approximately \$335 million. The funding is designed to increase access to care among people who are uninsured, medically vulnerable or socially isolated. Each health center grantee will receive a base amount of \$175,000, as well as an additional \$4.00 per health center patient, and \$10.00 per uninsured health center patient. At least two-thirds of the funding must be used to reach new patients, including hiring new staff to perform outreach or to treat patients outside of the clinic. The remaining funding can be used to expand services. Community clinics can use the remaining funds for a variety of purposes, including provision of services, like case management, when dealing with permanent supportive housing. This funding, as well as future funding rounds, is a potential opportunity for clinics to create new partnerships with permanent supportive housing developers, as well as to strengthen existing partnerships.

FQHCs also bill Medi-Cal and/or Medicare on a per visit basis, according to the FQHC’s established rate. Medi-Cal, California’s version of the federal Medicaid program, is health care insurance provided to people who meet income eligibility criteria and who are either disabled, pregnant, or eligible for Cal WORKS (welfare). An FQHC may bill Medi-Cal for a visit if (1) the client is eligible for Medi-Cal benefits, (2) the service is within the scope of practice of the FQHC, (3) the appropriate FQHC staff has provided the service, and (4) the service was medically necessary.

Other funding such as Federal Community Health Center funding provides primary care services to “housed” patients. However, currently, most community health centers have very limited capacity to provide care for new uninsured adults.

---

<sup>9</sup> Patient Protection and Affordable Care Act, PL 111-148, 5601.

Finally, another source of funding through Los Angeles County is the Public Private Partnership (PPP) program, which reimburses health care services to indigent populations that are below 133% Federal Poverty Level (FPL). This is a very small source of funding and should be reserved for tenants that may not be eligible for other sources of funding.

Reimbursement through Medi-Cal provides financial sustainability to continue to provide services to supportive housing tenants on a long-term basis. Because eligibility for Medi-Cal for an indigent adult is currently tied to eligibility for Supplemental Security Income (SSI), that person must establish that he/she suffers from a disability that prevents him/her from engaging in any gainful employment existing in the national economy. The SSI application process can be lengthy, taking approximately 2-6 months depending on the strength of the application. Initiating an application should therefore be a top priority when the participant first enters the program. Many tenants in permanent supportive housing qualify for SSI, and therefore Medi-Cal, but the burden of proof is on the applicant to show that disability impairs their ability to obtain and retain gainful employment.

Beginning in 2014, under the PPACA, all indigent adults with incomes under 133% of the FPL will qualify for Medi-Cal. When Medi-Cal is expanded to all indigent adults in California, tenants in permanent supportive housing will no longer have to apply for SSI to receive Medi-Cal, significantly expanding a crucial funding stream to FQHCs.<sup>10</sup>

Moreover, beginning in 2011, under an 1115 Medicaid waiver California finalized with the Centers for Medicare and Medicaid Services on November 2, 2010 (the “Waiver”), California counties have the option of offering health insurance to adults not eligible for Medicare or Medi-Cal. Counties who choose this option will receive federal matching funds for the benefits the county offers. For enrollees of this option with incomes of 133% of FPL and below (who will be enrolled in the “Medicaid Coverage Expansion” portion of the waiver), federal matching funds will not be capped.<sup>11</sup> A county can also choose to offer services to people with incomes between 134% and 200% of FPL as well (enrollees of this option will be part of the “Health Care Coverage

Initiative”<sup>12</sup> under the Waiver). Federal funding for these programs is capped. The Waiver mandates a minimum set of benefits. These benefits include mental health services for the Medicaid Coverage Expansion enrollees.<sup>13</sup> At the time this guide is being written (December 2010), we do not know how Los Angeles County will implement the Medicaid Coverage Expansion or Health Care Coverage Initiative. However, Los Angeles County expects to enroll approximately 82,000 new enrollees into the Medicaid Coverage Expansion program, in addition to enrollees of a prior program designed to provide similar benefits to uninsured indigent adults that was implemented in 2007.

### FQHC Look-alikes

An FQHC Look-alike is an organization that meets all of the eligibility requirements of an organization that receives a PHS Section 330 grant, but does not receive grant funding. FQHC Look-alikes receive many of the same benefits as FQHCs, including:

- Enhanced Medicare and Medicaid reimbursement.
- Eligibility to purchase prescription and non-prescription medications for outpatients at reduced cost through the 340B Drug Pricing Program.
- Automatic designation as a Health Professional Shortage Area (HPSA). The HPSA designation provides eligibility to apply to receive National Health Service Corps personnel and eligibility to be a site where a J-1 U.S. Visa physician can serve.

### FQHC Billable Services and Staffing Requirements

Once a client is eligible for Medi-Cal benefits, FQHCs (and Look-alikes) can bill on a per visit basis for the services listed in the following table. It is important to note that in order for the service to be reimbursed, they must be provided by the appropriate staff, as designated by the State of California. Please also be aware that FQHC providers in California can be reimbursed for only one visit per day for primary and behavioral health services out of the same facility (primary and dental care may each be billed for services offered on the same day). *See Figure 1.*

<sup>10</sup> Patient Protection and Affordable Care Act, PL 111-148, 2001

<sup>11</sup> Centers for Medicare and Medicaid Services Special Terms and Conditions, California Bridge to Reform Demonstration, 48.a.i. (hereinafter California Waiver).

<sup>12</sup> Id. at 48.a.ii.

<sup>13</sup> Id. at 63-65.

Figure 1.

FQHC Billable Services	Staffing Requirements
Primary/Preventive Health Care	Medical Doctor (MD), Doctor of Optometry (DO), Nurse Practitioner (NP), Physician's Assistant (PA)
Chronic Disease Management/ Care Coordination	MD, DO, NP, PA
Health Education	NP or PA
Medical Nutrition Therapy	MD, DO, NP, PA
Preventive and Restorative Dental Services	Doctor of Dental Surgery (DDS)
Psychiatric Evaluation	MD only
Medication Management	MD, DO, NP, PA
Individual Psychotherapy	Licensed Clinical Social Worker (LCSW)/Doctor of Psychology (PsyD)/ Doctor of Philosophy, Psychology (PhD)

## FQHC Clinics and Satellites

Health care services may be provided in a variety of settings, including the primary FQHC facility, a satellite clinic, in a mobile van or in a client's residence, and will be determined by the model that is the best fit for your program.

A state licensed FQHC facility can serve as the primary site of health and mental health service provision for your integrated service team. It can also be the medical home to satellite clinics and/or mobile health care teams that deliver services on-site in single site and scattered site supportive housing projects. FQHCs can strategically place satellite clinics within a community in order to reach a wider segment of their target population. A satellite clinic can be physically located in a supportive housing facility. Satellite clinics can operate under the license of the medical home and do not need additional licensing if they meet the following conditions.

- Satellite clinics cannot operate for more than 20 hours per week and need to be linked to a health center that is licensed by the California Department of Health Care Services. If the clinic is operating for more than 20 hours per week, it must have its own license. To be safe, many FQHCs only operate for 15-19 hours per week and allocate the remaining hours for staff to complete any charts or administrative paper work.

- The satellite clinic can share its space with another service provider, but, in practice, this can be complicated given that an FQHC may need to utilize the room to store medications and/or other patient care supplies.
- Satellite clinic rules also apply to Mobile Health Care Vans.

## Staffing Integrated Services in Permanent Supportive Housing

While the staffing model for each team varies based on the needs of consumers at each site, the type of housing and the availability of resources in each community, a team should include the following.

FQHC staff will consist of various medical and mental health providers. An FQHC must be under the medical direction of a physician who may be an employee of the center. Its mid-level health professionals (e.g., physician assistants, nurse practitioners, qualified clinical psychologists, and clinical social workers) must be licensed or certified according to state and local laws and are able to bill encounters.<sup>14</sup>

<sup>14</sup> Grimaldi, Paul, Healthcare Financial Management, January 1993. <http://www.allbusiness.com/health-care-social-assistance/355573-1.html>

The following are examples of staff time relevant to permanent supportive housing sites:

- A **Mid-level Practitioner or Physician** to deliver primary medical care at the housing site at least once a week who can also see clients at a nearby full-service primary care clinic if needed.
- **Licensed Clinical Social Worker** to provide direct services or linkages to mental health and substance abuse treatment services.
- A **Medical Assistant** to provide services that are “incident to” the services of the physician, nurse practitioner, physician assistant, clinical psychologist or clinical social worker. The medical assistant’s services are not directly billable, but may be included in calculating the FQHC’s rate.
- **Benefits Eligibility Specialist** to enroll participants in Medi-Cal. Although many social service providers and some permanent supportive housing providers have this position on staff, FQHCs have invested in this position as well. This is a paraprofessional position and may be funded under 330 grants however, it is not directly billable.<sup>15</sup>

Housing management staff are usually employees or contractors of the housing operator. These costs are typically covered through rental revenue as building operating expenses.

- A **Property Manager** determines tenant eligibility, rent payment and building maintenance. The property manager’s priority is to represent the owner’s interest (i.e. through timely payment of rent, maintaining high occupancy, and maintaining the building). It is not expected that the property manager provide any social services.
- A **Service Coordinator** facilitates effective teamwork among property management and service provider partners to prevent and respond to crises and intervenes quickly to prevent loss of housing for tenants. The service coordinator also navigates community services, resources and relationships for the overall population of the building rather than specific tenants.

Supportive Services Staff may be employees of the housing provider if they have a separate supportive services department or they may be employees of a third supportive services

partner. Their costs are usually paid for through grants and contracts with human services agencies. The supportive service provider’s primary responsibility is to assist the tenant in maintaining tenancy.

- A **Case Manager** works one on one with assigned tenants of the supportive housing project; provides counseling, support, advocacy; and systems linkage and navigation.
- **Peer Support Staff** persons have personal experience with homelessness, mental illness, recovery from drug or alcohol addiction, HIV/AIDS or other special need.
- **Other Supportive Services Staff** may include substance abuse specialists, vocational/employment counselors, recreation staff or other roles depending on population needs.

## Additional Staffing Considerations

Appropriate staffing is essential to the success of permanent supportive housing projects integrated with health care services. As we evolve services in permanent supportive housing, we also need to shift the way we think about different qualifications and skills sets for the positions of those who are providing the services and how we prepare them to become valuable team members. It is not enough to transplant staff from one program to an integrated program without analyzing the fundamental changes in program expectations. The following are some areas that collaborative partners may want to consider before hiring or transferring staff into an integrated project structure.

### Treatment/Tenant Engagement Philosophy

It is important that each collaborative spend time clarifying how the client engagement strategy will be used to help tenants access services. Project leadership may make the ultimate decision about which strategies or best practices should be used to engage clients; however, they should also ensure that staff are able to implement the chosen philosophy.

### Working in a Collaborative

One of the primary expectations and staff responsibilities should be the ability and skills required to work in a collaborative. Some of these skills include the following:

- The ability to respond to and follow directives of project leadership from various organizations.
- The ability to understand and integrate basic knowledge of health care into their tenant advocacy work.

<sup>15</sup> Paraprofessional positions may be filled with higher credentialed individuals and have billable encounters if qualified (see FQHC—Billable Services/Staffing Requirements table).

- The ability to assist with the coordination of services for tenants.
- The demonstrated understanding of the business models of all the collaboration's partners.

### Modeling Health and Wellness

Ensure that all project staff understand the intention of the collaborative to increase the health and wellness of the tenants, model healthy choices and have a basic understanding of the chronic illness the tenants face. For example, many tenants struggle with Type II Diabetes, a chronic illness that can be managed with dietary and lifestyle changes. It is important that staff support the health and wellness of the tenants in all aspects of their responsibilities. For example, provide healthy snack options for tenant meetings and gatherings.

### Hiring and Training Medical Provider Staff

Many collaboratives have found it difficult to hire and retain health care staff for their projects. They experience a high turnover rate due to the challenge of working with higher-acuity target populations of permanent supportive housing, the location of the housing facility, and the lower-than-average salary. Health care providers may not be familiar with providing services to the target population and need to be trained to understand the specific needs and the tenant engagement philosophy employed by the housing staff.

### Reducing Medical Provider Staffing Costs

As noted above, only health care services provided by licensed clinical staff are directly reimbursable through Medi-Cal billable visits. The challenge that many new projects face is the high cost of the personnel, particularly in the start-up phase of the project when so few tenant visits are actually reimbursable. Many projects have chosen to utilize Licensed Vocational Nurses (LVN's) or Registered Nurses (RN's) to provide the bulk of the health care during the start-up phase, with the understanding that the cost incurred would come from a funding source other than Medi-Cal. Although the services performed by the LVN are not Medi-Cal billable, the cost of an LVN is half that of a Nurse Practitioner. When making the decision to use LVNs or RNs as a cost saving strategy an organization must consider the tradeoffs of not using more highly skilled medical staff that can bill. It is important to consider the health care needs and vulnerabilities of tenants—not just cost and revenue considerations. The lower level of care may be balanced with intensive referral, follow up, and communication with the higher-level health care provider. As more clients receive

Medi-Cal benefits, the staffing pattern should change to bill Medi-Cal for the services provided. An alternative cost saving strategy is keeping higher skilled staff, but limiting the number of clinic operating hours, thereby reducing staffing time and cutting costs. However, this strategy may also conflict with the needs of the tenants. The balance of operating hours and staffing is common in all businesses and can be achieved through consistent monitoring, flexibility and quick reaction to changing conditions.

### Weekend and Holiday Staffing

The decision to provide staffing during the weekend and during holidays is unique to each project, although most projects only appoint one or two project staff to handle any emergency situations that may arise. Some collaboratives choose to appoint housing management or supportive service staff in this role, while others maintain one to two health care providers on call over the weekend in case of emergencies. This duty is rotated among the integrated service team members each week.

### Assisting Individuals and Families Apply For Benefits—SSI/SSDI/Medi-Cal

The financial success of any project depends upon the ability of the project partners to assist tenants to attain Supplemental Security Income (SSI)/Social Security Disability Insurance (SSDI) and Medi-Cal or Medicare benefits. For single adults who are not pregnant or do not have children, eligibility for Medi-Cal is generally linked to receiving Supplemental Security Income (SSI) for indigent adults with limited work histories. Medicare is the health care coverage linked to Social Security Disability Insurance (SSDI) for anyone with an adequate work history to qualify. Families (parents or caretakers of relatives and children up to 20 years old) can apply for Medi-Cal through their local Department of Public and Social Services Office. Qualification for Medi-Cal benefits is dependent on the family's monthly income after certain allowances for child-care and working expenses.

The disability claims process requires a thorough evaluation of the tenant's physical and mental health, work history and education history in order to establish that the tenant's disability prevents him/her from substantial gainful activity.

---

“The law defines disability as the inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.”<sup>16</sup>

---

The application process is not necessarily simple, as the burden of proof rests on the applicant. However, a high Medi-Cal enrollment rate is possible if there is a considerable effort put forward by the collaborative. To reach this goal, collaborative partners need to invest in benefits specialists that are trained to coordinate, collect, compile and submit strong benefit applications. They should also ensure that the health care providers are trained to document their findings in a comprehensive manner. Without a concerted effort, Medi-Cal enrollment rate will likely be around 50-60%, which will not provide the revenue necessary to make the project sustainable on a long-term basis.

### Benefits Assistance Programs

Another option is to work closely with local benefits initiative projects that assist and homeless individuals apply for SSI/Medi-Cal benefits. A good example of local benefits initiative project in Los Angeles County is the Benefits Entitlement Service Team (B.E.S.T.) Project. The B.E.S.T. project, a collaborative of JWCH Institute and Volunteers of America, helps homeless individuals obtain Social Security Benefits and/or Supplemental Security Income they are eligible to receive. A multi-disciplinary team of case managers, outreach workers and health care providers help prepare the Social Security application, as well as provide health, mental health and case management services during the application process.<sup>17</sup> Operated at four field sites throughout Los Angeles County, the project plans to screen 1,200 homeless individuals and process 960 disability claims. Building on a strategic partnership between local government, community based organizations and the local Social Security Administration office, this project has managed to reduce the application disability claim process to less than two months.

---

<sup>16</sup> Social Security Administration. (2010). Disability Evaluation Under Social Security (Blue Book- September 2008). <http://www.ssa.gov/disability/professionals/bluebook/general-info.htm>

<sup>17</sup> B.E.S.T. Project. (n.d.). *B.E.S.T. Project* [Brochure].

### Changes in Medi-Cal Under Health Care Reform and Section 1115 Waiver

As previously discussed, beginning in 2014, the health care reform law will ensure that indigent adults with incomes at or below 133% FPL will be eligible for Medi-Cal, regardless of disability. Further, beginning in 2011, under California’s Section 1115 Waiver, Los Angeles County has the option of providing health care benefits to low-income individuals who do not qualify for Medi-Cal or Medicare. Of course, even if tenants are automatically enrolled in Medi-Cal or in a benefits package under the Waiver, they will still have to apply for SSI in order to receive monthly income.

The Waiver also requires that all seniors or persons with disabilities (SPDs) on Medi-Cal enroll in a managed health plan, under which a beneficiary may only access health providers who are part of that health plan’s network. Rather than a fee-for-service model, health plans will receive a capitated payment per enrollee. Beginning on June 1, 2011, SPDs will begin enrolling in one of two managed health plans in Los Angeles County.<sup>18</sup> Individuals who do not affirmatively choose a plan will automatically be enrolled by the State based on the individual’s previous providers and utilization history.<sup>19</sup> It is therefore critically important that the collaborative not only enroll tenants in Medi-Cal, but make sure that those on Medi-Cal enroll in a managed health care plan that includes the FQHC partner. Like with Medi-Cal enrollment, this endeavor may require a considerable investment of staff time to assist tenants in enrolling in an appropriate plan and choosing a treating FQHC physician.

---

<sup>18</sup> California Waiver at 80.a

<sup>19</sup> Id. at 80.b.

## Defining the Target Population and Understanding Their Service Needs

Before planning the design of your project, collaborative partners need to clearly identify the target population to be served by the project. Usually, the permanent supportive housing developer will need to identify the target population during the planning phases of the facility in order to secure funding for acquisition, construction, rehabilitation or leasing of the property. Ideally, the proposed projects should be designed in response to the local homeless priorities, based on the most recent homeless census data and should be in alignment with community need.

Individuals and families that are eligible for permanent supportive housing have complex challenges including homelessness, chronic homelessness and one or more disabilities. They may have serious chronic health conditions, persistent mental health issues, substance use issues and HIV/AIDS, often exacerbated by long periods of time outside and/or long-term poverty. Many tenants often have one or more condition, some presenting with more than two serious health conditions. Projects such as Project 50 in Los Angeles have utilized the information learned from Common Ground's Registry Process that utilizes the Vulnerability Index to prioritize a particular target population.

*The Vulnerability Index is a tool for identifying and prioritizing the street homeless population for housing according to the fragility of their health. It is a practical application of research into the causes of death of homeless individuals living on the street conducted by Boston's Healthcare for the Homeless organization, led by Dr. Jim O'Connell. The Boston research identified the specific health conditions that cause homeless individuals to be most at risk for dying on the street. For individuals who have been homeless for at least six months, one or more following markers place them at heightened risk of mortality:*

- *More than three hospitalizations or emergency room visits in a year.*
- *More than three emergency room visits in the previous three months.*
- *Aged 60 or older.*

- *Cirrhosis of the liver.*
- *End-stage renal disease.*
- *History of frostbite, immersion foot, or hypothermia.*
- *HIV+/AIDS.*
- *Tri-morbidity: co-occurring psychiatric, substance abuse, and chronic medical condition.*

*The Vulnerability Index process is a tool to help communities create a name and photograph registry of the homeless population, which is then rank-ordered from highest to lowest mortality risk.<sup>20</sup>*

Once the target population has been identified it would be advisable to conduct focus groups and/or work with a consumer advisory committee to better understand the specific needs of the future tenants.

Identifying and understanding the needs of the target population will inform the intensity and frequency of services and the level of staffing required, and will ultimately determine the program design and budget. Services are provided with a varying degree of intensity and service levels described in the chart can be increased or decreased on an individual project basis. *See Figure 2.*

---

<sup>20</sup> Common Ground. (n.d.). *Vulnerability Index 101*. [http://www.commonground.org/?page\\_id=789](http://www.commonground.org/?page_id=789)

Figure 2.

	High-intensity Services	Medium-intensity Services	Low-intensity Services
<b>Services</b>	<ul style="list-style-type: none"> <li>• Access to Health and Dental Care</li> <li>• Mental Health Care</li> <li>• Substance Use Treatment</li> <li>• Pre-vocational/Vocational Services</li> <li>• Services that Support Housing Retention</li> <li>• Parenting Skills Classes</li> <li>• Age-Appropriate Services for Children in Families</li> <li>• Transportation</li> <li>• Recreational Programs</li> </ul>	<ul style="list-style-type: none"> <li>• Case Management</li> <li>• Mental Health Care</li> <li>• Access to Health and Dental Care</li> <li>• Substance Use Treatment</li> <li>• Linkages to Mainstream Resources</li> <li>• Services that Support Housing Retention</li> </ul>	<ul style="list-style-type: none"> <li>• Limited Case Management</li> <li>• Housing Assistance</li> <li>• Linkages to Mainstream Services</li> </ul>
<b>Ideal Case Management Ratio</b>	Individuals— 1:10–15 Families— 1:6–8		
<b>Length of Services</b>	Available for as long as needed, typically once per week	Typically, weekly for 6 months–1 year, at less frequent intervals (once per month) for a 1–2 year period thereafter, and then on an as needed basis	Duration of services typically limited by tenant but can be quickly reactivated if necessary
<b>Service Configuration</b>	<ul style="list-style-type: none"> <li>• Single Site: On-site service providers and/or mobile service team.</li> <li>• Scattered Sites: mobile service teams, including case managers, who travel to tenant units. Additional community building and educational activities are offered at the service provider’s office or in a community space.</li> </ul>	<ul style="list-style-type: none"> <li>• Single Site: On-site service providers and/or mobile service team.</li> <li>• Scattered Sites: mobile service teams, including case managers, who travel to tenant units. Additional community building and educational activities are offered at the service provider’s office or in a community space.</li> </ul>	<ul style="list-style-type: none"> <li>• Services, such as case management, are provided in a tenant’s home by on-site staff or a mobile service team. Tenants can also access services at the service provider’s office. Community building activities may be limited and tenants are likely to be referred to community-based resources for educational activities.</li> <li>• With a clear understanding of the target population, level of acuity and the types of services that should be made available, the project can now design the mode of service delivery or choose the service model that best fits tenants’ needs.</li> </ul>



# Three Program Models in Los Angeles

There are three basic models that are currently being utilized to integrate health care services into permanent supportive housing. Although it is an important consideration, there is no perfect model; they all have advantages and challenges. It is important to choose the model that best fits your target population, and blends a number of funding streams, including Medi-Cal reimbursement, allowing for a financially sustainable project. The models presented explore the scope of health services that are typically provided and billed to Medi-Cal through an FQHC, including some basic mental health care. However, homeless individuals and families may benefit from the broader range of mental health services that can be provided by partnering with the Los Angeles County Department of Mental Health (DMH) or DMH contracted providers. There are several benefits that a contract for mental health services through DMH provides for an FQHC serving persons in permanent supportive housing. A DMH contract allows the FQHC to provide enhanced mental health services that are not normally billable under the FQHC. A contract with DMH for mental health services will allow the FQHC to offer more holistic care to those who need it, including case management, groups, and more intensive psychiatric services, especially if the DMH contract allows for indigent care. An FQHC with a DMH contract allows the FQHC to focus its other

resources on those who will not qualify for Medi-Cal. In this way, the FQHC can serve a larger continuum of patients by matching resources and services in a cost efficient manner. This is also true for substance use services contracted through the Los Angeles County Department of Public Health, Substance Abuse Prevention and Control (SAPC). The details of partnering with DMH and SAPC providers will be explored in future guides.

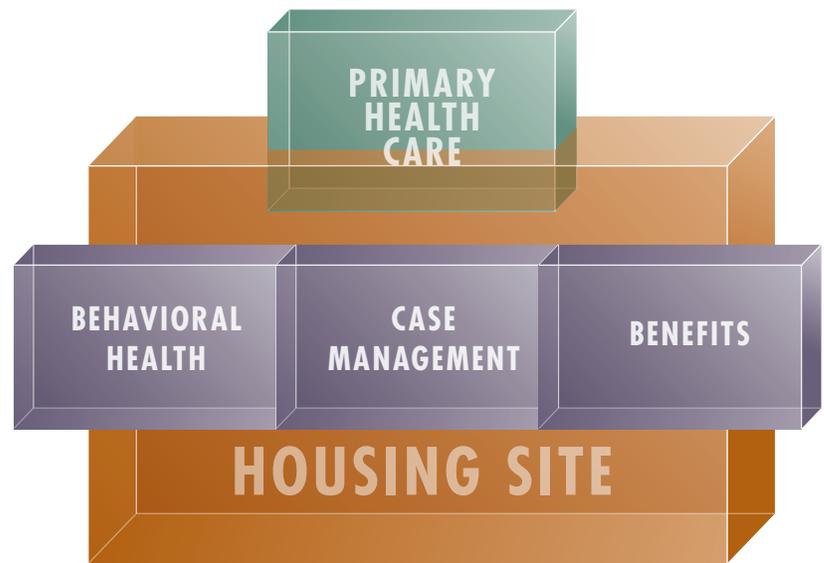
The three models that we will review, project based with on-site satellite clinic-, mobile team services and off-site clinic based services, are the most frequently used models by partners in Los Angeles today and can be implemented as a standalone model, or as a hybrid of two or more models. The budgets and projected reimbursements detailed along with each model are based on the research gathered from projects already operating and is only intended to provide a starting point for understanding the resources required to start an integrated health care project. The budget line items are suggested and can be altered to fit individual project needs. The sources listed in the budget are a combination of actual and potential sources.

Figure 3.

## Project-based Services with On-site Satellite Clinic

The Integrated Service Model in which the services are offered on-site at the housing project is most often used with projects serving tenants with high intensity service need. Although services are voluntary, the staff actively engages clients on a regular basis. The health care services are provided in a satellite FQHC clinic operating within the housing facility. The satellite clinic is linked to a “full service” clinic operated by the FQHC and, generally, is no more than 5-10 miles away. The on-site clinic is available to tenants for up to 20 hours per week and has medical equipment to handle routine medical exams. In the event that the tenant requires additional testing and/or specialty care, they are usually referred and/or transported to the clinic or other specialty care provider. *See Figure 3.*

The primary advantage of having a medical clinic at the housing site is accessibility. Many organizations have recognized that homeless and chronically homeless individuals and families experience real barriers to accessing medical care, one of the most significant being fear and mistrust of the medical system. However, the fact that there is an on-site clinic does not equate to clients actively seeking or accessing services. The health care staff also need to actively engage clients and build relationships with tenants whenever possible. This will require a certain level of capacity building for the health care staff as this type of engagement is outside of the typical medical model.



### Advantages and Challenges

#### Advantages

- Clients have regular access to services.
- Relationships between provider and client are built on a continual basis.
- The sustainability of healthcare services are not as dependent on clients initiating or seeking out services.

#### Challenges

- Expensive startup costs.
- Housing needs at least one private treatment room.
- Additional staff to provide treatment at satellite site.
- Depending on the number of tenants at the housing site and the volume of service provided, it may be difficult to obtain enough income to cover the costs of services.

A common challenge related to having an on-site medical clinic is that tenants may feel hesitant to divulge private health information without a clear understanding of staff roles and responsibilities, confidentiality of their medical information and how their health information might affect their housing.

Due to the complexity of these issues, projects need to include staff that can increase accessibility, and provide a bridge between the tenant and the health care provider. This service is usually provided by housing-based case managers or housing advocates that can engage tenants on a regular basis to discuss their service plan and the options available to them.

Housing advocates can be instrumental in brokering initial health care visits. Once the initial health care visit(s) have been completed, it should then be the responsibility of the health care or mental health care provider to build trust with the tenant. The ongoing relationship-building and consistency of care allows health care providers to effectively manage complex, chronic physical and mental health conditions.

### Sample Budget for Project-based Services with On-site Satellite Clinic

The budget presented in Figure 4 assumes a mixed-population building with approximately 60 disabled homeless tenants and/or families that are eligible for supportive services usually found in permanent supportive housing projects. It also assumes that the target population presents with *severe physical and/or behavioral health conditions*. The size of the housing development is therefore a determining factor in the practicality of implementing this model, as the cost of operating an on-site clinic can be expensive and the maximum number of persons to be served is finite and fixed.

The sample budget is a compilation of project budget line items gathered from various organizations that are currently operating projects integrated health care. The sources are suggested potential sources to pursue. This is a sample first year budget for a comprehensive and integrated health care project with a satellite clinic on-site, serving 60 tenants. The budget includes full-time housing advocate/case manager staff, a full-time benefits advocate and a substance use counselor. The approximate ratio of full-time equivalent supportive services staff (including medical personnel) to tenants is 1:10. The on-site clinic will operate no more than 20 hours per week and will require a part-time health and mental health care team. The budget also includes start-up costs associated with setting up the clinic and the cost of providing services to tenants that are in the process of obtaining Medi-Cal Benefits. Please note that not all tenants will be eligible for and/or obtain Medi-Cal benefits. *See Figure 4.*

The budget shows staffing for health and mental health services totals approximately \$110,011 annually during the first operating year, with about one third of those costs being eligible to be billed to Medi-Cal. The number of patients

seen, costs and reimbursable visits increase as more patients become engaged with the healthcare team and are qualified to receive Medi-Cal. Especially during the first year, the satellite clinic should plan on absorbing unreimbursable costs and costs such as diagnostic testing and treatment, as they will serve all tenants of the housing facility regardless of their Medi-Cal status. However, many of these costs can be funded through a 330 grant as applicable.

In this first year budget, the total annual cost of all supportive services located on-site is approximately \$497,971 or \$8,299 per tenant. Although this per tenant figure represents intensive, comprehensive, and integrated services, it is expected that the staffing will increase as more tenants engage the FQHC as their health services provider, thus, increasing the annual cost for health and mental health services \$176,488 and the overall project cost of all supportive services to \$564,488 or \$9,408. The health and mental health services costs can be expected to level out at around \$176,488 for comprehensive services for a high service need population.

The allocation of funding toward overall project management and administration in the budget above is a conservative estimate; depending on the number of service partners included in the project design and complexity of the project partnership, this cost may increase. These costs are not eligible for FQHC funding, and partnerships are essential to ensure these services are funded and that housing stability and, therefore, health and mental health stability, are not jeopardized.

In the budget presented, the case manager, benefit specialist and substance abuse counselor positions cannot bill Medi-Cal under the FQHC if filled by paraprofessional staff and would be dependent on other funding sources. They can be covered by 330 grant funds to the extent that they are providing enabling services as defined under the HRSA guidelines. Otherwise, some of the potential funding sources such as Department of Mental Health contract, Substance Abuse Treatment and Control contract are noted as potential sources to fund these positions. There are several other ways to allocate staff in order to (1) reduce cost and (2) maximize the ability to bill Medi-Cal. Consider the following alternative staffing configurations:

- Hire a LCSW in the Program Manager position. Include direct client services in the job description to increase Medi-Cal billing. Although as a Program Manager the LCSW will serve all tenants, only encounters with those that have Medi-Cal will be able to be billed to Medi-Cal.

Figure 4.

Sample Budget: Project-based Services with On-site Satellite Clinic—Year 1 (highly intensive)										
USES	SOURCES									
	Base annual salary	FTE	Annual salary with benefits	FQHC Medi-Cal	330 Grant*	DMH Co. contract	SAPC contract	Housing development/operations	Total sources	GAP
<b>Program Management/Oversight</b>										
Administrative Director	80,000	0.02	2,080					2,080	2,080	
Program Manager (LCSW)	70,000	1.00	91,000		44,000	20,000	10,000	10,000	84,000	-7,000
<b>Subtotal Program Mgmt</b>			<b>93,080</b>		<b>44,000</b>	<b>20,000</b>	<b>10,000</b>	<b>12,080</b>	<b>86,080</b>	<b>-7,000</b>
<b>Case Management</b>										
Case managers/Service Coordinator	43,000	2.00	111,800		33,000	33,000	33,000	12,800	111,800	
Benefits Advocate	50,000	1.00	65,000		65,000				65,000	
<b>Subtotal Case Mgmt</b>			<b>176,800</b>		<b>98,000</b>	<b>33,000</b>	<b>33,000</b>	<b>12,800</b>	<b>176,800</b>	
<b>Substance Abuse Services</b>										
Substance Abuse Counselors	40,000	1.00	52,000		17,160	17,160	17,680		52,000	
<b>Subtotal Substance Abuse Tx</b>			<b>52,000</b>		<b>17,160</b>	<b>17,160</b>	<b>17,680</b>		<b>52,000</b>	
<b>FQHC SERVICES</b>										
<b>Mental Health Services</b>										
Psychiatrist	180,000	0.10	23,400	7,000	6,310	10,090			23,400	
LCSW	80,000	0.30	31,200	9,000	11,200	11,000			31,200	
<b>Subtotal Mental Health Svcs.</b>			<b>54,600</b>	<b>16,000</b>	<b>17,510</b>	<b>21,090</b>			<b>54,600</b>	
<b>Health Care Services</b>										
Physician	160,000	0.10	20,800	7,000	13,800				20,800	
Nurse Practitioner (\$50/hr)	104,000	0.20	27,040	8,500	18,540				27,040	
Medical Asst./Medical Case Manager	29,120	0.20	7,571		7,571				7,571	
<b>Subtotal Health Care</b>			<b>55,411</b>	<b>15,500</b>	<b>39,911</b>				<b>55,411</b>	
<b>Subtotal FQHC Personnel</b>		<b>0.90</b>	<b>110,011</b>	<b>31,500</b>	<b>57,421</b>	<b>21,090</b>			<b>110,011</b>	
<b>Total Personnel</b>		<b>5.92</b>	<b>431,891</b>	<b>31,500</b>	<b>216,581</b>	<b>91,250</b>	<b>60,680</b>	<b>24,880</b>	<b>424,891</b>	<b>-7,000</b>
<b>Operations</b>										
Equipment (Copeir lease, toner, fax, phones)			10,000		5,000			5,000	10,000	
Office supplies										
Furnishings										
Transportation			10,000							-10,000
Medical Software			4,000		4,000				4,000	
Training			5,000		5,000				5,000	
Other Medical Expenses			30,000		30,000				30,000	
<b>Operations Subtotal</b>			<b>59,000</b>		<b>44,000</b>			<b>5,000</b>	<b>49,000</b>	<b>-10,000</b>
Operations Indirect Costs (10%) **			7,080		4,400			500	4,900	-2,180
<b>Total Operations</b>			<b>66,080</b>		<b>48,400</b>			<b>5,500</b>	<b>53,900</b>	<b>-12,180</b>
<b>TOTAL PROGRAM COST</b>			<b>497,971</b>						<b>478,791</b>	<b>-19,180</b>

\* For FQHCs that are PHS 330 grant recipients, the biggest benefit is the grant funding. For new starts, funding up to \$650,000 can be requested. Grants for New Access Point or Expanded Services Grants vary.

\*\* Indirect cost (IDC) are not reimbursable unless the recipient has an indirect cost rate covering the applicable activities and period. If an organization is planning to negotiate an IDC rate, the organization may request 10% of salaries/wages until the rate is determined

\*\*\* FQHCs funds only cover the cost of case management and benefits eligibility services through Enabling Services Grants from HRSA.

- Consider increasing the LCSW included under Mental Health Services from .5 FTE to 1FTE and include substance abuse in the job description. This would eliminate the need for an additional Substance Abuse counselor and also allow the services to be billed to Medi-Cal.
- The benefits counselor position is optional only if:
  - › The Case Managers are trained to assume the responsibility of assisting tenants apply for benefits.
  - › The project is connected to a community benefits program that can actively assist clients apply for benefits. See *Assisting Individuals and Families Apply for Benefits—SSI/SSDI/Medi-Cal*.

## Suggestions for Reducing Costs

Another way to cut back on operating costs is to limit the hours of the health care clinic during the first few months and gradually increase provider hours as health services demand is increased through engagement and education provided by less costly staff. The disadvantage in doing so is limiting direct access to health care providers for the tenants, especially during the first year when their medical need may be greater and building trust is important.

As mentioned above, the ability to work with mental health care providers or FQHCs that are contractors with the Los Angeles County Department of Mental Health (DMH) allows for the FQHC to provide more appropriate mental health services in a more cost effective manner. Mental health services funded by DMH allow for various levels of personnel to provide billable services to tenants. For example, a Master's of Social Work (MSW) could take on the role of the housing case manager thus enabling DMH eligible services, provided to DMH eligible tenants to be billed to the DMH Medi-Cal contract. Another example is limiting the use of an LCSW to oversight and providing counseling services through an MSW, thereby reducing your personnel expenditures. Working with a DMH approved provider allows more flexibility in staffing and could potentially increase the overall billing potential. An FQHC may also wish to pursue its own contract with DMH.

Once an estimated project budget has been completed, the next step should be to identify potential sources of funding including the amount of potential revenue that Medi-Cal reimbursement will bring to the project. Estimating Medi-Cal revenue for this model of health care services model the projection will be based on the number of clients that reside or will reside in the building, the percentage of tenants

who are (or will become) eligible for Medi-Cal, the level of services tenants need, and success in engaging tenants in care. In Los Angeles County, housing and FQHC providers have also successfully partnered with Los Angeles County's Department of Public Health Substance Abuse Prevention and Control division to provide substance abuse treatment services in permanent supportive housing.

## Projecting Medi-Cal Revenue

Medi-Cal can be billed for reimbursable costs discussed to the extent that it can cover the staffing and other costs that are incurred when providing primary and mental health care services for tenants in permanent supportive housing. Projecting potential reimbursement costs to cover the first three years of the project will help develop an accurate budget and determine the sustainability of the project. The financial projections should include the following elements:

- The total number of tenants to be served.
  - › It is important to note that not all tenants will access services immediately and providers should estimate a gradual increase in participation with active engagement.
  - › Providers should also be aware that a certain number tenants may already have providers and will not access proposed services.
- The total number and percentage of tenants on Medi-Cal.
- The projected number of visits per month.
  - › This should be driven by the severity of the target population's needs.
  - › This is the number of visits for all tenants regardless of Medi-Cal.
  - › For example: 60 tenants with severe chronic illness and persistent mental illness may require 2-4 visits per month.
  - › Visits may be a combination of services listed in FQHC Billable Services Chart.
  - › The number of visits will also gradually increase over time as trust is built between tenants and treatment staff. Some projects have found that either at start up or without intensive engagement, visits only average about .5 per tenant, per month.
- The number of reimbursable visits per month.
- The FQHC billing rate.

Figure 5.

Projecting FQHC Medi-Cal Revenue: Project Based Health Care Services for 60 Permanent Supportive Housing Tenants							
A. Month	B. Total # of tenants	C. # of tenant visits/month	D. % of tenants with Medi-Cal	E. # of tenant visits with Medi-Cal/month**	F. # of reimbursable visits/year	G. FQHC Billing rate	H. Annual reimbursement
		Enter total visits	= C/B x100	= C x D	= E x number of months	Enter rate	= (E x G) x number of months
Months 1–6	60	45	30%	13.5	84	140	\$11,340
Months 7–12	60	60	40%	24.0	144	140	\$20,160
Months 13–24	60	90	75%	67.5	810	140	\$113,400
Months 25 on	60	120	90%	108.0	1296	140	\$181,440

\*320 visits per month is equivalent to 80 visits per week or 16 visits per day.  
 Given at least three providers on any given day, this is 5–6 clients per provider/per day.

\*\* This is considered a reimbursable encounter.

Utilizing the data elements above, sample annual Medi-Cal reimbursement revenue can be projected based on the provision of health care services to approximately 60 permanent supportive housing tenants. *See Figure 5.*

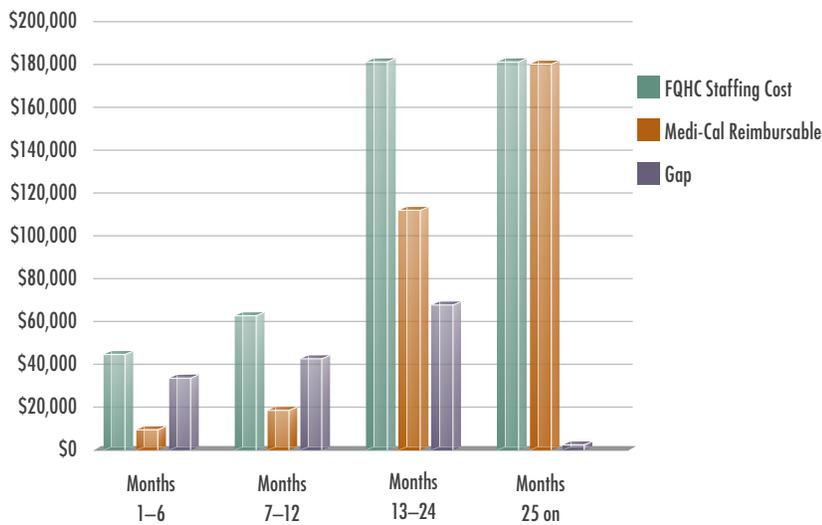
### Assumptions

The projection assumes that health care services will be offered to tenants regardless of Medi-Cal benefits. It also assumes that overtime, the benefits advocate will gradually increase the number of Medi-Cal recipients over a 3-year period, by coordinating the application segments with treatment staff and assisting tenants to successfully apply for SSI/Medi-Cal. At the end of 3 years we can project that approximately 90% of the tenants receiving care will have Medi-Cal benefits and subsequently 90% of all visits with approved health care clinicians will be reimbursable. Please note that some tenants will not qualify for Medi-Cal and others will wish to remain in the care of their current provider.

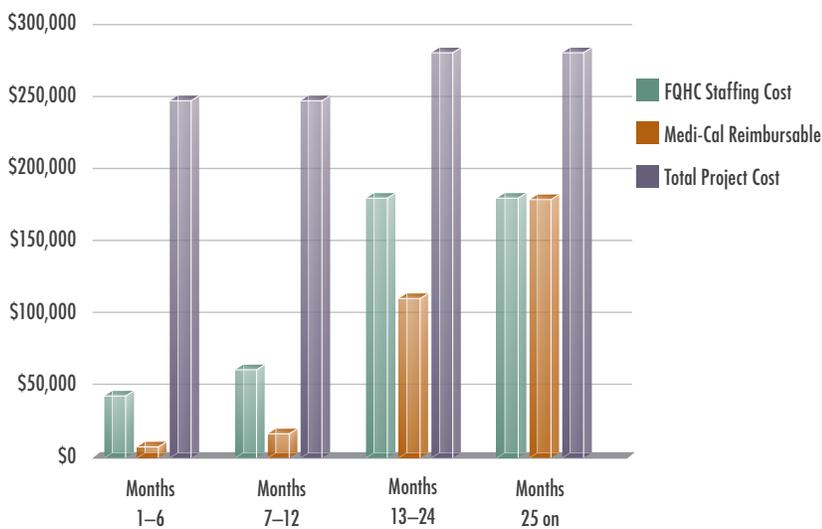
Again, the target population in this model does have medium to high service needs and, after a long period of time without access to healthcare, we can estimate multiple visit per month per tenant. However, we also know that it will take some time for the health care provider to establish a relationship that encourages tenants to access services. The average number of visits should therefore increase over the 3 years to an average of 2 visits per month. It is likely that the tenants will have varying levels of engagement in services, some with more than 2 visits per month and some with less. Additionally, some tenants will prefer to access services off-site.

There is also some debate as to the intensity of services required over the course of 3 years. Although it may be the experience of some that the need for intensive service will decrease over a 3-year period, some have had an entirely different experience, indicating that a target population with high needs will continue to experience periods of instability beyond 3 years and will continue to need intensive services.

**Figure 6.**  
**FQHC Services with On-site Clinic: Cost vs. Medi-Cal Revenue.**



**Figure 7.**  
**Total Service Costs Permanent Supportive Housing Project with FQHC Services On-site.**



With an engaged tenant population, the projections indicate that by the end of the third year revenue could be \$181,440, enough to cover all of the annual health care expenses. These projections assume that the number of billable encounters and the number of insured patients increase over time and that the services are available to 60 permanent supportive housing tenants. With Medi-Cal enrollment peaking at 90% and the number of billable encounters with the FQHC’s medical providers peaking at approximately twice per month. The variables, number of tenants served, percentage of tenants with Medi-Cal benefits and number of visits per month are subject to change throughout the life of the project. Medi-Cal revenue will depend upon the scale of the intended project, since larger scale housing developments benefit from the increased number of tenants served. For smaller scale projects, the provider hours can be adjusted downward to a break-even point. *See Figures 6 and 7.*

### Summary

Although FQHC Medi-Cal health and mental health services in permanent supportive housing can be self-sustaining and are critical services to provide a high need population, these services are by no means all of the services necessary to have a successful permanent supportive housing project. To sustain the entire project it is critical to have alternative sources of funding. Please note that every project will have a differing level of need and all of the projections presented are meant to be suggestions that can be altered to fit the needs of projects coming on line. If it is unlikely that tenants will visit with clinicians who can bill Medi-Cal two times per month, then the project budget may need to be revised to lower the total project services cost.

## Mobile Services

The mobile team model provides on-site health care services without a permanent project based clinic. The mobile team can offer services in the tenant's unit, other temporary facilities, or can be based inside a mobile van. Generally, a community health care clinic is within 5-10 miles of the housing sites and tenants are referred/transported to the primary clinic based on medical necessity. This model is typically employed with tenants that have a medium to high level of acuity and service needs. The main advantage of this model is the ability to provide on-site services in multiple housing developments, thereby maximizing resources and increasing the potential for reimbursable visits. This model is applicable in urban areas and suburban geographic areas that may not have a dense homeless population or large-scale housing developments. *See Figure 8.*

The challenge of this model is the complexity of coordinating services at more than one housing site each day. Mobile health care, provided at multiple sites, requires a certain amount of flexibility and ability to prioritize tenants in crisis, while still routinely providing services to clients according to a regular schedule.

Figure 8.



## Advantages and Challenges

### Advantages

- Providing care at multiple locations maximizes service dollars.
- Mobile team increases potential for billable encounters.
- Clients have access to regular on-site services on a regular basis.
- Clients are not required to initiate or seek out treatment.

### Challenges

- Logistical and operational aspects, i.e. scheduling could potentially be difficult.
- On-site services may not be as comprehensive as in a clinic.

Figure 9.

Sample Budget: Mobile Services—Year 1 (medium acuity)											
USES	SOURCES										
	Base annual salary	FTE	Annual salary with benefits	FQHC Medi-Cal	330 Grant*	DMH Co. contract	Housing sources	SAPC contract	Private grants	Total sources	GAP
<b>Program Services Costs</b>											
<b>Program Management/Oversight</b>											
Program Manager (LCSW)	80,000	1.0	104,000	16,000	40,000	20,000	28,000			104,000	
<b>Subtotal Program Mgmt</b>			<b>104,000</b>	<b>16,000</b>	<b>40,000</b>	<b>20,000</b>	<b>28,000</b>			<b>104,000</b>	
<b>Case Management</b>											
Housing Case managers/Benefits Advocates	43,000	2.0	111,800		30,000	35,900	35,900	10,000		111,800	
<b>Subtotal Case Mgmt</b>			<b>111,800</b>		<b>30,000</b>	<b>35,900</b>	<b>35,900</b>	<b>10,000</b>		<b>111,800</b>	
<b>FQHC Services</b>											
<b>Mental Health Services</b>											
Psychiatrist	180,000	0.1	23,400	7,020	7,020	7,360		2,000		23,400	
LCSW (Also Provides Substance Use Counseling)	80,000	1.0	104,000	32,700	32,700	18,600		20,000		104,000	
<b>Subtotal Mental Health Svcs</b>			<b>127,400</b>	<b>39,720</b>	<b>39,720</b>	<b>25,960</b>		<b>22,000</b>		<b>127,400</b>	
<b>Health Care Services</b>											
Physician	160,000	0.4	83,200	9,000	70,000			4,200		83,200	
Nurse Practitioner	70,000	1.0	91,000	27,300	56,700			7,000		91,000	
<b>Subtotal Health Care Personnel</b>			<b>174,200</b>	<b>36,300</b>	<b>126,700</b>			<b>11,200</b>		<b>174,200</b>	
<b>Subtotal FQHC Services</b>			<b>301,600</b>	<b>76,020</b>	<b>166,420</b>	<b>25,960</b>		<b>33,200</b>		<b>301,600</b>	
<b>Operating Costs</b>											
Office Supplies			4,860		4,860					4,860	
Other Health Care Costs			25,000	8,750	4,250	6,000		6,000		25,000	
Van			5,000	1,750					3,250	5,000	
Van Maintenance, Insurance, Gas			8,400	2,940					5,460	8,400	
<b>Subtotal Operating Costs</b>			<b>43,260</b>	<b>13,440</b>	<b>9,110</b>	<b>6,000</b>		<b>6,000</b>	<b>8,710</b>	<b>43,260</b>	
<b>Subtotal FQHC Mobile Costs</b>			<b>344,860</b>							<b>344,860</b>	
<b>Total Program Cost</b>			<b>560,660</b>							<b>560,660</b>	

\* For FQHCs that are PHS 330 grant recipients, the biggest benefit is the grant funding. For new starts, funding up to \$650,000 can be requested. Grants for New Access Point or Expanded Services Grants vary.

\*\* Indirect cost are not reimbursable unless the recipient has an indirect cost rate covering the applicable activities and period. If an organization is planning to negotiate an IDC rate, the organization may request 10% of salaries/wages until the rate is determined

\*\*\* FQHC funds only cover the cost of case management and benefits eligibility services through Enabling Services Grants from HRSA.

Figure 10.

Projecting FQHC Medical Revenue: Mobile Health Care Services					
A. Month	B. Total visits per month	C. % of tenants with Medi-Cal	D. # of reimbursable visits/month	E. FQHC billing rate	F. Annual reimbursement
	Enter total visits per month	Total # with Medi-Cal/total served	= B x C	Enter rate	= D x E x number of months
Months 1–6	224	30%	67	\$140	\$56,448
Months 7–12	275	45%	124	\$140	\$103,950
Months 13–24	320	60%	192	\$140	\$322,560
Months 25 on	320	70%	224	\$140	\$376,320

\*320 visits per month is equivalent to 80 visits per week or 16 visits per day. Given at least 3 providers on any given day, this is 5-6 clients per provider/per day.

### Sample Budget Mobile Services

The sample budget in Figure 9 includes the costs associated with a mobile service team along with the average staffing levels used by teams around the nation. This sample budget assumes a mobile team operating approximately 5 days per week, with at least 3 providers on any given day, providing services to approximately 8-20 people per day. *See Figure 9.*

The cost of the mobile team is largely due to the level of providers, such as physicians and psychiatrists, included on the team. However, serving a large number of people across multiple housing sites offsets the cost. The flexibility of the model allows for a natural fluctuation in client participation and for the concentration of services needed during crisis intervention. The budget above demonstrates the staffing suggestions that were mentioned in the project based services model. The following is a summary of the alternative staffing configurations:

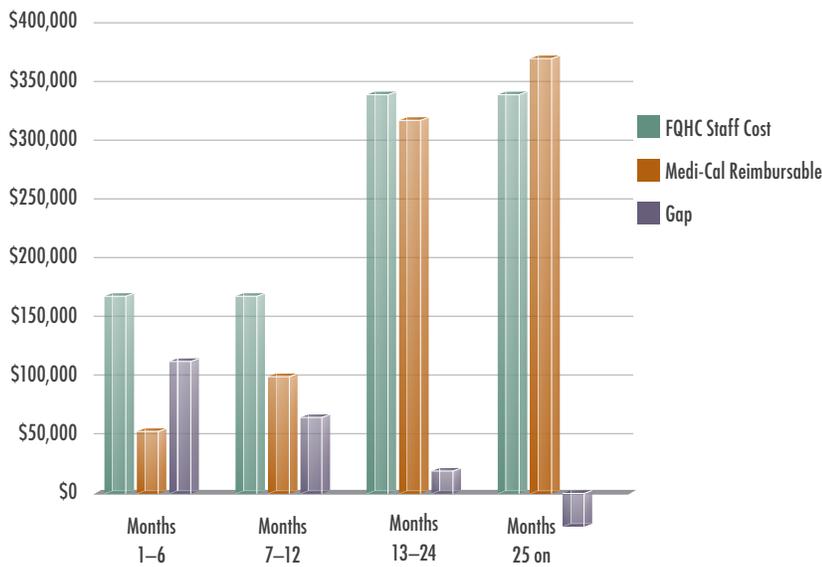
- The Licensed Clinical Social Worker will provide individual substance use counseling as well as mental health services. This eliminates the need for an additional Substance Use Counselor.

- Hire an LCSW for the Program Manager position and include direct client services in the job description. The program manager can also provide services to tenants and help handle the caseload.
- Housing Case Managers can be trained to help assist clients coordinate and apply for benefits.

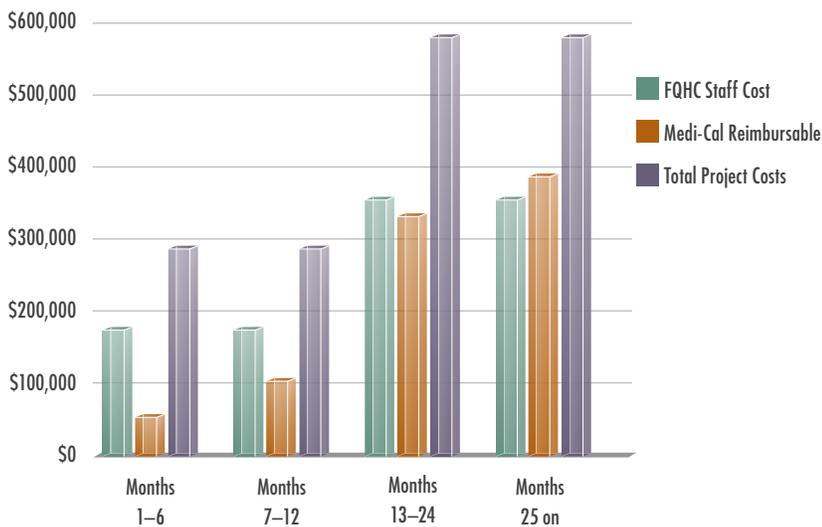
### Projecting Medi-Cal Revenue for the Mobile Services Model

Given that the mobile health care team will potentially visit several sites and provide services to a larger audience, revenue calculations are based on number of visits per month rather than a finite number of tenants. If we assume the mobile team operates 8 hours per day, 5 days a week, the potential number of visits per day is approximately 8-20. Based on these numbers we can make projections. *See Figure 10.*

**Figure 11.**  
**Mobile FQHC Health and Mental Health Services:**  
**Cost vs. Medi-Cal Revenue.**



**Figure 12.**  
**Total Project Costs with Mobile FQHC Health and**  
**Mental Health Services: Cost vs. Medi-Cal Revenue.**



## Assumptions

The numbers projected were calculated based in the following assumptions:

- Health care services are offered to all tenants within the housing developments visited, regardless of Medi-Cal benefits.
- Benefits counselors will gradually increase the number of Medi-Cal recipients over a 3-year period by helping tenants apply for SSI/Medi-Cal. *See Figures 11 and 12.*

## Summary

The first year annual cost for providing mobile health and mental health services in scattered site permanent supportive housing is \$344,860. Although these annual costs would increase in years 2 and 3, the projected Medi-Cal revenue from FQHC encounters will also increase; with revenue potentially exceeding costs annually after the second year (*see Figure 11*). Implementing suggested budget changes helps to reduce cost, increase Medi-Cal billing potential, and move the project toward sustainability. The projected numbers are based on the number of tenants accessing service and the frequency in which they do so. It is important that the number of housing facilities and the potential number of tenants that will access services be considered when adopting this model.

Based on the projections, Medi-Cal revenue will cover the entire cost of the health services after 3 years, but will only cover approximately 56% of the total project services cost after the third operating year (*see Figure 12*). Since the mobile FQHC services model is not attached to a particular housing project, it is essential that each housing site cover the other housing based services through alternative resources.

## Off-site Clinic-based Services

The off-site clinic-based services model encourages tenants to access health and mental health care services at an off-site, full-service clinic that provides services by appointment or on a walk-in basis. Depending on the proximity of the housing developments to the clinic, projects may find it advantageous to provide a private transportation system to ensure that tenants arrive for scheduled appointments. This model is most successful where the off-site clinic is situated amongst a number of existing permanent supportive housing developments or when there is a regular transportation system to bring tenants to and from the clinic. Alternatively, developers in the siting phase may make the presence of a nearby FQHC clinic one of their siting considerations. Clinics and housing providers may also enter into cooperative agreements to increase tenant access. See Figure 13.

### Advantages and Challenges

#### Advantages

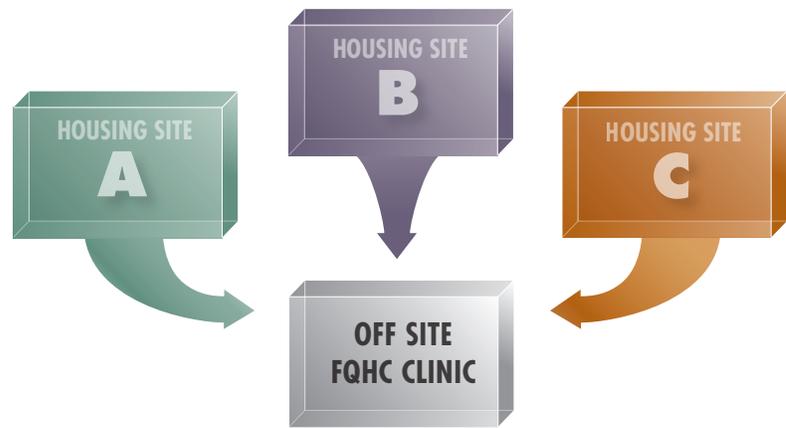
- Fewer start-up costs.
- Client privacy is protected.
- FQHC off-site clinic is fully equipped to handle most client needs and may have the capacity to serve as a medical home.

#### Challenges

- Can limit clients access to services.
- May require a transportation system.
- Relies on the traditional medical model that requires clients to initiate treatment.
- Assumes there are an adequate number of permanent supportive housing units in the area.

The main advantage of this model is the ability to utilize existing community resources and provide tenants with access to a full range of health care and specialty services. Although this model is most appropriate for tenants that have a low acuity level, it can still be argued that designing a program based on the assumption that tenants will proactively access off-site services is erroneous. There are several barriers to access-

Figure 13.



ing health care that still exist for homeless and formerly homeless individuals and families. As noted in the Urban Institute's 2002 evaluation of HUD's Continuum of Care:

*"The obstacles homeless people may encounter in trying to access mainstream services include often unspoken attitudinal barriers, logistical problems, and lack of sufficient funding: 'Mainstream services often prefer not to serve homeless clients, often are not readily accessible to homeless people, and usually do not have enough resources to serve their non-homeless target populations.' Wireman (2007), a formerly homeless man now working as a mental health services administrator, describes barriers such as the rudeness, disrespect, even disdain, that homeless people often face from mainstream service providers."*

*"Additionally, [in] a study describing barriers to public services encountered by people with psychiatric disabilities, the Bazelon Center (1995) identified obstacles that could easily affect homeless people with or without disabilities, including negative reactions from staff; ignorance of the existence or location of services; difficulty sitting for long periods in waiting rooms or difficulty keeping appointments; and a lack of assistance in completing confusing, complicated application forms."<sup>21</sup>*

<sup>21</sup> U.S. Department of Housing and Urban Development Office of Policy Development and Research, Strategies for Improving Homeless People's Access to Mainstream Benefits and Services, March 2010, <http://www.huduser.org/publications/pdf/StrategiesAccessBenefitsServices.pdf>

Figure 14.

Sample Budget for Off-site Clinic Services—Low Level Acuity											
USES	SOURCES										
	Base annual salary	FTE	Annual salary with benefits	FQHC Medi-Cal	330 Grant *	DMH Co. contract	Housing sources	SAPC contract	Private grant	Total sources	GAP
<b>HOUSING BASED SERVICES</b>											
<b>Program Management/Oversight</b>											
Program Manager	70,000	1.00	91,000			20,000	68,000	3,000		91,000	
<b>Subtotal Program Mgmt</b>			<b>91,000</b>			<b>20,000</b>	<b>68,000</b>	<b>3,000</b>		<b>91,000</b>	
<b>Case Management</b>											
Housing Case managers/Benefits Advocates	43,000	2.00	111,800		30,000	35,900	35,900	10,000		111,800	
Van Driver	28,000	1.00	36,400		25,000	5,700	5,700			36,400	
Substance Abuse Counselor	40,000	0.50	26,000			10,000	6,000	10,000		26,000	
<b>Subtotal Case Mgmt</b>			<b>174,200</b>		<b>55,000</b>	<b>35,900</b>	<b>35,900</b>	<b>10,000</b>		<b>174,200</b>	
<b>Subtotal Personnel</b>			<b>265,200</b>		<b>55,000</b>	<b>55,900</b>	<b>103,900</b>	<b>13,000</b>		<b>265,200</b>	
<b>Operating Costs</b>											
Office Equipment			8,000		8,000					8,000	
Office Supplies			1,260		1,260					1,260	
Van			11,000						11,000	11,000	
Van Maintenance, Insurance, Gas			11,500						11,500	11,500	
Training			5,000		5,000					5,000	
<b>Subtotal Operating Costs</b>			<b>36,760</b>		<b>14,260</b>				<b>22,500</b>	<b>36,760</b>	
<b>Total Program Cost</b>			<b>301,960</b>		<b>69,260</b>	<b>55,900</b>	<b>103,900</b>	<b>13,000</b>	<b>22,500</b>	<b>301,960</b>	

\* For FQHCs that are PHS 330 grant recipients, the biggest benefit is the grant funding. For new starts, funding up to \$650,000 can be requested. Grants for New Access Point or Expanded Services Grants vary.

\*\* Indirect cost are not reimbursable unless the recipient has an indirect cost rate covering the applicable activities and period. If an organization is planning to negotiate an IDC rate, the organization may request 10% of salaries/wages until the rate is determined

\*\*\* FQHC funds only cover the cost of case management and benefits eligibility services through Enabling Services Grants from HRSA.

However, depending on the geography and available resources, this existing model could be fine-tuned to address the needs of the target population and guarantee health care access. It is critical to examine the FQHC's capacity for dealing with tenants that have complex health and behavioral health conditions and whether homeless adults with serious mental health conditions will be welcome at the FQHC. Many of the FQHCs primarily serve families and are not familiar with serving the target population. The following are some of the issues on the part of the patient and the provider that need proactive solutions before proceeding with this model.

- Does the FQHC have the capacity to deliver mental health and or substance use services?
- Is there available transportation to the FQHC?
- Is there a mechanism for prioritizing permanent supportive housing tenants in order to avoid long wait times?
- Have the providers been trained in a client engagement model that establishes trust?
- Does the FQHC have the capacity to appropriately care for the complex health and behavioral health conditions of the tenants?
- Does the FQHC primarily serve families with young children? Will permanent supportive housing tenants be welcome in the FQHC clinic?

Figure 15.

Projecting FQHC Medi-Cal Revenue: Off-site Clinic-based Services					
A. Month	B. Total visits per month	C. % of Tenants with Medi-Cal	D. Number of reimbursable visits/month	E. FQHC billing rate	F. Annual reimbursement
	Enter total visits per month	Total number with Medi-Cal/total served	= B x C	Enter rate	= D x E x number of months
Months 1–6	30	30%	9	\$140	\$7,560
Months 7–12	40	45%	18	\$140	\$15,120
Months 13–24	45	60%	27	\$140	\$45,360
Months 25 on	60	70%	42	\$140	\$70,560

Some projects are taking the current model and making adjustments. The Center for Community Health Downtown Los Angeles, operated by JWCH Institute, has developed an appointment system that allows clients from the housing developments to be seen in a timely manner, avoiding long wait times and or waiting room problems. FQHC staff have committed to participating in cross-training sessions to learn models of client engagement employed by the housing case management staff. Medical staff provided on-site health education classes and/or health screening events in order to develop relationships with the tenants.

Case conferencing among medical and other project staff occurs on a regular basis, as do management-level meetings to address any emerging operational issues. Transportation to and from the off-site primary clinic can also be implemented to facilitate tenants’ access to and engagement in care.

Whether this model is a stand-alone project with one permanent supportive housing development, multiple permanent supportive housing developments, or is operating in conjunction with the other models presented above, issues of accessibility, coordination and treatment strategies need to be considered and addressed before the project begins. Financially speaking, the FQHC can continue operations as usual and only hire minimal staff or reallocate existing staff to include time spent on planning and implementation of the project. Medical assistants can also be appointed to scheduling and interfacing with housing staff and tenants. The primary investment required to make this model work is a transportation system to bring tenants from the housing development to the off-site clinic for services. If the FQHC medical home is within walking distance, providing staff escort to appointments may be a consideration.

Additionally, it is still important that the FQHC and housing provider develop shared leadership and ownership of the project, develop a clear plan for client engagement and relationship building with the tenants and meet regularly to ensure that the challenge of off-site services are met.

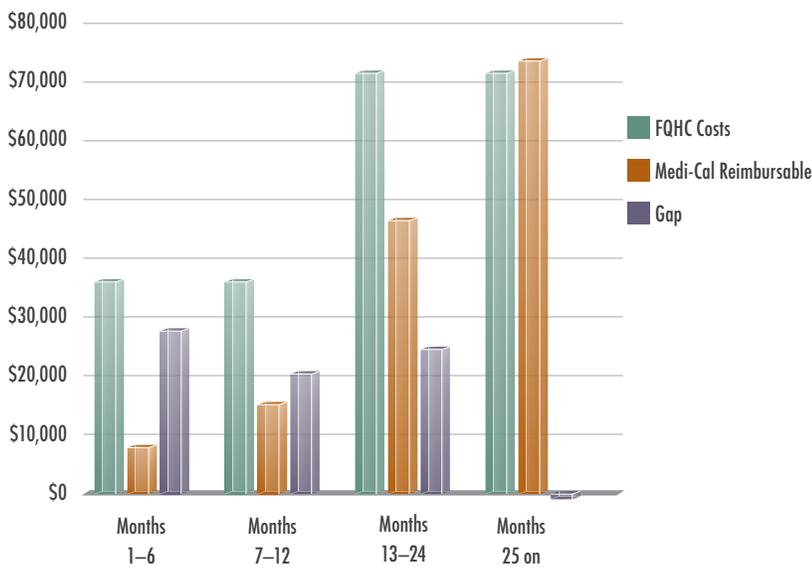
### Sample Budget for the Off-site Clinic-based Services Model

This budget assumes that an existing FQHC off-site clinic can be used to provide health and mental health care services. Depending on the number of tenants that will be accessing services and the current providers’ ability to serve the target population, additional providers may be unnecessary. However, additional providers may need to be hired over time to meet tenant needs. Each collaborative should monitor the project and adjust the balance of staff to clients as needed. For purposes of this sample budget, minimal time has been allocated for off-site clinic leadership and administrative staff to reflect time spent developing and ensuring the operation of the added project. Transportation has also been added into the budget, assuming that the off-site clinic is not within walking distance. *See Figure 14.*

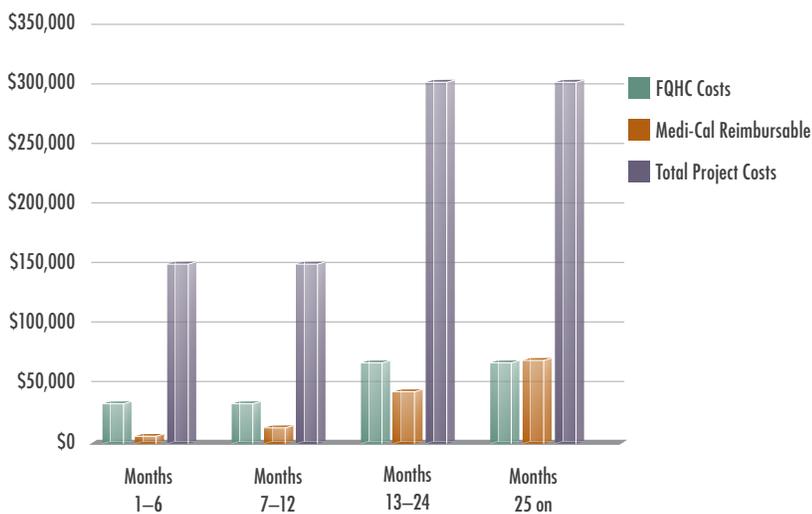
### Projecting Medi-Cal Revenue in Off-site Clinic-based Services

Projecting Medi-Cal reimbursement for this model depends upon how many housing developments are feeding into the FQHC. The sample projection following is based on a housing development(s) with a total of 50–60 tenants that will utilize clinic services. *See Figure 15.*

**Figure 16.**  
Off-site Clinic Health and Mental Health Services: Costs vs. Medi-Cal Revenue



**Figure 17.**  
Off-site Clinic: Total Project Costs with Off-site Clinic Cost vs. Medi-Cal Revenue



## Summary

The costs directly related to health care services are absorbed by the FQHC as a component of daily operations. The potential Medi-Cal revenue is dependent upon the number of housing developments feeding into the FQHC, the number of tenants accessing services and the frequency in which they do so.

Using the assumptions above, if the FQHC medical home provided services to 50-60 tenants, the revenue potential for FQHC services could cover the cost of those services by the end of the second year. This model is most effective with low acuity tenants, as they will be required to access services off-site. However, this will still require active relationship building and client engagement in order to overcome the barriers of negative experiences and resulting fears that tenants may have about the western medical model.

As the services are not provided on-site in the housing and there is no opportunity for the FQHC services to overlap with housing-based services, other sources of funding need to be identified to cover the cost of separately providing on-site, housing-based services such as case management, substance use counseling and transportation to the clinic.

Many projects have chosen to use this model in combination with the other models mentioned above to maximize patient's access to care, particularly when additional diagnostic procedures need to be performed. *See Figures 16 and 17.*

## Securing Start-up Funding

All of the models presented will require at least 2-3 years of start-up funding to sustain the project until the projected level of Medi-Cal revenue can be attained. Identifying start-up funding for an integrated health care project will require submitting your project to private foundations, private donors and identifying government grant funding. The outlook is positive as local and federal government agencies understand the cost effectiveness of providing integrated services in permanent supportive housing and are beginning to allocate money for those projects. A strong presentation detailing cost, projected revenue and length of time until your project can be sustainable should encourage private foundations and government agencies to invest money in these projects.

## Evaluating Integrated Health Care Projects

An assessment of cost effectiveness of the project, the achievement of outcomes and the process of service delivery are just some of the ways to evaluate integrated health care projects. If project leadership has an understanding of the results they intend to produce with the services provided, the program evaluation can provide valuable feedback, information and insight into the project's successes and challenges.

### Cost Effectiveness

Many new integrated health care projects attempt to measure cost effectiveness as a way of securing future funding for their project. Cost effectiveness is a measurement of the decrease in costs associated with high utilization of the crisis systems compared to the cost of providing housing and health care in a permanent supportive housing setting.

### Process-based Evaluation

This type of evaluation is useful in understanding how a program works and identifying inefficiencies or gaps in service delivery. They are also useful for helping to accurately portray how a project works to investors or other interested parties. Using qualitative data gathered from staff and tenants, this information can be used to understand the systems in place that are successful or identify where staff training may be needed.

### Outcome-based Evaluation

The outcome-based evaluation will identify if the program services are leading to the intended results. Outcomes measure the benefit a client gains by participating in the program such as enrollment in mainstream benefits, tenant stability, and increased access to health care.

- **Tenant stability**—Tenant stability is assessed by measuring how long a participant remains in permanent housing. Milestones are generally 6 months and 1 year.
- **SSI/Medi-Cal enrollment rates**—Measured by a pre/post survey of enrollment rates per participant at regular intervals.
- **Increased access to primary and behavioral health care**—Increased access to primary and behavioral health care can also be measured by type and frequency of encounters with integrated health care team members compared to frequency of non-emergency health care visits prior to placement in permanent supportive housing.
- **Behavior change**—More specific health care outcomes can be measured by each service provider and shared collectively.

All types of evaluation require a high level of coordination among service providers with a centralized data tracking mechanism to track various data elements on a daily basis. Tracking systems can be as simple as a universal form utilized by all service providers or can be advanced web-based data collection systems that are shared amongst project staff.

Most likely, large scale projects need to be responsive to data collection and reporting requirements for multiple funders, each requiring a distinct data management system. All effort should be made to integrate an existing data collection system and to avoid adding additional data collection tools.

# Developing Service Partnerships

**A**s with most of the planning decisions in establishing a permanent supportive housing project, decisions about the target population to be served will determine what organizations need to be involved in service delivery. This guide has focused on the integration of health care services into the project, but other services will be defined by the needs of the tenants.

## Identifying Potential Partners

The needs, intensity, and frequency of services will determine what partners are needed to offer the services required by the target population. This is most often led by the housing developer but can be done jointly with an FQHC if the relationship is already established.

The first questions to be addressed in assessing potential partnerships are:

- What are the services required by our target population?
- Which of the needed services do we have the capacity to provide our tenants?
- Which of the needed services do we need to have provided by partners?
- What potential partners can provide these services in this location and to this population? Capacity? Interest, desire, and willingness?

Based on the answers to these and additional questions generated, the process of recruiting partners can begin. Although this guide focuses on partnerships between FQHCs and permanent supportive housing developers, other organizations such as mental health, substance abuse, and legal services providers may be part of the overall collaboration needed for a successful integrated service delivery model. It is important to include all the service partners in the planning of the project from the beginning of the housing development phase, as this is critical to building a cohesive and coordinated service delivery system.

In Los Angeles County, there are far more permanent supportive housing developers than there are FQHCs that receive Section 330 (h) funding to provide healthcare to the homeless tenants. For that reason, a permanent supportive housing developer will need to work with one of the 330 (h) FQHC grantees or recruit an FQHC that doesn't currently serve homeless people. Both present challenges, as the current 330 (h) grantees are already involved in any number of projects and other FQHCs may be reluctant to serve homeless individuals.

The selected service delivery model will, to a great extent, determine the degree and level of intensity of the relationship between the partners. This guide outlines three basic models used by organizations to create structure and processes to meet their specific needs: project-based, clinic-based, and mobile team.

The project-based and mobile team models require a more intensive relationship between the FQHC and permanent supportive housing developer partners than the clinic-based model. These two models require the integration of service and operational processes, not merely collaboration between two or more organizations. *See Figure 18.*

The clinic-based model is not so much about shared operations as about building a strong communication and case management process. The challenges include the fact that the clinic will have many patients and the permanent supportive housing tenants may get a bit lost in the shuffle. It is vital for staff of each partner organization to ensure that communication lines are open and strong, and that tenants get to primary care and other treatment appointments.

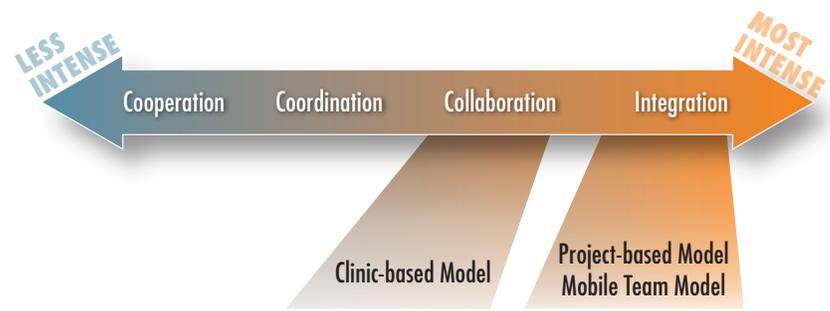
With the project-based and mobile team models, it is best to conceive these operations as a separate entity—an organization spun off from the FQHC and permanent supportive housing developer. This entity would be separate operationally, but not legally, from the “parent” organizations. The next sections are most applicable to these two models. However, lessons can be gleaned for all three.

## Building a Shared Culture and Governance Structure

Delivering services to clients from multiple providers in an integrated delivery system has been a “leading practice” for at least three decades. However, doing it well and in a manner that is truly seamless to the client continues to be an on-going challenge.

Several factors create this challenge, not the least of which are organizational cultures, governance models, and service delivery models.

Figure 18.  
Service Delivery Integration



## Organizational Culture

Organizational culture includes the attitudes, experiences, beliefs, and values of an organization. It has been defined as “the specific collection of values and norms that are shared by people and groups in an organization and that control the way they interact with each other and with stakeholders outside the organization.”<sup>22</sup>

For healthcare providers and housing developers, not only does each organization have a different culture, there are differences between the cultures of the two professions. Add to this mix the cultures of mental health, substance abuse, legal services, or other organizations and you have quite a cocktail. The differences in each of these should be acknowledged and understood. As the partnership evolves, the goal should be to build a unique organizational culture for the site or the mobile team entity.

The above Service Delivery Integration model outlines some of the elements of organizational culture to consider when planning a service partnership. In the planning, the question for each element is: Do we want to be cooperative between our organizations? Coordinated? Collaborative? Or do we want to be integrated with all that this entails? *See Figure 19.*<sup>23</sup>

<sup>22</sup> Charles W.L. Hill, and Gareth R. Jones, (2001) *Strategic Management*. Houghton Mifflin.

<sup>23</sup> Adapted from Ellis/Edwards. Pam Ellis and Peggy Edwards for Western Michigan Leadership Council, 2003.

Figure 19.  
Service Delivery Integration

	Cooperation	Coordination	Collaboration	Integration
PLANNING ELEMENTS	KEY CHARACTERISTICS			
Vision, Mission, Values	Reviewed for understanding	Supportive	Shared	Distinct for partnership entity
Strategic Goals and Objectives	Reviewed for understanding	Supportive	Shared	Distinct for partnership entity
Programs and Services	May refer clients	Reviewed to avoid overlap	May have joint service projects	Distinct for partnership entity
Service Philosophy	Aware of others'	Understand the focus of each	Understand the focus of each	Distinct for partnership entity
Leadership	Distinct	Distinct	Joint service projects have shared leadership	Distinct for partnership entity
Operating Agreements	Distinct	Distinct	Distinct	Distinct for partnership entity

### Governance and Leadership

There are many examples of both successful and unsuccessful shared leadership of integrated service delivery partnerships. In the successful ones, the participants have developed an approach, tested it, and adapted it until it worked for them. They have done this in a way that is transparent to all involved and with a feedback loop that is designed to correct processes, not criticize the participants.

Many such partnerships have found that having a matrix-style organization is most effective for bringing together a number of different professions and functions working in one partnership. In a matrix organization, people report to a leader responsible for the daily operations, as well as to a functional leader who gives specific professional guidance in areas such as health-care, mental health and legal services. In such an organization, the operational leader may conduct the performance feedback and evaluation sessions with input from the functional leader or it may be done jointly.

No matter the leadership model, the entity needs to be under the overall direction of one Board of Directors, usually the board of the housing developer. This Board needs to be well versed in the requirements and challenges of permanent supportive housing. If the housing developer and FQHC plan to develop several partnerships, it may be helpful to elect an executive or board member of the FQHC to the housing developer's Board of Directors.

### Service Delivery

Service philosophies are a reflection of organizational culture and will be very different between the various entities involved in a permanent supportive housing development. Issues such as use of alcohol or illegal substances, response to tenant behavior issues, participation in programs for tenants and even housing priority lists may cause these differences in philosophies to surface. These are all issues that need to be addressed in the planning phase, so that they don't derail the partnership once it is operating.



# “Operationalizing” It All

There are three primary tools necessary to lay a foundation for successful operations: a planning process, written agreements and a feedback and process improvement loop.

## Planning Process

The planning process can be viewed as writing the chapters of a book. Each major topic will have its own goals and objectives, implementation plan, and operating plan. The line items in the budget can be used to identify the “chapters”: staffing, facilities, finances, services etc.

Organizational culture and leadership issues need to be addressed and planned, as well. When these are just left to develop by chance, the results usually are not optimal and a lot of additional work may need to be done to repair the resulting damage. The following chart outlines some of the questions that need to be addressed in planning these areas. *See Figure 20.*

## Written Agreements

Often, it is not the written agreement itself that becomes the important deliverable in establishing an integrated service delivery system, but the process of identifying and addressing the issues and questions raised through the discussions. Answering the questions identified by the planning process will give organizations the key points to be covered in any written agreement.

## Memoranda of Understanding

Most formal partnership agreements take the form of a Memorandum of Understanding (MOU). An MOU outlines an agreement between two or more organizations. It usually governs the legal and financial aspects of the relationship. It also describes the shared goals of the organizations and how they intend to work together to achieve these goals. It indicates that the organizations signing on to the MOU have a commitment to each other to maintain the relationship. An MOU is often required by funders to ensure that the partnership they are funding will be a long-term relationship.

## Operating Agreements<sup>24</sup>

Operating Agreements are often used to specify how people within the new entity have agreed to work together. They are statements that are behavioral and process-oriented, and address areas such as methods of communication, decision-making, addressing conflict, and conducting meetings.

Operating Agreements make clear some of the organizational culture issues that stump new people joining an organization. They allow people to understand expectations because these agreements were developed and agreed to by all. When an Operating Agreement is not followed, having them allows a person’s behavior—not character—to be questioned.

<sup>24</sup> Adapted from Ellis/Edwards. Pam Ellis and Peggy Edwards, *Teams in Transition*, 2006.

**Figure 20.**  
**For Project-based and Mobile Team Models**

Planning Elements	Key Planning Questions
Vision, Mission, Values	<ul style="list-style-type: none"> <li>• What is the purpose of this development?</li> <li>• What do we aspire to achieve through this development?</li> <li>• What are our core values and key beliefs?</li> </ul>
Strategic Goals and Objectives	<ul style="list-style-type: none"> <li>• What are the major pieces of work that need to be accomplished in the next 1–3 years to achieve our aspirations?</li> <li>• How will we measure progress towards our goals?</li> </ul>
Programs and Services	<ul style="list-style-type: none"> <li>• What programs and services will be offered our tenants?</li> <li>• What programs and services will we refer our tenants to?</li> </ul>
Service Philosophy	<ul style="list-style-type: none"> <li>• What service philosophy will guide the daily decisions of our staff?</li> </ul>
Leadership	<ul style="list-style-type: none"> <li>• What leadership structure will best serve this partnership?</li> </ul>
Governance	<ul style="list-style-type: none"> <li>• Where should responsibility for governance should lie?</li> </ul>
Operating Agreements	<ul style="list-style-type: none"> <li>• How will we ensure effective communication?</li> <li>• How will we make decisions?</li> <li>• How will we address conflict?</li> <li>• How will we conduct meetings?</li> </ul>

An Operating Agreement can pilot an organization through rough times. If members trust and respect their Operating Agreements, they don't necessarily have to trust and respect each other. They allow people to have strong working relationships without necessarily having strong personal relationships.

### Examples of Operating Relationships

#### Communication

- Communication about client needs is of the highest priority to all team members.
- Team members will ensure that all medical and case management records are completed within 24 hours of interaction with the client.
- All team members are bound by professional confidentiality standards and regulations.

#### Decision-Making

- When there is clear accountability, the person with the accountability determines how decisions will be made.
- For shared decisions, the team will use consensus decision-making as the primary style and will use time limits and fallback positions.

#### Addressing Conflict

- If a team member has an issue with another team member, s/he will address the issue with him/her before taking it to anyone else.

#### Conducting Meetings

- Team meetings will be on a regularly scheduled basis and all team members will give these meetings the highest priority.
- Meeting agendas will be distributed for input 48 hours before the meeting.
- Meeting notes will be distributed within 48 hours of the meeting.

For clinic-based models, Operating Agreements may be the glue that holds the relationship between the developer and the FQHC together. Because staff don't "live" together at a site or work together directly as part of a mobile team, they will need to make the time in their busy schedules to ensure that they build the communication links and strong collaboration needed to successfully serve their shared clients. This should be a large part of the discussion when developing Operating Agreements for use in this model.

## Feedback and Process Improvement Loop

Strong organizations are continually in the learning mode and identify lessons learned from both their successes and stumbles. There are several appropriate times to exercise a feedback loop to improve processes: progress review of strategic goals and objectives, evaluation of operating agreements and debriefing staff meetings.

### Progress Review of Strategic Goals and Objectives

If the planning process has been complete, each goal and objective will have an action plan that delineates how the objective will be reached and who is accountable for each action. Holding people accountable means reviewing progress on a regular schedule. Many organizations establish a quarterly review process. That allows real progress to be made between check-in points and keeps any missteps from taking the project off too far in the wrong direction.

## Evaluation of Operating Agreements

Review of the Operating Agreements should happen more often in the early months after they are established. It is essential that these be modified and added to as the need arises. Good Operating Agreements to propose might be:

- Any team members can propose an addition or modification to an Operating Agreement at any time.
- Operating Agreements will be reviewed by the entire team every quarter.

## Debriefing Staff Meetings

The goal of any meeting process is to ensure that these sessions are a productive use of time and energy. Too often, this is not the case. There are many meeting techniques that prove effective. One is use of a debriefing process. This simple and effective technique can help teams become more efficient and effective in their work together.

Take 3–5 minutes at the end of every meeting to allow all participants to address these questions:

- What did we do well today in working together in this meeting?
- What were our struggles?
- What lessons did we learn for our future meetings?



# Appendices

## Appendix A: Steps to Creating an Effective Partnership

See Figure 21.

## Appendix B: Zoning

### Introduction

After a target population and program model has been chosen, the collaborative partners need to choose and secure a site for the housing development, if one does not already exist. The site of the development will depend on the zoning regulations in the jurisdiction in which the facility will be built.

The process of securing a location can be expensive and lengthy. Certain procedures, such as seeking a conditional use permit or a variance, can add cost and delay construction by months or even years, with no certain outcome. Project sponsors should, therefore, determine at the outset the extent to which they are able to dedicate resources toward securing a location. Some projects may be forced to choose a less than ideal location to save costs, minimize public input (which often equals public opposition), or hasten the process. The developers, the program director, the medical director and others must grapple with these questions early on and understand the cost implications of their decisions.

### Zoning Basics

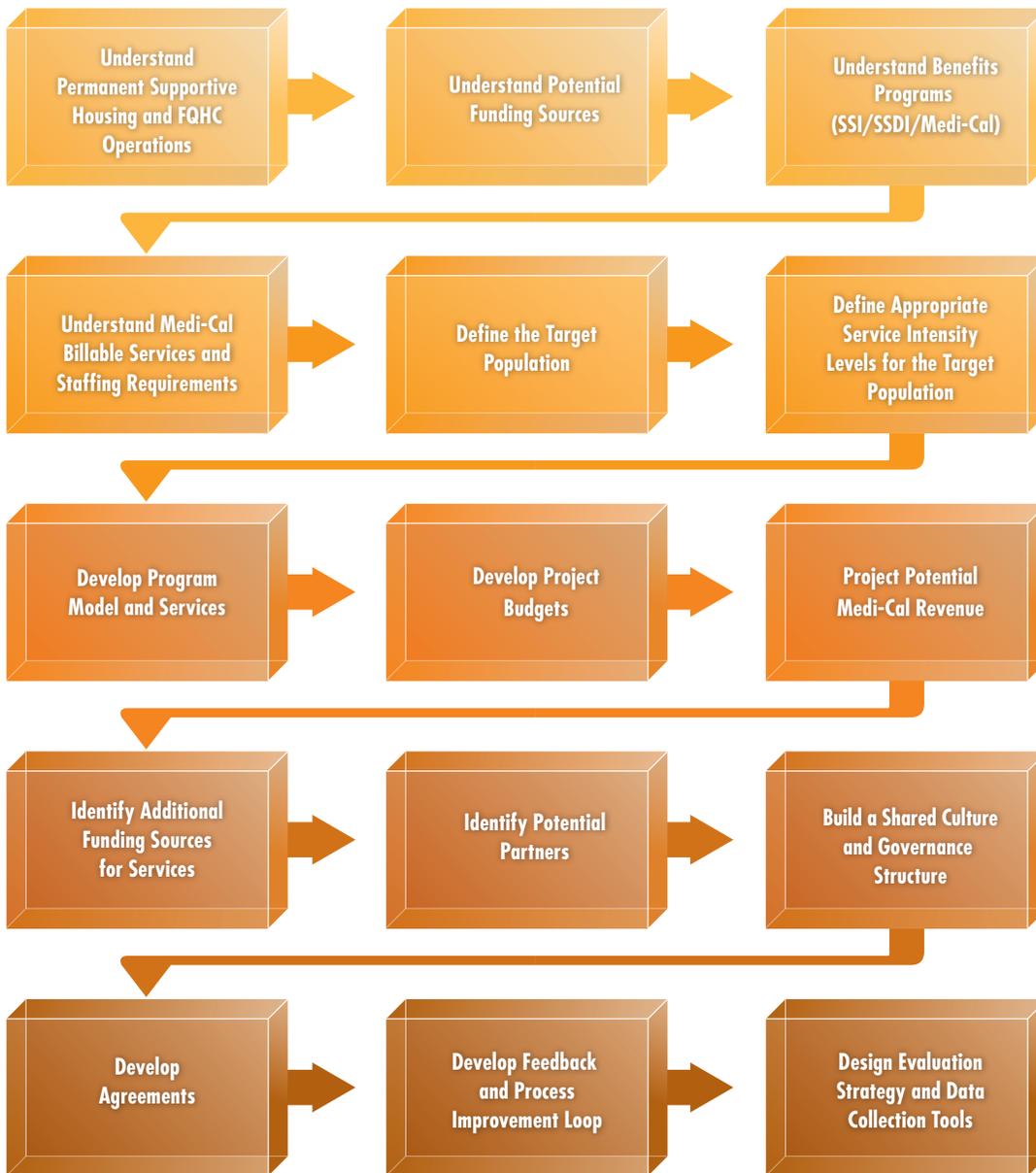
Local governments divide municipalities into zones, and create rules about what is permitted to be built and operated in each zone. These rules are called “zoning” regulations.<sup>25</sup> Generally, zoning regulations are of two types: (1) those which prescribe the use of buildings, structures, and land in certain designated zones and (2) those which regulate the design or structure of the buildings within certain designated zones.<sup>26</sup> A supportive housing developer needs to be cognizant of both types of regulations in siting a development.

A municipal zoning code typically specifies which uses are permitted as a matter of right, prohibited, or permitted by entitlement in each of the zones. If a lot is zoned as single-family residential, a single family home will be permitted by right on that lot. If a use is permitted by entitlement, then a developer or landowner needs to obtain a conditional use permit in order to use the land for that purpose. A conditional use permit is a permit issued to a landowner by an administrative agency (such as the planning commission), which allows for a particular use or activity not allowed as a matter of right in a zoning district.

<sup>25</sup> See *O’Loane v. O’Rourke* (1964) 231 CA2d 774, 780.

<sup>26</sup> See *Miller v. Board of Public Works* (1925) 195 C 477, 486.

Figure 21.  
Steps to Creating an Effective Partnership



By definition, a developer has no legal right to a conditional use permit, and whether it is granted depends on a variety of factors. Obtaining a conditional use permit involves a public hearing during which “Not-In-My-Backyard” (NIMBY) attitudes directed at homeless and disabled populations may emerge. The developer and service providers must work with the local community to alleviate concerns about housing for people with special needs.

In addition to regulating uses of land, a zoning ordinance may also regulate the structure of buildings in a particular ordinance, such as lot or set-back requirements. If a developer is un-

able to comply with these requirements, he or she may seek a variance. A variance is a permit issued to a landowner by an administrative agency to build a structure not otherwise permitted under the zoning regulations. A variance generally requires a public hearing.<sup>27</sup>

In order to encourage the development of affordable housing and housing for seniors, California requires local governments to provide a “density bonus” to affordable housing developers and developers of housing for seniors. A density bonus allows a developer to build at a

<sup>27</sup> Cal. Gov. Code 65905.

greater density than what would normally be permitted by the district’s zoning regulations.<sup>28</sup> Municipalities are also required to grant concessions or incentives to developers of affordable housing that would make development more financially feasible, such as modifications in architectural design requirements and reduced parking requirements.<sup>29</sup>

A zoning code may also require different processes for approval depending on the structure proposed. As an example, in the City of Los Angeles, a proposed development consisting of 50 or more residential units will be subjected to site plan review—a heightened review procedure which may involve public hearing.<sup>30</sup>

In designing or renovating a permanent supportive housing development that integrates primary health services, a developer may also have to take into account site certification requirements for health facilities—for example, rules regarding adequate sink space, privacy, waiting room space, and examining room size.

## Protections for Supportive Housing

Given the unique needs of the tenants, effective and safe supportive housing for people with disabilities or for low income people may not be feasible under the zoning code in a given area. Or, a community’s or planning commission’s prejudice against people with disabilities or homeless people may result in opposition to the development of a supportive housing development. Federal and California law offer some protections to developers to mitigate these barriers to developing supportive housing.

In general, state and federal law prohibits land use actions that discriminate against individuals on the basis of, among other things, disability.<sup>31</sup> Even if a local government does not intend to discriminate against a person with disabilities, a court may find a local ordinance or zoning decision to violate fair housing laws if it has a discriminatory effect on people with disabilities.<sup>32</sup> For example, a zoning ordinance limiting the number of unrelated persons that may reside together in a single family residential zone may have the effect of discriminating against people with disabilities who frequently live together in shared housing arrangements.

Local jurisdictions also have an affirmative duty to provide “reasonable accommodation” in zoning rules and policies to ensure equal opportunity housing for individuals with disabilities.<sup>33</sup> As an example, a jurisdiction may be required to waive requirements that a structure be set back from the edge of a lot so that a paved path of travel can be provided to tenants with mobility impairments.

In California, local governments are required to create a reasonable accommodation procedure that a developer may use when unable to comply with a zoning requirement.<sup>34</sup> Thus, rather than seek a variance, a developer may request a reasonable accommodation from a jurisdiction that has denied siting, or is expected to deny a variance or conditional use permit.

Local governments must treat “supportive housing” as a residential use of property and may not subject supportive housing to restrictions that do not apply to other residential buildings of the same type in the same zone.<sup>35</sup> To illustrate, if a developer wanted to build a supportive housing apartment complex in a zone in which apartment buildings are allowed as a matter of right, a municipality may not impose any barriers to development that would not be imposed on other apartment buildings in that district. If the developer wanted to build the supportive housing apartment complex in a commercial zone, then the city must treat the supportive housing development the same way that it would treat all other residential apartment buildings in the commercial zone. In order to be considered “supportive housing,” the housing must have no limit on length of stay, be linked to on-site or off-site services aimed at retaining housing, improving health, and maximizing the ability of the tenant to live in the community, and be occupied by either low-income adults with one or more disabilities or chronic health problems (including substance abuse) or by tenants with developmental disabilities.<sup>36</sup>

<sup>28</sup> Cal. Gov. Code 65915

<sup>29</sup> Cal. Gov. Code 65915(d); (k); (p).

<sup>30</sup> Los Angeles Municipal Code 16.05.

<sup>31</sup> 42 U.S.C. 3601 et seq; Cal Gov. Code 12900 et seq.

<sup>32</sup> *Gamble v. City of Escondido*, 104 F.3d 300, 304-05 (9th Cir. 1997).

<sup>33</sup> 42 U.S.C. 3604(f)(3)(B); Cal Gov. Code 12927(c)(1).

<sup>34</sup> Cal Gov. Code 65583(c)(3)

<sup>35</sup> Cal Gov Code 65583(a)(5). This restriction only applies to local governments that updated their housing element after March 31, 2008. A housing element is a document that each local government must create and update on a periodic basis that outlines how the jurisdiction is going to meet various housing needs. See Cal Gov Code 65580-65589.3.

<sup>36</sup> Cal Health & Safety Code 50675.14; Cal Gov. Code 65582(f).

Also, a local government may not disapprove a housing project for lower- or moderate-income households or condition approval of the project in a manner that renders the project unfeasible unless the government makes one of five specific findings.<sup>37</sup> This law, known SB 2, or the Housing Accountability Act, is designed to promote predictability for the development of affordable housing for lower- and moderate-income households.

For an excellent and more detailed discussion of protections for permanent supportive housing in federal and California fair housing laws and in California land use law please see Goldfarb & Lipman, LLP, *Between The Lines: A Question and Answer Guide on Legal Issues in Supportive Housing, California Edition* (2010).<sup>38</sup>

Although these protections are robust, enforcing these protections can be costly and may delay a project considerably, perhaps even by years. Like with zoning regulations, the project directors need to decide at the outset how much time and money they are able to spend to enforce their rights.

## Helpful Tips on Zoning and NIMBY-ism

We have compiled some useful tips.

- If possible, buy a property already “entitled” for intended use. Buying an entitled property can save the developer the time and expense involved in obtaining a conditional use permit or variance, and mitigates the chances that NIMBY-ism will derail the project. Some developers also recommend designing the project in a way that would minimize opportunities for public input (e.g., site plan review, parking reductions). Keep in mind that this may not be possible in your jurisdiction or in the specific neighborhood in which you intend to build.
  - Alternatively, if a conditional use permit is necessary, a developer can enter into a lease or purchase agreement that is contingent on receiving the necessary entitlement.
  - Consider making a request under your jurisdiction’s reasonable accommodation procedure before requesting a variance or a conditional use permit. The reasonable accommodation standard is more favorable to developers of supportive housing than the variance or conditional use permit standard and does not involve a public hearing. Unfortunately, not all jurisdictions will consider a reasonable accommodation request outside of the entitlement procedure or before a determination has been made on the variance or conditional use permit. In these jurisdictions, consider making a reasonable accommodation request as part of the entitlement process.
- If an entitlement is necessary, the developer should get community support early on. Before you buy the property, research the neighborhood and the key players who may oppose your project. Listen to their concerns and attempt to address them.
  - Obtain the support of the councilmember or other elected official who serves the area in which the property is located. Developers have expressed that support of elected officials is crucial in getting the project approved and in negotiating with those in the neighborhood who are most opposed to the project.
  - Hire an architect who is respected in the neighborhood. Aesthetically pleasing and innovative design can placate opposition.
  - Be prepared to address community members’ concerns about the design of the building and your tenant selection process and managerial approach. Although community members may state that they oppose the project for reasons related to parking, density, or aesthetics, they likely also have concerns about the tenants.
  - Be prepared to compromise and make concessions. You may not get everything you want.
  - Even if a conditional use permit or variance is not necessary, it is always a good idea to reach out to the community for support. One developer joined the neighborhood council in order to preemptively diffuse any criticism that the development was not benefitting the community.

For a fuller discussion on zoning and NIMBY-ism, you may wish to read, “A Guide to Successful Siting Strategies: Ensuring Delivery of Mental Health Services and Supportive Housing in Community Setting,” a useful and nuanced guide published by Los Angeles County Department of Mental Health.<sup>39</sup>

<sup>37</sup> Cal. Gov. Code 65589.5(d).

<sup>38</sup> This resource can be found at <http://documents.csh.org/documents/pubs/BTLCA.Chapters.pdf>

<sup>39</sup> The guide is available at [http://dmh.lacounty.gov/ToolsForAdministrators/Agency\\_Administration/documents/A\\_Guide\\_to\\_Successful\\_Siting\\_Strategies.pdf](http://dmh.lacounty.gov/ToolsForAdministrators/Agency_Administration/documents/A_Guide_to_Successful_Siting_Strategies.pdf)

## Zoning Issues Concerning Specific Models

### Project-based Model

The project-based care model offers health care services in a satellite FQHC operating within the housing facility. The services can be offered in a program room that functions as an exam room. Some developers have suggested that, in their experience, a conditional use permit has not been necessary to provide medical services on-site when the medical services are limited to tenants of the housing facility; rather, the services are treated like any other non-medical services that are offered to the tenants, none of which require a conditional use permit. This view would be consistent with California land use law which requires supportive housing to be treated like any other residential building, regardless of the on-site provision of supportive services.

In designing a facility with a program room that will also serve as an exam room, it is important to be aware of health clinic licensing requirements that affect the design of the room. Developers have mentioned requirements regarding adequate sink space, exam table position, locked medicine cabinets, privacy, room size, and waiting rooms.

### Mobile Team Model

In the mobile team model, the FQHC will offer health services in a fully-equipped van, a program space, or in a tenant's unit. Like with the on-site clinic, a conditional use permit will likely not be necessary if offering medical services solely to tenants. If services are going to be offered in a program room, make sure that patient privacy is protected in the room.

If providing services in a van, make sure that the parking lot is designed to accommodate a large mobile unit.

### Clinic-based Model

In the clinic-based care model, health care services are provided at the FQHC and permanent supportive housing tenants walk or take transportation in order to access the services. This model will not pose any unique zoning concerns because the clinic and the housing development will be zoned separately.

## Case Study

A developer relayed to this guide's authors an example of the difficulties involved in securing a site for a development. The developer selected a site in the City of Los Angeles for a permanent supportive housing project that would integrate health care services from a FQHC. Luckily, the site was already entitled for multi-family use and a conditional use permit was not needed. Moreover, because the proposed development was under fifty units, site plan review was not required. Due to the fact that the development was going to house fewer than sixty individuals, the partner FQHC determined that a satellite clinic on-site would not be financially feasible. Instead, the developer and the FQHC decided that health care services would be provided on a large van or Winnebago by a mobile team.

However, the chosen site was in a neighborhood that was subject to a specific plan. A specific plan refers to zoning requirements that apply to a specific neighborhood for the purpose of ensuring that land uses and development in that neighborhood occur in a manner that is compatible with or complements the existing community. This particular specific plan required that there be an overhang over an outdoor parking lot. Unfortunately, an overhang would not allow sufficient room for a large van to park outside the building. At the time of writing, the developer is strategizing as to how to obtain community support for a variance from the specific plan so that the development can go forward.

This example illustrates that, despite one's best attempts at minimizing public input, even "perfect" sites pose challenges. Although the developer specifically sought out a lot entitled for intended use and designed a development that would not require site plan review, the specific parking requirements of the neighborhood have made it necessary for the developer to obtain approval from the community.

## Appendix C: Funding Sources

### Sources of Capital Funding in Los Angeles, California

Note: The following represents the Corporation for Supportive Housing's best interpretation of the programs, policies, and regulations described, but interested individuals and organizations should consult with the appropriate administrative agencies and regulatory information.

#### FEDERAL

##### DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT (HUD)

###### Home Investment Partnership (HOME) Program

This source of federal funds represents the largest federal block grants to state and local governments designed exclusively to create affordable housing for low-income households. Each year, HUD allocates more than \$1 billion in HOME funds as formula grants to "entitlement communities" (cities and urban counties) and states that communities use: to construct, acquire and/or rehabilitate affordable housing for rent or homeownership; or, to provide direct rental assistance to low-income people.<sup>40</sup> HUD establishes Home Investment Trust Funds for each grantee, providing a line of credit that the jurisdiction may draw upon as needed. The program's flexibility allows state and local governments to use HOME funds for grants, loans, loan guarantees or other forms of credit enhancement, and/or rental assistance and security deposits.

###### Housing Opportunities for Persons with AIDS (HOPWA)

The purpose of the Housing Opportunities for Persons with AIDS (HOPWA) Program is to provide states and localities with the resources and incentives to devise long-term comprehensive strategies for meeting the housing needs of persons with HIV/AIDS or related diseases and their families. HOPWA is the leading federal source of capital, operating and services financing for the development and operation of housing programs that serves persons with HIV/AIDS, and

is principally allocated to cities and states based on the incidence of AIDS diagnoses in their communities. HOPWA grant funds for capital financing are typically combined with other sources of capital funds.

###### Community Development Block Grant (CDBG)

Beginning in 1974, the Community Development Block Grant (CDBG) program provides funding to entitlement communities (cities and urban counties) and states. States and entitlement communities receive their allocation of funds on an annual basis and they use these funds either on their own projects or sub-allocate funds to local non-profits for eligible activities.

The amount of funding HUD allocates to entitlement communities and states is based upon a formula comprised of several measures of community need, including population, the extent of poverty, housing overcrowding, age of housing and population growth in relationship to other metropolitan areas. Each state and entitlement community establishes its own competitive process for awarding of CDBG funds to sub-grantees.

###### Supportive Housing Program (SHP)

The Supportive Housing Program (SHP) is one of three grant programs collectively known as the Continuum of Care (CoC) funding. SHP is the only program that may be used for capital costs. The other two CoC programs, the Shelter Plus Care (S+C) Program and the Section 8 Moderate Rehabilitation Single Room Occupancy (SRO) Program, are rent subsidy programs. SHP provides funding for the development and operation of programs that help homeless persons transition from homelessness to living as independently as possible. HUD makes the Continuum of Care funding available under the annual SuperNOFA process, and applications for this competitive grant program are administered through local CoC councils<sup>41</sup>, which determine priorities and application evaluation processes in compliance with HUD regulations and policies.

###### Supportive Housing for Persons with Disabilities (Section 811)

HUD's Supportive Housing for Persons with Disabilities (Section 811) program provides financing for acquisition, rehabilitation or construction, as well as an operating subsidy,

<sup>40</sup> Entitlement communities include communities of 50,000 or more residents, other local governments designated as central cities of metropolitan areas, and urban counties with populations of at least 200,000.

<sup>41</sup> Los Angeles Homeless Service Authority is the joint powers entity of the City and County of Los Angeles that is the CoC body that administers the SHP and other CoC Programs.

for supportive housing for persons with disabilities, such as physical disabilities, developmental disabilities, chronic mental illness or any combination of the three. This funding source has been frequently used to create supportive housing for homeless adults with disabilities, particularly in communities with limited capital or rental subsidy funds. The clear advantage of this program is that the capital sources are accompanied by the necessary rental subsidies, but disadvantages include that only relatively limited funds are available each year and the allowable developers' fees are low.

### **The Supportive Housing for the Elderly Program (Section 202)**

SECTION 202 provides a no interest capital advance and rental subsidies for the rehabilitation or construction and operation of permanent supportive housing for the elderly (persons 63 and older), and has been used successfully by many developers of housing for the elderly. The capital advance does not have to be repaid so long as units remain rented to very low-income elderly for at least 40 years. While not targeted for elderly persons who are homeless, the housing projects developed can be targeted toward that population. Challenges for using this source successfully for supportive housing developments include the lack of service funding attached to this program, the limited allowances for the development of common areas and/or services spaces and the low allowable developers fees.

### **HUD/DEPARTMENT OF DEFENSE (DOD) BASE CLOSURE COMMUNITY REDEVELOPMENT AND HOMELESS ASSISTANCE ACT OF 1994**

#### **Base Realignment and Closure (BRAC) Program**

Public agencies and private nonprofit homeless assistance organizations that provide or propose to provide assistance to homeless persons and families are often eligible for one of several public benefit conveyance programs that make surplus properties available at up to a 100-percent discount of fair market value. Surplus military property may be conveyed to these public agencies and private nonprofits to provide vital public services including permanent housing, supportive services, job and skills training, employment programs, or any other activity that clearly meets an identified need of the homeless and fills a gap in the local Continuum of Care.

### **Federal Home Loan Bank of San Francisco (AHP)**

The Federal Home Loan Bank (FHLB) Affordable Housing Program (AHP) is operated through the FHLB's 12 District Banks located throughout the United States. Each of the District Banks contributes at least 10% of its annual net earnings to AHP funding, which subsidizes the cost of housing for very low-income and low- or moderate-income owner-occupied and rental housing projects by providing gap financing for affordable housing projects, including permanent supportive housing projects. For a rental project to qualify, at least 20% of the units must be for families earning 50% or below of area median income. Developments serving homeless, special needs, and/or very low-income populations receive additional points in the application scoring process, and AHP grants are frequently sought by supportive housing project sponsors due to the flexibility of the funds and the ability to fill financing gaps in the later phases of developing a financing package.

### **Low Income Housing Tax Credits (LIHTC)**

Low Income Housing Tax Credits are incentives for private individuals and corporations to invest in low-income housing. The Tax Reform Act of 1986 created this program, which provides a dollar-for-dollar credit against income taxes owed to the federal government, as opposed to tax deductions, which reduce taxable income. In exchange for these benefits, individuals and corporations invest in low-income housing, paying less than a dollar for a dollar's worth of credit (thereby creating a return on their investment). Non-profit housing developers have become quite sophisticated in accessing tax credits for their projects. Developers can then sell the credits to investors, and use the proceeds as equity in the project—often providing between 30%-50% of the total development costs. The tax credits are offered by state agencies, typically state housing finance agencies, which receive an allocation of credits from the federal government on a per-capita basis.

## **STATE OF CALIFORNIA**

### **Governor's Homeless Initiative**

This initiative integrates three funding programs in its effort to reduce homelessness. The foundation of the initiative was \$37 million in Multifamily Housing Program (MHP) funds being set aside for permanent development financing throughout the state. The monies are for financing of hous-

ing for persons with severe mental illness who are chronically homeless. Announced in November 2005, the funds are currently exhausted and need to be refunded.

## DEPARTMENT OF HOUSING AND COMMUNITY DEVELOPMENT MULTIFAMILY HOUSING PROGRAM (MHP)

### General Pool

The Multifamily Housing Program is a statewide program designed to assist with the development of permanent and transitional rental housing. Through the General Pool, \$345 million has been made available with Proposition 1C funds. The Program is legislatively mandated to ensure a reasonable geographic distribution of funds. Local public entities, non-profit organizations, for-profit entities, limited equity co-operatives, limited partnerships, individuals, Indian reservations and rancherias are eligible to apply for funding. Besides the development of housing units, MHP funds can be used to develop facilities for child care, after school care and social services linked to assisted housing units. Refinancing to retain affordable rents, property acquisition, on-site and off-site improvements, development fees, consulting costs and capitalized reserves are all eligible items for funding. Though these are all eligible items, MHP funds only are provided for post-construction permanent financing.

### Supportive Housing Pool

Projects must include supportive housing units equal to the greater of 5 or 35% of total project units. Projects serving the homeless are eligible for a higher loan amount; or are provided the ability to use the MHP funding as leverage with 9% tax credit applications.

### Homeless Youth Supportive Housing Pool

Projects must contain at least 5 homeless youth housing units (rooms in single family houses or apartments do not count as units). Projects must include new construction, rehabilitation or conversion, and development costs are eligible. The target population is individuals between the ages of 18-24 who are homeless, at-risk of homelessness, or have aged out of the foster care system; have run away from home or a person less than 18 who is emancipated and homeless or at risk of homelessness.

## CALIFORNIA HOUSING FINANCE AGENCY (CALHFA)

### Special Needs Financing Program

Offers low interest rate financing for the development of rental housing to serve special needs tenants requiring an array of supportive services to live independently.

### Housing Enabled by Local Partnerships (HELP) Program

The HELP Program offers to local government entities (Cities, Counties, Housing Authorities, and Redevelopment Agencies) twice annually an opportunity to apply for funds to increase housing opportunities consistent with their housing priorities. Shelters and group home projects as well as other housing to meet special needs are eligible.

## MENTAL HEALTH SERVICES ACT (see MHSA—Los Angeles County)

### California Tax Credit Allocation Committee Programs (TCAC)

TCAC administers the federal tax program and a State of California tax credit program. To be eligible for State Tax Credits, a project must first be awarded tax credits under federal tax credit program.

### California Debt Limit Advisory Committee (CDLAC)

CDLAC was created in response to the 1984 Tax Reform Act to allocate the state's bond ceiling. CDLAC is responsible for establishing procedures and allocating the annual debt ceiling which is done through a series of funding pools, including a general pool which has more than 50% of the units designated as restricted rental units; and a mixed income pool having 50% or less of the units designated as restricted rental units. Public agencies or joint powers authorities may file an application. Private and non-profit developers may apply for funding through one of the recognized public bodies.

## LOS ANGELES COUNTY

### COMMUNITY DEVELOPMENT COMMISSION

#### City of Industry Housing Program (COI)

The City of Industry Funds (Industry Funds) is another financing resource for the development of affordable housing. Industry Funds are tax increment set-aside funds administered by the Housing Authority of the County of Los Angeles (HACoLA). Industry Funds help fund affordable rental housing for Non-Special Needs and Special Needs popula-

tions, and affordable homeownership developments. City of Industry funds are awarded on a competitive basis through a request for proposals issued by the Community Development Commission. Industry funds may be used in any jurisdiction within a 15-mile radius of the City of Industry.

The program has a set aside for Special Needs populations including persons who are homeless or at-risk of homelessness, domestic violence victims, emancipated foster youth, persons with HIV/AIDS, developmentally disabled persons, mentally ill persons and persons who are frequent users of services of the Department of Health Services and/or Department of Mental Health. Applications for Special Needs housing must set aside 35 percent of the units to serve one of the above special needs populations earning at or less than 50% of the Los Angeles County median income.

## DEPARTMENT OF MENTAL HEALTH

### Mental Health Services Act (MHSA)

This program is administered by the California Housing Finance Agency (CalHFA) under an interagency agreement with the Department of Mental Health.

On August 6, 2007 the California Department of Mental Health (State DMH) and the California Housing Finance Agency (CalHFA) launched the Mental Health Services Act (MHSA) Housing Program that provides funding to support capital development and capitalized operating subsidies for supportive housing for individuals with psychiatric disabilities and their families who are homeless or at risk of homelessness. Each County had the ability to assign MHSA funds to this program. Los Angeles County allocated \$115,571,200 to the MHSA Housing Program for the development of supportive housing, a third of which can be used for capitalized operating subsidies. To obtain additional details, refer to the State's website at [http://www.dmh.ca.gov/Prop\\_63/MHSA/Housing/default.asp](http://www.dmh.ca.gov/Prop_63/MHSA/Housing/default.asp). As stated on the State's website, eligible developers and borrowers must develop proposals in conjunction with local departments of mental health, which will then submit an application to CalHFA. Applications must include a local commitment to provide mental health services for individuals who will reside in the proposed housing units. For information on the Los Angeles County Department of Mental Health process for obtaining the funds, visit [http://dmh.lacounty.gov/DMHServices/Countywide\\_Services/mhsa\\_housing.html](http://dmh.lacounty.gov/DMHServices/Countywide_Services/mhsa_housing.html).

## CITY OF LOS ANGELES

### CITY OF LOS ANGELES HOUSING DEPARTMENT

#### Permanent Supportive Housing Program

This low interest, residual receipts loan program is administered by the Los Angeles Housing Department in collaboration with 4 city or quasi-public agencies: Los Angeles Housing Department (LAHD), Housing Authority of the City of Los Angeles (HACLA), Community Redevelopment Agency of Los Angeles (CRA), and the Los Angeles Department of Water and Power (LADWP). Under this program, a minimum of 50% of a development's units must be reserved for formerly homeless households. In projects serving single adults, a minimum of 35% and a maximum of 60% of the units must serve people with special needs who are chronically homeless. Projects must be a minimum of 40 units excepting projects serving transition-age youth, which may be less than 40 units. Priority is given to applicants who have a partnership with a County-designated "Full Service Partnership" provider or FQHC.

#### Affordable Housing Trust Fund (AHTF)

Through the Affordable Housing Trust Fund, the City is creating housing for low and very-low income households, as well as revitalizing neighborhoods and removing blight. All units created must be affordable to households at or below 60% of the area median income. Housing for populations requiring extensive service (such as chronically homeless, chronic substance abusers, persons with serious emotional disturbances) is excluded from consideration. Applications to provide housing for them may be submitted through the Permanent Supportive Housing Program.

#### Community Redevelopment Agency of the City of Los Angeles Low and Moderate Income Housing Program

CRA/LA is responsible for implementing the California Legislature's intent to supply decent, safe and sanitary housing affordable to persons and families of extremely low, low- or moderate-income in designated redevelopment areas. In the City of Los Angeles these areas include 32 redevelopment projects areas and three revitalization areas in seven regions: East Valley, West Valley, Hollywood and Central, Downtown, Eastside, South Los Angeles and the Harbor. By providing low interest, residual receipts loans, CRA's goal is to assist in reducing the homeless population through

balancing the production of permanent affordable housing with appropriate support services and transitional housing for homeless and potentially homeless persons and families. A priority for both permanent and transitional housing assistance is given to serving chronically homeless individuals, families with children, women, youth, the physically or developmentally disabled and the chemically dependent.

## Sources of Operating Subsidies and Rental Assistance Funding in Los Angeles, California

### FEDERAL

#### DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT (HUD)

##### Section 8 Program

This HUD-administered resource is unique in that it offers both tenant-based and project-based rental assistance. Both programs are designed to bridge the gap between the cost of operating and maintaining housing units and what low-income individuals and families can afford to pay in rent. Fortunately for sponsors seeking to serve homeless persons, who have little, and often fixed, incomes, HUD has mandated that at least 75% of families admitted to the Section 8 program must be extremely low-income (i.e., less than 30% AMI). The Section 8 Program is administered at the local level by Local Housing Agencies, also known as Housing Authorities, who receive Section 8 funding through an Annual Contributions Contract.

##### Shelter Plus Care Program

The Shelter Plus Care program is one of three HUD sources collectively known as the Continuum of Care (CoC) funding (the others are the Supportive Housing Program and the Section 8 SRO Moderate Rehabilitation Program), which is made available annually by HUD as part of their Super-NOFA competition. The program provides rental assistance so long as the project sponsor can match those funds with supportive services from sources outside of the program. Similarly to the Section 8 program, tenants pay 30% of their adjusted income for rent, and the assistance can be provided in a tenant-based, project-based or sponsor-based format. The program is a very popular mechanism to deliver supportive housing to homeless, disabled households and in some respects is a bit more flexible than the Section 8 program.

##### Supportive Housing Program

The HUD Supportive Housing Program (SHP), discussed earlier under capital resources, is another CoC program and a widely popular supportive housing resource in that it funds a range of activities (from rehabilitation to supportive services) and project types (permanent housing, transitional housing, Safe Havens, etc.). SHP permanent housing projects, which are required to serve only disabled households, are eligible to receive operating funds considered by HUD to represent the costs associated with the day-to-day functioning of supportive housing and for which cash is needed. Eligible activities include maintenance, repair, operations staff, utilities, equipment, supplies, insurance, food, relocation and furnishings. Project sponsors requesting funding for operations expenses must match HUD's commitment with 25% of the total operating budget. Regrettably for Los Angeles supportive housing sponsors, the program has been over-subscribed for several years, leaving local CoCs in the unenviable situation of having to revisit their funding priorities.

### LOS ANGELES COUNTY

#### DEPARTMENT OF MENTAL HEALTH

##### Mental Health Services Act (MHSA) Housing Program

The Mental Health Services Act (MHSA), discussed earlier under capital resources, also provides for project operating support in the form of capitalized operating subsidies. Projects that request these subsidies must require them to cover their operating costs, receive funds for capital costs from the MHSA Housing Program, and have applied for but have been denied rental or operating subsidies from all other available and appropriate sources (for at least one application cycle), including Section 8 Project-Based Vouchers, S+C, and SHP. The tenant portion of the rent must be limited to 30% of the current SSI/SSP amount for a single individual living independently or 30% of total household income, whichever is higher.

# Sources of Services Funding in Los Angeles, California

## FEDERAL

### DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT (HUD)

#### Supportive Housing Program Supportive Services Grant (SHP)

The Supportive Housing Program (SHP) helps develop housing and related supportive services for people moving from homelessness to independent living. Services directly facilitating the movement of homeless participants to independent living are eligible for SHP grants. Program funds help homeless people live in a stable place, increase their skills and their income and gain more control over the decisions that affect their lives. SHP support includes activities such as outreach, case management, childcare, job training/ placement, health care and transportation. SHP grantees must share in the costs of supportive services, including a 20 percent cash match of the total services budget. Grantees are encouraged to augment the support received in this activity via mainstream resources like Medicaid or Supplemental Security Income (SSI).<sup>42</sup>

The majority of HUD SHP money is coordinated and managed by the Los Angeles Homeless Services Authority (LAHSA), a Joint Powers Authority established in 1993 as an independent agency by the County and the City of Los Angeles. LAHSA is the lead agency in the Los Angeles Continuum of Care. The Continuum of Care (CoC) is a set of three competitively-awarded programs created to address the problems of homelessness in a comprehensive manner with other federal agencies.<sup>43</sup> (See Los Angeles County, Los Angeles Homeless Services Authority)

#### Housing Opportunities for Persons with AIDS (HOPWA)

HOPWA funding is available for supportive services that assist Persons Living with HIV/AIDS (PLWH/A) and their families in adjusting to their new living arrange-

ments, successfully maintaining independent living, and coordinating their overall housing and services needs. The program includes both a Formula Grant and a Competitive Grant component. Approximately 90% of the funding is distributed to states and cities in formula grants, while the remaining 10% is competitively available on an annual basis for model projects or programs. HUD decides which states and municipalities receive a Formula Grant based upon the rate of incidence of HIV/AIDS diagnoses as recorded by the Center for Disease Control. The states or municipalities that have the highest incidences of HIV/AIDS receive formula grants which can establish their own processes for awarding HOPWA funds to sub-grantees. States, municipalities and individual not-for-profit organizations can also apply directly to HUD for HOPWA funding under the Competitive Program.

The Los Angeles Housing Department administers the HOPWA grant.<sup>44</sup> (See City of Los Angeles, Los Angeles Housing Department, HOPWA).

### DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS)

#### Centers for Medicare and Medicaid Services (CMS)

##### Medicaid

Medicaid is a federal entitlement program, matched by state and local dollars, that funds primary health care and behavioral healthcare for low-income families and disabled or elderly individuals. The Medicaid health care reimbursement program is jointly funded and administered by the Federal and state governments and plays a critical role in assisting people who experience or are at risk of homelessness to access vital medical, behavioral health and support services. These services can make important contributions to meeting the immediate needs of homeless people and help them to achieve self-sufficiency. Providers must meet certain criteria as set by the state in order to enroll in the Medicaid program. (See also: State of California, Department of Health Care Services, Medi-Cal).

<sup>42</sup> *Supportive Housing Program Fact Sheet* <http://www.hudhre.info/index.cfm?do=viewSupportiveHousingProgram>

<sup>43</sup> U.S. Department of Housing and Urban Development, Community Planning & Development: Competitively Awarded Homeless Programs (Continuum of Care). <http://www.hud.gov/offices/cpd/homeless/programs/coc>

<sup>44</sup> Corporation for Supportive Housing, November 2007, Corporation for Supportive Housing Financing Guide: Housing Opportunities for Persons with AIDS (HOPWA).

## Substance Abuse and Mental Health Services Administration (SAMHSA)

The majority of SAMSHA resources in community services systems are Federal block grant resources. In some cases, ongoing funding for services in supportive housing are funded through contracts with local departments of health, mental health, behavioral health and social services using these dollars. For supportive housing providers, what is important about these programs is to know they exist and that there is oftentimes flexibility at the state and local level to use these resources to fund many of the services most commonly found in supportive housing.

The majority of funding from SAMHSA comes through the California Alcohol and Drug Program (ADP) to the Los Angeles County Department of Public Health's Substance Abuse Prevention and Control (SAPC) program through SAMHSA Substance Abuse Treatment (SAPT) Block Grant (see Los Angeles County Department of Public Health, Substance Abuse Prevention and Treatment). However, SAMSHA also awards grants directly to organizations through periodic Requests for Applications. Recent applicable grant and awards include Services in Supportive Housing and Primary and Behavioral Health Care Integration grants. In general, supportive housing sponsors should familiarize themselves with the Services and Best Practices Planning and Implementation standard grant programs as the majority of discretionary funding for substance abuse and mental health services that can be used in supportive housing will be found there.

## DEPARTMENT OF VETERANS AFFAIRS (VA)

### Supportive Services for Veteran Families Program (SSVF)

The Supportive Services for Veteran Families Program is a relatively new VA program that will award grants to private non-profit organizations and consumer cooperatives that will provide supportive services to very low-income Veterans and their families residing in or transitioning to permanent housing. The grantees will provide a range of supportive services designed to promote housing stability.<sup>45</sup>

---

<sup>45</sup> United States Department of Veteran's Affairs, Homeless Program Supportive Services for Veteran Families Program webpage. <http://www.va.gov/homeless/ssvf.asp>

## Veterans Affairs Supportive Housing Program (HUD-VASH)

While the HUD VASH Program does not provide services funding directly to Community Based Organizations (CBOs), they will provide comprehensive case management services to program VASH Voucher program participants in order to guarantee the highest possible rates of housing retention. HUD-VASH participants must live in areas accessible to case management services as determined by the partnering VA Medical Center.

## STATE OF CALIFORNIA

### DEPARTMENT OF HOUSING AND COMMUNITY DEVELOPMENT (HCD)

#### Multi-family Housing Program (MHP)

The Multifamily Housing Program is a statewide program designed to assist with the development of permanent and transitional rental housing. Besides the development of housing units, MHP funds can be used to develop facilities for child care, after school care and social services linked to assisted housing units. HCD program funds may be used for approved costs of on-site supportive services coordination as a project operating cost, payable from operating income. It is important to note that direct services are not allowable costs for this source of funding.

### DEPARTMENT OF HEALTH CARE SERVICES (DHS)

#### Medi-Cal

In California, the federal Medicaid Program is administered by the state as the California Medical Assistance Program (Medi-Cal). This program provides health care services to welfare recipients and other qualified low-income persons (primarily families with children and the aged, blind, or disabled). The federal Centers for Medicare and Medicaid Services oversees the program to ensure compliance with federal law. At the state level, the Department of Health Services (DHS) administers the Medi-Cal Program.

Other state agencies, including the California Medical Assistance Commission, the Department of Social Services, the Department of Mental Health, the Department of Developmental Services, the California Department of Aging and the Department of Alcohol and Drug Programs (ADP) receive Medi-Cal funding from DHS for eligible services that they

provide to Medi-Cal beneficiaries through an Interagency Agreement. At the local level, county welfare departments determine the eligibility of applicants for Medi-Cal and are reimbursed by DHS for the cost of those activities.<sup>46</sup>

The objective of the Medi-Cal program is to provide essential medical care and services to preserve health, alleviate sickness, and mitigate handicapping conditions for individuals or families on public assistance, or whose income is not sufficient to meet their individual needs. The covered services are generally recognized as standard medical services required in the treatment or prevention of diseases, disability, infirmity or impairment. These services are comprehensive and provide care in the major disciplines of health care.<sup>47</sup>

## DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS

### Drug Medi-Cal

The Department of Alcohol and Drug Programs (ADP) administers Drug Medi-Cal (DMC) funding through its Interagency Agreement with the Department of Health Services. ADP licenses and certifies DMC treatment providers; funds reimbursements for substance abuse treatment through county alcohol and drug programs and directly to some treatment providers (see Los Angeles County Substance Abuse Prevention and Control); and monitors treatment providers in order to ensure that they are following the California Code of Regulations (CCR), Title 9 and Title 22, which govern DMC treatment.<sup>48</sup> Services must be provided at a location certified by ADP. Any DMC certified provider choosing to provide DMC services can contract with the local county. If the county declines to contract for services, the DMC provider can contract with State ADP. Providers interested in providing Drug Medi-Cal services are through the state ADP must first apply to be certified through ADP.

## LOS ANGELES COUNTY

The majority of service providers that have been awarded a County contract have participated in a County competitive selection process. Providers interested in participating in the competitive selection process to become a County contractor must register with the County. Agencies MUST be regis-

tered vendors with the County to receive a contract from any County agency. Registered vendors are eligible to respond to county Open Bids/Requests for Proposals.<sup>49</sup>

## COMMUNITY DEVELOPMENT COMMISSION (CDC)

### City of Industry Funds (COI)

City of Industry funds are available within a designated 15-mile radius of the City of Industry boundaries. The funds are intended to cover expenditures associated with creating affordable rental housing for both special needs and non-special needs populations. Industry Funds help fund affordable rental housing for Non-Special Needs and Special Needs populations, and affordable Homeownership developments.

Awarded with capital funds, COI program funds may be used for approved costs of on-site supportive services coordination as a project operating cost, payable from operating income. It is important to note that direct services are not allowable costs for this source of funding.

## DEPARTMENT OF CHILDREN AND FAMILY SERVICES (DCFS)

### Transitional Housing Program-Plus (THP Plus)

The THP-Plus program was established by the California State Legislature in 2001 to address the needs of a growing yet largely overlooked group of at-risk youth: those who “age out” or “emancipate” from the state’s foster care system. The THP-Plus program provides affordable housing and comprehensive supportive services for up to 24 months to help former foster care and probation youth ages 18 to 24 make a successful transition from out-of-home placements to independent living. With input from stakeholders The County Department of Children and Family Services submits an initial and then annually updated plan outlining, need, services implementation schedule and rate to the state. Once the plan is approved the county distributes the funds to providers through an RFP process.

<sup>46</sup> California Department of Healthcare Services: Alcohol and Drug Programs. [http://www.adp.cahwnet.gov/dmc/dmc\\_introduction.shtml](http://www.adp.cahwnet.gov/dmc/dmc_introduction.shtml)

<sup>47</sup> California Department of Healthcare Services, Provider Manual, Part 1—Medi-Cal Program and Eligibility.

<sup>48</sup> Ibid.

<sup>49</sup> County of Los Angeles Department of Public Health, Substance Abuse Prevention and Control—Frequently Asked Questions.

## DEPARTMENT OF MENTAL HEALTH

Through various federal, state and local funding sources Los Angeles County Department of Mental Health including its network of community based organizations (CBOs) that it contracts with provides specialized mental health services to adults with Serious Mental Illness and children who are Seriously Emotionally Disturbed (SED). In order to maximize resources and leverage Federal Medicaid matching dollars, most providers selected for contracts must be certified to be eligible for reimbursement for providing Medi-Cal services. Primary mental health services include targeted case management, medication support, rehabilitation, crisis intervention and individual and group therapy. Requests for Statement of Qualifications and Request for Services are announced as funding is available. The Department selects contractors based on the evaluation of qualified proposals that are submitted through the solicitation process.

## DEPARTMENT OF PUBLIC HEALTH SUBSTANCE ABUSE PREVENTION AND CONTROL DIVISION (SAPC)

### Substance Abuse Prevention and Treatment Block Grants (SAPT)

Largely through SAMHSA SAPT Block Grant and state and local general funds, SAPC contracts with community-based organizations to provide a wide array of alcohol and other drug prevention, treatment and recovery programs and services for individuals. In addition to becoming a registered vendor with the County of Los Angeles, providers interested in contracting with SAPC to provide substance abuse services should sign up for the SAPC's bidders' list. Agencies on this list will be notified of any new RFPs.

### Drug Medi-Cal (DMC)

Drug Medi-Cal services are services that are provided by an ADP/SAPC certified provider. Billing for reimbursement through Drug Medi-Cal may be separate and distinct source of funding for substance abuse services than the SAPC contract services described above. Drug-Medi-Cal may also be in addition to a SAPC contract awarded through an RFP. DMC services must be approved by a physician as medically necessary to an individual who is otherwise Medi-Cal eligible. The services eligible for reimbursement through the DMC system are outpatient drug free, narcotic treatment program (formerly outpatient methadone maintenance), day care rehabilitative, naltrexone, and perinatal residential. Reimbursement for DMC services will normally be obtained through a DMC contract with the county.

## LOS ANGELES HOMELESS SERVICES AUTHORITY

The Los Angeles Homeless Services Authority (LAHSA) is a Joint Powers Authority established as an independent agency by the County and the City of Los Angeles and is the lead agency in the Los Angeles Continuum of Care. LAHSA coordinates and manages over \$70 million dollars annually in Federal, State, County and City funds for programs providing shelter, housing and services to homeless persons in Los Angeles City and County. Additionally, LAHSA partners with both the City of Los Angeles and the County of Los Angeles to integrate services and housing opportunities to ensure wide distribution of service and housing options throughout the Los Angeles Continuum of Care.

Through LAHSA, funding, program design, outcomes assessment and technical assistance is provided to over 100 non-profit partner agencies who operate within the City and County assisting persons who are homeless achieve independence and stability in permanent housing. LAHSA selects and funds providers to operate homeless programs through a public solicitation process. Interested parties are notified of released funding availability through an email notification that is typically an issued Request for Proposals (RFP).<sup>50</sup> Providers interested in receiving notification from LAHSA should join their mailing list.

## CITY OF LOS ANGELES

### LOS ANGELES HOUSING DEPARTMENT (LAHD)

#### Los Angeles Housing Department Permanent Supportive Housing Program (LAHD PSHP)

The purpose of the Permanent Supportive Housing Program (PSHP) is to Increase the supply of supportive housing for L.A.'s homeless population. Awarded with capital financing, funds may be used for approved costs of on-site supportive services coordination. Direct services are not allowable costs for this source of funding.

#### Los Angeles Housing Department HOPWA Grant

The City of Los Angeles administers the HOPWA grant for 29 agencies and 4 housing authorities to provide housing related supportive services and rental assistance programs to low income, homeless and at risk homeless persons living with HIV/AIDS in the County of Los Angeles. LAHD awards contracts to providers based on an RFP process.

---

<sup>50</sup> <http://www.lahsa.org/fundingopportunities.asp>

