Building Community Collaborations for Supportive Housing – the Untold Story in Health Care Reform

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Wayne State University Department of Psychiatry and Behavioral Neurosciences
June 23, 2011
Wayne County Michigan
A Community in Transition

• The Motor City that was...
  – Automobiles and Rock and Roll
  – Set the stage for the Middle Class with high paying jobs in the auto industry

• Today—the only city in America that had a population over a million people to fall below one million people
  – A city that struggles to address poverty, crime, and provide needed social supports and health care for its citizens
Some Detroit Statistics

- Only 40% of Detroit residents are in the work force
- Unemployment rate is 16%
- National Institute for Literacy reports 47% of Detroiter are functionally illiterate
- Detroit ranks in the top ten among US Cities for murder, forcible rape, robbery, and aggravated assault
- Over 50,000 buildings (houses and businesses are vacant.
- Median income 2000 = $52,000  Today = $26,000
- 36% of adults live in poverty  51% of children
Detroit’s Homeless: Demographics

HMIS Data for 2010 Suggests That:

- 20,284 people are homeless in Detroit’s Continuum of Care
- 5,235 Individuals meet the criteria for chronic homelessness
  - The chronically homeless consume the greatest share of resources allocated to homelessness programming.
- Within the homeless population, there are:
  - 5,895 people who are severely mentally ill
  - 8,466 have a chronic substance abuse problem
  - 3,032 have HIV/AIDS
  - 3,596 are veterans
Issues for Detroit’s Homeless: A Survey

Demographics

- 14% surveyed were Veterans. 59% of surveyed veterans are Vulnerable. (note: VA and S.W. C.M.H.)
- 15% of respondents report having a history of foster care
- 49% report having no insurance
- 35% of respondents reported having been in prison and 71% in jail.
- 36% report being a victim of a violent attack since becoming homeless
Detroit’s Homeless: Demographics

- The average years homeless for the total population is 5.38
- The average years homeless for the Vulnerable Cohort is 6.75 years.
- The average years homeless for the Non Vulnerable Cohort is 3.97 years.

- 47% reported a dual diagnosis of mental illness and substance abuse
- 35% reported a history of substance abuse only
- 6% reported signs or symptoms of mental illness only
More About Detroit’s Homeless

Income
• 34% of people report working off the books for their primary source of income
• 27% of people report having food stamps as their primary source of income
• 24% report having SSI and/or SSDI/SSA as their primary source of income
• 10% of people report having no income source

Health Conditions
• 10% reported having asthma
• 13% reported having diabetes
• 8% reported having Hepatitis C
• 14% reported having heart conditions
• 5% reported having emphysema
• 3% reported having cancer
Detroit Briefing:
100,000 Homes Campaign

• Completed in April of 2010

• 211 surveys were administered

• Assessed the likelihood of individuals to die on the street based on the fragility of their health and other factors such as mental illness and substance abuse.

• Practical application of research into the causes of death of homeless individuals
## Detroit Homeless Vulnerability

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<td>&gt; 60 years old</td>
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<td>% vulnerable</td>
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Detroit: Vulnerability Index Results

Emergency Room Visits (Total Surveyed)
• A total of 456 ER visits were reported by respondents in the proceeding 3 months
• 1 respondent, of the 211 respondents, accounted for 42% of the reported ER visits

Health System Impacts (Total Surveyed)
• 103 (49%) report having no insurance
• The majority of reports having no insurance go to Detroit Receiving Hospital (52%) and Henry Ford Hospital (9%)
D.R.H.’s Frequent Users

- In 2010, 6,729 visitors made 11,234 visits to the DMC Crisis Center
- 95.8% of visitors had less than 5 visits
- Fourteen individuals had 21+ visits
- Those 14 individuals had 409 visits
- The highest user had 45 visits in 2010
D.R.H’s Frequent Users

**Individuals with 5+ Visits by Age**

- LT 21: 3.52%
- 21-30: 25.00%
- 31-40: 19.72%
- 41-50: 28.87%
- 51-60: 20.42%
- 61-70: 2.46%

**Visits by Gender**

- Male: 57.1%
- Female: 42.9%

**Visits by Diagnostic Group**

- Mood Disorders: 52.29%
- Schizophrenia/Other Psychotic Disorders: 38.65%

- Male: 71.83%
- Female: 27.11%

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**Legend**

- Mood Disorders
- Schizophrenia/Other Psychotic Disorders
Estimated Cost per Day for Frequent Users

- Shelter $ 28.63
- Supportive Housing $ 30.88
- Prison $ 79.05
- Jail $ 81.18
- Mental Hospital $ 550.11
- Hospital $ 1,638.10
The Problem:
Costly and Inefficient Utilization of Hospital and other Crisis Systems

EMERGENCY PSYCHIATRY BECOMES ONLY SITE WITH ALL SUPPORT (FOOD, CLOTHING, SAFETY, MEDICAL, PSYCHIATRIC CARE ETC.)

Transportation (cars vs mass transit)
Adult foster care home system (500)
Entitlement applications (DHS staff, Hospital length(s) of stay )
Emergency rooms without mental health support
Shelters with limits (time)
Soup Kitchens with limits (days, meals etc)
Strateg

• To establish a Cross-System Collaboration—Frequent Users Systems Engagement (FUSE)

• In September of 2010, the Detroit Initiative began with a Hospital Summit, which brought together providers from all the hospital systems toward a common goal, reducing cost and improving the quality of service for “frequent users”.

• Prior to the initial Workgroup Meeting in November of 2010, stakeholders were recruited from other systems of care, including mental health, criminal justice and community health.
Defining the Target Population

Detroit’s Homeless Population is Extremely High--Must Have a Very Specific Frequent User Definition

Requirements for Participants:
• Homeless (Per HUD McKinney Vento Act definition)
• A Minimum of 6 Emergency Room Visits Annually
• OR
• A Minimum of 3 Hospital Admissions/Readmissions Annually
• AND
• Severe and Persistent Mental illness

AND
One or More of the Following Medical Conditions:
• Dialysis
• Wheelchair User
• Oxygen Needs
• Substance Abuse
• TBI/Organic Brain Disease
• Persons with a PICC-Line
• HIV/AIDS
OR
• 3+ Chronic Health Conditions
The FUSE Premise…

Thousands of people with chronic health conditions cycle in and out of crisis systems of care and homelessness - at great public expense and with limited positive human outcomes.

Placing these people in supportive housing will improve life outcomes for the tenants, more efficiently utilize public resources, and likely create cost avoidance in crisis systems like hospitals and shelter.
Workgroup Structure

The Detroit FUSE Project has taken a two-pronged approach to the project through the establishment of a Case Analysis Subcommittee, which works concurrently with the Steering Committee.

- **Steering Committee**—Attended by stakeholders from participating agencies; uses de-identified data to examine the systems cost for frequent users, as well as demographics on these individuals.

- **Case Analysis Team**—Evaluates the cases of individuals to determine system overlap, determine eligibility and complete referral for the FUSE services.
Next Steps for Detroit FUSE

- Demonstration Project with 10 frequent users will begin within the next month.
- We will utilize data from the demonstration project to make the case for FUSE as an evidence based practice in hospitals, and on a local, state and national level.
- Education and training for cross discipline hospital staff on Permanent Supportive Housing/Housing First and available assistance within the Detroit Continuum of Care.
A Framework for Action: How to Get Started

- Develop an inter-agency collaboration with partners from health care, housing, and behavioral health to develop shared goals

- Assess opportunities and conduct administrative match to identify the target population

- Design a supportive housing intervention

- Identify public and philanthropic resources to target for investment
Potential Roles for Hospitals

- Assist with data match/ & analysis
- Key partner in inter-agency collaboration
  Leadership/Public and Political Support
- Resource Re-Investment
- Direct role in service provision
- Outcomes/performance measurement
Contact Information

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Corporation for Supportive Housing

Webinar

June 23, 2011
• MHS is a not-for-profit, 501(c)(3) corporation founded in 1988, providing mental health and supportive services in Cuyahoga County for more than 14,000 adults and children each year.

• It operates the most comprehensive single-agency continuum of care services for homeless people in Ohio. Thirteen homeless assistance programs provide assertive outreach, emergency shelter, residential services, case management, and psychiatric services. The services assist clients to achieve and maintain permanent housing and recovery from their mental disorder.

• The MHS Mobile Crisis Team operates the County’s 24 hour suicide hotline and is the sole County provider of 24 hour mobile crisis intervention services for children and adults.
DECISION TO PARTICIPATE IN HOUSING FIRST

- Good fit for Agency Mission to end homelessness
- Required a change in thinking from services being transitional to long-term
- Frustration with a system that was not working
- Enterprise capacity building grant to work with consultants from CUCS to implement Housing First
  - Visits to Chicago, Columbus and NYC
  - Facilitating partner meetings
  - Developed operations manual
- Building partnerships with EDEN, Inc. AIDS Task Force, Veterans Administration, and Recovery Resources
Housing First
Moving from Crisis Response
to Improving Lives

• Permanent housing for “chronic homeless”
  – Long term and/or frequent homeless episodes
  – Typically Singly or Dually Diagnosed or Symptomatic (Substance Abuse/Mentally Ill) and long-term unemployed

• Residents referred directly from emergency shelters and, in some cities, street
“Housing First” Operating Principals

• Housing Stabilization is primary focus
• Service participation is voluntary
• Lease Compliance is only major requirement
• Deal with residents from where they are at – Engage over time
Housing First in Cuyahoga County

• Convened by Sisters of Charity Foundation, Cleveland/Cuyahoga County Office of Homeless Services & Enterprise Community Partners in 2002

• Urgent priority:
  – Existing emergency shelters overflow
  – Cleveland singles homeless population is “chronic” homeless
Housing First Key Providers

• Cleveland Housing Network
• EDEN Inc.
• Mental Health Services
• AIDS Task Force of Cleveland
• U.S. Department of Veterans Services
• Famicos Foundation
Housing First
Local Funding Partners

- Alcohol, Drug Addiction & Mental Health Services Board of Cuyahoga County
- City of Cleveland
- Cleveland/Cuyahoga County Office of Homeless Services
- Cleveland Department of Public Health
- Cleveland Foundation
- Cuyahoga County
- Cuyahoga Metropolitan Housing Authority
- Enterprise Community Partners
- Fannie Mae
- Forest City Enterprise
- Key Bank
- Saint Luke’s Foundation
- Sisters of Charity Foundation of Cleveland

n Affairs, Louis Stokes Cleveland
Cuyahoga County Housing First
511 Apartments Completed or Underway

- 401 apartments occupied
- 70 units currently under construction
- 40 units recently received tax credits and will begin construction in the spring
## Funding

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Housing First Client Profile

- Severe and Persistent Mental Illness – 65%
- Severe Alcohol or other Drug Dependency – 75%
- Serious Physical Health Issues – 50%
- Past Criminal Justice Involvement – 70%
- Average Days Homeless Prior to moving in – 700 days
- Employment Rate at Entrance – 1%
- Average Income at Entrance - $370
- Male – 61%
- African-American - 69%
- Veterans – 17%
- Average Age – 45 years old
Housing First Outcomes

• 73% of Cleveland's Housing first residents have remained in their apts. while 25% have moved to other permanent housing. There is only a 2% return to homelessness.

• Nearly all have engaged in meaningful support services and half are participating in volunteer, educational or employment activities.

• Average incomes increased by 36%

• Rates of emergency room & hospitalization are reduced by 50% in the first year.

• Prior to entering Housing First 197 clients accounted for 329 admissions. After entering Housing First 10 clients accounted for 14 admissions.
Housing First

Permanent Supportive Housing Locations

- Northridge Commons
  - 30 units, Rehab Occupied

- Emerald Commons
  - 52 units, New Construction Occupied

- 1850 Superior
  - 44 units, Rehab Occupied

- Liberty at St. Clair
  - 72 units, New Construction Occupied

- Emerald Alliance V
  - 70 units, New Construction Estimated Completion: Summer 2011

- South Pointe Commons
  - 82 units, New Construction Occupied

- Edgewood Park
  - 63 units, New Construction Currently Leasing

Housing First Scattered Sites - 58 units throughout Cuyahoga County
Emerald Commons

52 units
New Construction
11/06
CHN, EDEN, MHS
Superior Apartments

44 units
Rehab
11/07
Famicos, MHS
Liberty at St. Clair

72 units
New Construction
3/08
CHN, EDEN, MHS, VA
South Pointe Commons

82 units
New Construction
9/08
CNH, EDEN
MHS, VA
Northridge Commons

30 units
Rehab
12/09
EDEN, Connections

06/16/2008
Edgewood Park

63 units
New Construction
11/09
CHN, EDEN, MHS
Emerald Alliance V

70 units
New Construction
7/11
CHN, EDEN & MHS
Ohio Freight

- 40 units
- Rehab
- 9/12
- CHN, EDEN & MHS

HOUSINGfirst
E 116th & Buckeye
Impact of Affordable Care Act

- More residents eligible for Medicaid
- Medical Home
- Partnering with FQHC’s
- Cost driven market

http://www.thenationalcouncil.org/cs/center_for_integrated_health_solutions
Contact Info

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eric@mhs-inc.org
Innovation in Supportive Housing
Skid Row Los Angeles

Al Ballesteros, MBA
President & Chief Executive Officer

JWCH Institute, Inc.
www.jwchchstitute.org
213-484-1186
JWCH Institute - Who We Are

Our mission is “to improve the health status of underserved segments of the population of Los Angeles County through the direct provision or coordination of health care, health education services and research.”

We are a Federally Qualified Community Health Center, with dual designation as a Community Health Center and Health Care for the Homeless Grantee from the Health Resources and Services Administration HRSA.

Our main clinic is located in Skid Row, with one of the largest concentrations of homeless persons in the County living in the community. Estimates are as many as 10,000 homeless persons live in the immediate area.
JWCH Institute - Who We Are

We operate eight medical clinics and 11 program sites including the Center for Community Health, a behavioral health and health services integrated model of care in the Skid Row area of Los Angeles County. We operate two respite care programs for the homeless. In this current fiscal year, we will provide more than 88,000 medical visits (MD or Mid-Level), plus ancillary health education, social work and HIV services visits. Last year, we served more than 22,000 unduplicated individuals with 4,558 being homeless persons.
Permanent Supportive Housing PSH in our Service Area

• There are numerous PSH providers in the downtown Skid Row area. We work with one main developer, the Skid Row Housing Trust which operates 22 PSH buildings in close proximity of our Health Center. More than 2,500 units of housing are offered throughout the sites which Skid Row Housing Trust operates.

• Skid Row Housing Trust constructs the buildings, acquires the necessary housing vouchers/subsidies for the homeless and provides the building management. JWCH provides enhanced medical and mental health care in a number of these facilities.
Medical Services in Permanent Supportive Housing and Alternative Locations

Connected to our main homeless clinic in Skid Row, we’ve set up six satellite clinic sites in these permanent supportive housing buildings. We utilize our main clinic’s license which serves as the “hub” clinic for the area. Staff in these sites also work out of our main clinic.
Locations and Facilities in PSH
11 exam rooms and 12 offices

Abbey Apartments:
• 1 exam room; 1 lab; 1 admin office

Rainbow Apartments:
• 1 counseling room; 1 intake office

Carver Apartments:
• 1 exam room; 1 intake office

St. George Hotel:
• 1 exam room; 1 intake office; 1 counseling room

Project 50 at the Simone Hotel (PC):
• 2 exam rooms; 1 intake/nursing office

Project 50 at the Cobb Apartments (MH):
• 2 counseling rooms

Downtown Women’s Center:
• 4 exam rooms; 1 lab; 1 counseling room; 1 dispensary; 1 nursing station; 1 medical records room; 1 dressing room; 1 mobile mammography room; 1 admin area

Oasis (Not PSH but supports PSH):
• 1 room for exams; 1 intake room

Hippie Kitchen (Not PSH but supports PSH):
• 1 exam room; 1 front desk area; 1 intake room
Considerations When Providing Medical Services in Permanent Supportive Housing

- PSH providers often need enhanced services; FQHC clinics often are ‘mission’ driven to serve this population.
- Form a firm collaboration between housing providers and health center, anchored by an MOU.
- Need to ensure proper licensure of the clinic in the housing sites by the FQHC. Be sure to include in scope.
- Develop a plan of action for operations and interaction between housing provider and FQHC.
- Assign proper management oversight to this collaboration.
- Have regular meetings between partners.
- Involve your county health department if you can.
- Set realistic expectations for visits and “ramp” up service delivery time on site as demand increases.
**JWCH Visits in Permanent Supportive Housing**

Data is for 11 months + 2 weeks of FY 2010-2011

Number of Visits: **4,834**

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Visits in Permanent Supportive Housing
Data is for 11 months + 2 weeks of FY 10-11

Number of Visits: 4,834

- FPACT: 0.23%
- Medi-Cal: 23.62%
- Medi-Medi: 8.27%
- Medicare: 0.56%
- HMO: 0.37%
- PPP: 10.55%
- PPP HWLA: 0.14%
- PPP SB 474: 0.06%
- Sliding Fee: 56.19%
How Do We Cover the Costs?

- We receive cost-based reimbursement via the Medi-Caid program which assists in the provision of this care.
- We have a Federal Grant that off-sets some of the costs as a Federally Qualified Health Center. As opportunities present, we apply for additional funding.
- We have local grants for indigent care through the health department.
- We seek foundation/private support of this service.
Project 50 is a collaboration of Los Angeles County, Skid Row Housing Trust (PSH) and JWCH. P50 was based on the work of Common Ground in New York. It identified the 50 sickest, most chronic homeless persons on the streets of Skid Row and offered them a “Housing First” model with enriched wrap-around services provided by JWCH and Los Angeles County. Those chosen were screened to most likely to die on the streets of skid row within 6 months without this intervention.
Drilling Down: A Look at One PSH Site
Project 50

- We co-located a medical clinic and a mental health clinic on the first floor of Permanent Supportive Housing where the 50 sickest homeless persons were provided housing.
- The housing provider Skid Row Housing Trust acquired the vouchers and provided the space on the ground floor for the clinic.
- We brought all our clinical and operational practices to this site and began providing intensive, wrap around services to this group.
- Protocols were developed and we provided an integrated team approach to this care.
Drilling Down: A Look at One PSH Site
The Staffing Pattern – P50

Project 50: Health Services

1. Nurse Practitioner 1 FTE
2. LVN 1 FTE
3. Billing Clerk 1 FTE
4. Physician Oversight (CMO) 0.05 FTE
5. Chief Operations Officer 0.05 FTE

Project 50: Mental Health Services

1. Psychiatrist 0.50 FTE
2. LCSW 1.00 FTE

There is also a team from Los Angeles County, Department of Mental Health and Department of Substance Abuse that is co-located with JWCH in this site that provides intensive mental health services.
## Drilling Down: A Look at One PSH Site

### Revenue and Expenses

#### Health Services

<table>
<thead>
<tr>
<th>Revenue</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grant</td>
<td>$148,075.00</td>
</tr>
<tr>
<td>Medi-Cal</td>
<td>$91,458.00</td>
</tr>
<tr>
<td>Medi-Cal MC (HMO)</td>
<td>$588.94</td>
</tr>
<tr>
<td>Medi-Medi</td>
<td>$7,314.62</td>
</tr>
<tr>
<td>Medi-Care</td>
<td>$3,177.36</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td><strong>$250,614.00</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expenses:</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries</td>
<td>$164,119.60</td>
</tr>
<tr>
<td>Benefits</td>
<td>$35,866.72</td>
</tr>
<tr>
<td>Operating Expenses</td>
<td>$14,590.90</td>
</tr>
<tr>
<td>Indirect cost</td>
<td>$29,681.00</td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td><strong>$244,258.22</strong></td>
</tr>
<tr>
<td><strong>Net (+/-)</strong></td>
<td><strong>$6,355.78</strong></td>
</tr>
</tbody>
</table>

#### Mental Health Services

<table>
<thead>
<tr>
<th>Revenue</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grant</td>
<td>$66,609.67</td>
</tr>
<tr>
<td>Medi-Cal</td>
<td>$104,678.07</td>
</tr>
<tr>
<td>Medi-Cal MC (HMO)</td>
<td>$5,884.04</td>
</tr>
<tr>
<td>Medi-Medi</td>
<td>$22,423.43</td>
</tr>
<tr>
<td>Medi-Care</td>
<td>$9,939.55</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td><strong>$209,534.76</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expenses:</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries</td>
<td>$151,331.92</td>
</tr>
<tr>
<td>Benefits</td>
<td>$20,735.07</td>
</tr>
<tr>
<td>Operating Expenses</td>
<td>$15,079.26</td>
</tr>
<tr>
<td>Indirect Costs</td>
<td>$9,817.00</td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td><strong>$196,963.25</strong></td>
</tr>
<tr>
<td><strong>Net (+/-)</strong></td>
<td><strong>$12,571.51</strong></td>
</tr>
</tbody>
</table>
Drilling Down: A Look at One PSH Site
Medical and Mental Health Visits Provided

Services Provided:
Mental health, crisis intervention, medical care, case management, psychiatry, transportation, assistance with benefits establishment, housing services, substance abuse treatment services.

<table>
<thead>
<tr>
<th>Month</th>
<th>Jul-10</th>
<th>Aug-10</th>
<th>Sep-10</th>
<th>Oct-10</th>
<th>Nov-10</th>
<th>Dec-10</th>
<th>Jan-11</th>
<th>Feb-11</th>
<th>Mar-11</th>
<th>Apr-11</th>
<th>May-11</th>
<th>Jun-11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visits</td>
<td>219</td>
<td>233</td>
<td>205</td>
<td>228</td>
<td>284</td>
<td>251</td>
<td>206</td>
<td>164</td>
<td>173</td>
<td>166</td>
<td>181</td>
<td>31</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Month</th>
<th>Jul-10</th>
<th>Aug-10</th>
<th>Sep-10</th>
<th>Oct-10</th>
<th>Nov-10</th>
<th>Dec-10</th>
<th>Jan-11</th>
<th>Feb-11</th>
<th>Mar-11</th>
<th>Apr-11</th>
<th>May-11</th>
<th>Jun-11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visits</td>
<td>94</td>
<td>112</td>
<td>100</td>
<td>82</td>
<td>100</td>
<td>128</td>
<td>80</td>
<td>85</td>
<td>118</td>
<td>103</td>
<td>74</td>
<td>18</td>
</tr>
</tbody>
</table>
Drilling Down: A Look at One PSH Site Outcome Measures – after 4 years

<table>
<thead>
<tr>
<th>Status</th>
<th># of Clients Housed</th>
<th>% of Clients Housed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housed</td>
<td>74</td>
<td>63%</td>
</tr>
<tr>
<td>Housed/ Exited</td>
<td>12</td>
<td>10%</td>
</tr>
<tr>
<td>Prison/Jail</td>
<td>6</td>
<td>5%</td>
</tr>
<tr>
<td>Alternatively Housed</td>
<td>18</td>
<td>15%</td>
</tr>
<tr>
<td>Deceased</td>
<td>8</td>
<td>7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>118</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
# Drilling Down: A Look at One PSH Site Outcome Measures – after 4 Years

<table>
<thead>
<tr>
<th>Overall Care Profile</th>
<th># of Clients Receiving Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Category</td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td>71</td>
</tr>
<tr>
<td>Physical Health</td>
<td>68</td>
</tr>
<tr>
<td>Substance Abuse Treatment</td>
<td>33</td>
</tr>
<tr>
<td><strong>Total Unduplicated Clients Receiving Integrated Services</strong></td>
<td><strong>74</strong></td>
</tr>
</tbody>
</table>
To fight homelessness, turn Project 50 into Project 10,000

The pilot program that puts the 50 most chronically homeless into supportive housing is a success. L.A. should follow New York's lead and turn Project 50 into real policy.

August 13, 2016 | By Dennis P. Culhane

In 2007, Los Angeles County launched a pilot program, Project 50, intended to provide "housing first" — no treatment or sobriety required — to the worst 50 cases of homelessness on skid row. A recent series in The Times profiled several of the new tenants and their caretakers.

To readers familiar with the story of Nathaniel Ayers, the occasional subject of Steve Lopez's columns and of a subsequent book and film, the portraits were unsurprising. The lives of the tenants were tragically derailed by unyielding addictions and terrifying, untreated psychoses, and the train wreck is tough to watch.

Advertisement
How to Approach FQHC’s in Your Community to Implement a Project Like This?

Reasons FQHCs would Assist:

- Mission to Serve.
- Ability to Satellite Services of Hub Clinics.
- Ability to Access PPS (Cost Based Reimbursement).
- Ability for these FQHCs to Access Additional New Grants as part of Health Care Reform and the Community Health Center Expansion that is anticipated as part of the Affordable Care Act.
Resources:

- CSH- Integrating FQHC Health Care Services
  http://documents.csh.org/documents/ca/IntegratingHealthReport_FINAL.pdf
- National Association of Community Health Centers
- Affordable Care Act Legislation, Section on Section 330 Federally Qualified Community Health Center Expansion
- Your State Primary Care Association
- National Health Care for the Homeless Council
Thank You For Listening and Good Luck.