



Defining and Funding the Support in Permanent Supportive Housing

Recommendations of Health Centers Serving Homeless People

Prepared by Patricia A. Post, MPA, Policy Analyst,
National Health Care for the Homeless Council
for the Corporation for Supportive Housing

February 2008
www.csh.org

NATIONAL
HEALTH CARE
for the
HOMELESS
COUNCIL



Defining and Funding the Support in Permanent Supportive Housing

Recommendations of Health Centers Serving Homeless People is a collaborative effort of the Corporation Supportive Housing and the National Health Care for the Homeless Council.

This report was produced with support from the Corporation for Supportive Housing's Taking Health Care Home project: a national initiative to reduce chronic homelessness through the creation of supportive housing, funded by the Robert Wood Johnson Foundation.



PREFACE

This report is the result of a collaborative partnership between the National Health Care for the Homeless Council (National Council), whose members provide health and social services to homeless people across the United States, and the Corporation for Supportive Housing (CSH), which helps communities create permanent housing with services to prevent and end homelessness.

The goals of this project were:

- To identify and document how Health Care for the Homeless (HCH) providers and Community Health Centers (CHCs) have linked to supportive housing;
- To identify policy opportunities and obstacles encountered in financing and delivering health care in supportive housing;
- To document and share promising practices in permanent supportive housing; and
- To recommend strategies for increasing the capacity of Federally Qualified Health Centers to participate in supportive housing.

To accomplish these goals, the National Council convened a working group comprised of HCH/CHC providers and supportive housing experts (including CSH representatives) whose initial charge was to identify program models and health service delivery and financing approaches in permanent supportive housing (PSH).

The recommendations contained in this report were derived from discussions involving members of this working group which occurred over a 10-month period, November 2006 – August 2007, during conference calls, conversations and e-mail exchanges with individual members, and site visits to three PSH programs. Draft recommendations of the working group were shared in roundtable discussions with CSH staff in May 2007 and with a larger group of HCH providers at the National HCH Conference in June 2007. This report was shared with the National Council's Policy Committee, which provides oversight and guidance for this project.

Members of the Permanent Supportive Housing Working Group are listed on the next page.

ACKNOWLEDGEMENTS

The National Health Care for the Homeless Council expresses its gratitude to the Health Centers that participated in the Permanent Supportive Housing Working Group, whose members are listed below:

- Josh Bamberger, MD, Medical Director, Housing and Urban Health, Department of Public Health, San Francisco, California
- Ed Blackburn, Director Health and Recovery Services, Homeless Health Care Coordinator, Central City Concern, Portland, Oregon
- Pearlina Byrd, MSA, RN, Program Director, Columbus Health Care for the Homeless, Columbus, Ohio
- Jennifer Louch, MPH, Health Care for the Homeless Network, Seattle-King County Department Public Health, Seattle, Washington
- Elaine Fox, MA, Vice President Specialized Health Services, Philadelphia Health Management, Philadelphia, Pennsylvania
- Edward Geffner, Executive Director, Project Renewal Health Services, New York, New York
- Laura Gillis, MS, RN, Senior Advisor, National Center on Family Homelessness; former Director, Baltimore City Homeless Services, Baltimore, Maryland
- Dana Knoll, MBA, Project Director, Skid Row Homeless Health Care Initiative, Community Clinic Association of Los Angeles County, Los Angeles, California
- Marty Lynch, PhD, MPA, Executive Director/CEO, and Brenda Goldstein, Director of Supportive Housing, LifeLong Medical Care, Berkeley, California
- Patrice E. Green, LCSW, MPH, Manager Mental Health & Substance Abuse Services, Saint Joseph's Mercy Care Services, Atlanta, Georgia
- Heidi Nelson, MHSA, Executive Director, Heartland Health Outreach, Chicago, Illinois
- John Parvensky, JD, Director, Colorado Coalition for the Homeless, Denver, Colorado
- Gerry Roll, Executive Director, Hazard Perry County Community Ministries, Inc., Hazard, Kentucky
- Erika Tribble, MSW, HCH Case Manager, Missoula City County Health Department Partnership Health Center, Missoula, Montana

Special thanks to Carol Wilkins, MPP, Director of Intergovernmental Policy for the Corporation for Supportive Housing, who provided overall guidance for this project and contributed valuable information during discussions of the topics covered in this report. Other members of the CSH staff who participated in conference calls and asked provocative questions were: Sue Augustus, Ann Corey, Rachel Fuller, Christina Garcia and Kristin Miller. Thanks also to John Lozier, Executive Director of the National Health Care for the Homeless Council, and several colleagues of working group members who reviewed drafts of this report and helped to improve its clarity and accuracy.

Table of Contents

EXECUTIVE SUMMARY	1
INTRODUCTION	2
DEFINING PERMANENT SUPPORTIVE HOUSING SERVICES	4
Outreach	
Engagement	
Medical Care	
Behavioral Health Care	
Case Management	
Life Skills Training	
SERVICE DELIVERY AND STAFFING	9
Roles of Health Centers	
On-site versus Off-site Services	
Roving/mobile versus On-site case management	
Obstacles for Health Centers	
Recommendations for Housing Providers	
RECOMMENDED MODELS OF CARE	16
Medical services	
Behavioral Health services	
Case Management services	
FINANCING PERMANENT SUPPORTIVE HOUSING SERVICES	22
Medicaid	
HRSA Health Center grants	
HUD grants	
Promising practices	
Obstacles for Health Centers	
Recommendations	
REFERENCES	42
PROFILES OF SELECTED PSH PROGRAMS	47
Central City Concern, Portland, Oregon	
Colorado Coalition for the Homeless, Denver, Colorado	
LifeLong Medical Care, Berkeley, California	
Dept. of Public Health Urban Housing & Health Services, San Francisco, California	
Project Renewal, New York, New York	

EXECUTIVE SUMMARY

This report is the product of a collaborative partnership between the National Health Care for the Homeless Council and the Corporation for Supportive Housing to learn more about the involvement of Federally Qualified Health Centers in permanent supportive housing (PSH), identify policy opportunities and obstacles they encounter in financing and delivering services to supportive housing residents, document and share promising practices, and recommend strategies for increasing the capacity of Health Centers to participate in supportive housing. The working group convened to accomplish these goals included Health Center administrators and direct service providers, representing 11 states and 14 communities. The report summarizes their recommendations, derived from discussions conducted between November 2006 and August 2007.

The report is divided into the following sections:

- **Introduction:** the rationale for permanent supportive housing and involvement of Health Centers
- **Defining Supportive Housing Services** that are needed to enable persons with a history of long-term homelessness to remain stably housed and live as independently as possible: outreach, engagement, medical care, behavioral health care, case management, and life skills training
- **Service Delivery and Staffing:** roles of Health Centers, on-site versus off-site services, roving versus on-site case management, use of paraprofessionals, obstacles for Health Centers, and recommendations for supportive housing providers
- **Recommended Models of Care** in providing medical, behavioral health, and case management services to supportive housing residents
- **Financing Permanent Supportive Housing Services:** federal funding options (Medicaid, HRSA Health Center grants, HUD grants); promising practices in combining different funding streams; and recommendations for federal agencies, state and local governments, permanent supporting housing providers, and PSH service providers
- **References:** an extensive list of publications consulted in writing this report and other resources of interest to permanent supportive housing and service providers
- **Appendix:** profiles of selected Health Centers involved in permanent supportive housing management and service provision:
 - Central City Concern, Portland, OR
 - Colorado Coalition for the Homeless, Denver, CO
 - LifeLong Medical Care, Berkeley and Oakland, CA
 - San Francisco Public Health Department's Direct Access to Housing program, San Francisco, CA
 - Project Renewal, New York, NY

Our intent is to use these recommendations to improve permanent supportive housing programs and as a basis for policy advocacy to create better funding mechanisms to assure their sustainability.

INTRODUCTION

What does it take to enable individuals experiencing prolonged homelessness to obtain and retain stable housing? This was the implicit question posed to participants in the Permanent Supportive Housing Working Group convened by the National Health Care for the Homeless Council in November 2006. This group was asked to develop a taxonomy of supportive services and service models for residents of permanent housing that are most likely to promote long-term stability, recovery, and improved health; and to propose more adequate and reliable funding mechanisms to sustain those services.

A comprehensive answer to this question must address both the structural and individual causes of prolonged homelessness as well as the most cost-effective means of addressing them. Poverty, lack of affordable housing, and limited access to health and social services needed by some individuals to achieve and maintain stability are among the *structural* causes of homelessness in the United States (Baumohl et al. 1996). Insufficient education to meet increasing job skills requirements, residual effects of child abuse or neglect, and functional disabilities secondary to trauma and/or uncontrolled chronic illnesses, including mental illness and substance dependence, are among the *individual* factors that give rise to homelessness. Health problems exacerbated by lack of shelter and limited access to needed health and social services impede resiliency and increase risk for prolonged or “chronic” homelessness (Bonin et al. 2006).¹ People with serious mental illness and co-occurring substance use disorders, who comprise a significant proportion of the chronically homeless population, often have the most difficulty maintaining residential stability, even when affordable housing is available (Pearson et al., July 2007).

Advocates and direct service providers working with homeless people are reaching consensus on some strategies to end long-term homelessness and prevent its recurrence. Among the most promising strategies is **permanent supportive housing (PSH)** – an approach to subsidized housing designed for people with very low incomes and chronic, disabling health conditions which provides voluntary access to a flexible and comprehensive array of supportive services and places no limits on length of tenancy as long as terms and conditions of the lease or agreement are met.² To the extent that PSH addresses both structural and individual factors associated with prolonged homelessness and does so in a cost effective

¹ According to the federal definition, a chronically homeless person is “an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more OR has had at least four (4) episodes of homelessness in the past three (3) years.” A disabling condition is defined as “a diagnosable substance use disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions.” (U.S. Department of Housing and Urban Development (HUD), Collaborative Initiative to Help End Chronic Homelessness, 2002 NOFA. <http://www.hud.gov/offices/cpd/homeless/apply/2002nofa/section3faq.pdf>, accessed 8/7/07) Approximately 23 percent of all people in the United States reported to be homeless in January 2005 (17 percent of the sheltered homeless population and 30 percent of the unsheltered homeless population) met this definition of chronic homelessness, based on HUD Continuum of Care applicants’ estimates. (HUD Annual Homeless Assessment Report to Congress, February 2007: <http://www.huduser.org/Publications/pdf/ahar.pdf>, accessed 9/12/07)

² Summary of CSH definition of supportive housing; full definition is available at: <http://documents.csh.org/documents/communications/shdefinedlogo.doc> (accessed 9/16/07)

Defining and Funding the Support in Permanent Supportive Housing

way, it is more likely to foster the retention of stable housing, even by formerly homeless individuals with serious behavioral health issues. In fact, a growing body of research is demonstrating the cost effectiveness of permanent supportive housing. Homeless people with disabilities who move to low-barrier permanent supportive housing experience marked reductions in shelter use, hospitalizations, length of stay per hospitalization, and time incarcerated, resulting in a significant reduction in the cost of public services (Culhane, Metraux and Hadley, 2002; Rosenheck et al., 2003; Martinez and Burt, 2006; Parvensky and Perlman, 2006). Some outcome studies are also demonstrating increased residential stability and improvement in health status and quality of life for permanent supportive housing residents (op. cit. Parvensky and Perlman; Pearson et al., July 2007). Nevertheless, research demonstrating positive outcomes for clients is still limited (CN, 2006). Although funders and policymakers would like to have a standard formula for determining which housing and service models work best for persons with particular disorders or demographic characteristics, individual variables often defy such generalizations. This unpredictability is part of the challenge that PSH providers face in assigning formerly homeless individuals to housing units with different service models.

An increasing number of Federally Qualified Health Centers³ have become involved in permanent supportive housing over the past 20 years, as service providers and housing providers. Their involvement in PSH is advantageous both qualitatively and financially. Many Health Centers – particularly Health Care for the Homeless (HCH) projects – are staffed by practitioners, experienced in the care of homeless people, who understand the service models that most effectively address the multiple and complex health needs of this population. Moreover, FQHCs receive federal funding for a range of health and wraparound services and can qualify for enhanced Medicaid reimbursement rates. Nevertheless, complicated and inadequate funding streams, together with diverse and sometimes counter-intuitive rules attached to government funding programs, have dissuaded some Health Centers from seriously considering involvement in supportive housing.

The premise of the National Health Care for the Homeless Council, the Corporation for Supportive Housing, and the Permanent Supportive Housing Working Group is that **housing is health care** – because housing stability itself improves health and makes health and social services easier to deliver and more effective. For this reason, we contend, Health Centers serving homeless people are ideal participants and leaders in supportive housing initiatives. The following report specifies **service elements** that working group members consider essential to supportive housing, describes **promising practices**, discusses **challenges and opportunities for Health Centers** involved in PSH, and recommends **better funding mechanisms** to assure the sustainability of this emerging health care and housing model.

³ Federally Qualified Health Centers refer to “all the diverse public and non-profit organizations and programs that receive federal funding under section 330 of the Public Health Service (PHS) Act, as amended by the Health Centers Consolidated Act of 1996 (P.L. 104-299) and the Safety Net Amendments of 2002. They include Community Health Centers, Migrant Health Centers, Health Care for the Homeless Health Centers, and Primary Care Public Housing Health Centers. The Health Resources and Services Administration (HRSA), Bureau of Primary Health Care (BPHC) currently administers the Consolidated Health Centers Program, within the U.S. Department of Health and Human Services (HHS).”
<http://bphc.hrsa.gov/about/>

DEFINING PERMANENT SUPPORTIVE HOUSING SERVICES

The supportive housing model is based on the premise that providing supportive services on site or in proximity to the housing site will help residents transition out of homelessness, remain housed, and live as independently as possible.⁴

Health Centers consulted during this project agreed that the comprehensive services to which permanent supportive housing residents and prospective residents should have access include the following elements:

- Outreach
- Engagement
- Medical Care
- Behavioral Health Care
- Case Management
- Life Skills Training

These services may be provided by a Health Center or as part of an interagency team. PSH service providers stress the importance of having “many tools in your toolbox” to meet the many different needs and preferences of homeless and formerly homeless individuals whom permanent supportive housing is designed to serve. Staffing, service delivery, and recommended models of care are discussed in subsequent sections.

Outreach

Outreach is generally understood as a distinct set of services provided to individuals who are not currently in the housing or health service delivery system. Outreach is necessary because the usual processes by which people receive services (referral, appointment, walk-in, screening, intake etc.) have not proven successful with people experiencing homelessness. To reach the individuals for whom permanent supportive housing is designed requires going out into the community and meeting homeless people where they are – on the streets, under bridges, in shelters and drop-in centers.

Outreach is also required once homeless people are housed, to encourage them to access the services they need to retain stable housing. Successful outreach requires flexible, low-demand services provided in an individualized manner, varying in frequency, duration, and scope depending on the client’s changing needs and wishes. The focus is on establishing

"Some people who are homeless are not engaged in services because they are unaware of what is available, either due to the complexity of the service system or being new to the area. For a variety of reasons, other people who are homeless actively avoid services of any kind. They may suffer from mental disorders that cause paranoia or lack of insight into their need for care. They may be substance abusers who cannot stay in shelters if they are drinking or using drugs, so they stay on the streets. They may be veterans suffering from post-traumatic stress syndrome, wary of the system. . . . Or they may simply be people who have had negative experiences with institutions in the past."

– Marsha McMurry-Avila, *Organizing Health Services for Homeless People: A Practical Guide*

⁴ Program Goals, HUD Supportive Housing Program (SHP): <http://www.hud.gov/offices/cpd/homeless/library/shp/shpdeskguide/dga.cfm>

relationships and meeting immediate needs. (For more information, see Outreach to People Experiencing Homelessness: A Curriculum for Training Health Care for the Homeless Outreach Workers by Ken Kraybill (2002), available at: [http://www.nhchc.org/Curriculum/.](http://www.nhchc.org/Curriculum/))

Engagement

Engagement refers to developing trust with individuals who are homeless or at risk of homelessness to provide or connect them with needed services. Engagement is also part of the process of building a therapeutic relationship, requiring nonjudgmental and supportive patient interactions with members of the clinical team. HCH providers stress that caring for homeless patients is as much about building relationships as about clinical expertise (Bonin et al., 2004). This is an ongoing process that can take days, weeks, months, or years, even after people are in permanent supportive housing. Engagement of homeless or formerly homeless individuals in services requires developing a relationship based on trust and repeatedly offering the services they need to support recovery and avoid crises that can prevent loss of housing. (See Kraybill 2002, Module 3A.)

“Engagement requires a complicated set of skills and attitudes. It includes being able to establish and develop trusting and caring relationships, responding quickly to client need priorities, being dependable but flexible, and being adept at covertly assessing a client’s often changing needs for intensive services or personal space.”

–Gary Morse, PhD, *A Review of Case Management for People Who Are Homeless*

Medical Care

The following clinical services should be available to adults, children and youth who have experienced prolonged homelessness and who are in transition to or residing in permanent supportive housing:

- **Urgent care** – the provision of immediate medical service (no appointment necessary) offering outpatient care for the treatment of acute and chronic illness and injury (American Academy of Urgent Care Medicine).
- **Preventive care** – including screenings for interpersonal violence, mental illness, substance use disorders, cognitive impairment, tuberculosis, HIV/AIDS and other sexually transmitted infection; baseline labs including liver function tests; testing of blood lead levels for children; comprehensive health and developmental assessments including vision, dental and hearing screenings and restorative services; mammograms and other cancer screening; immunizations; health education and anticipatory guidance (Bonin et al., 2004).
- **Primary care** – treatment and management of chronic diseases including diabetes, cardiovascular disease, asthma, chronic obstructive pulmonary disease, tuberculosis, HIV/AIDS, and hepatitis;

“It is not uncommon for health problems to be major or contributing factors leading to homelessness. At the same time, the condition of homelessness causes and exacerbates health problems, leading to rates of illness and injury from two to six times higher than for people who are housed. Homelessness also severely complicates the delivery of health services. Without access to appropriate health care, acute and chronic health problems may go untreated, creating medical complications and impeding the individual’s ability to overcome homelessness.”

– Marsha McMurry-Avila, *Organizing Health Services for Homeless People: A Practical Guide*

health promotion and primary care case management (care coordination, referrals, benefits assistance). Primary care should be integrated with behavioral health care.

- **Pain management** – analgesics and adjuvant, non-drug therapies to relieve acute and chronic pain. Common sources of *acute* pain among homeless people: trauma, unattended tooth decay, advanced gum disease, abscesses resulting from wound infections, complications of illness or injury exacerbated by unsafe and unsanitary living conditions; sources of *chronic*, non-malignant pain: low-back pain, post-traumatic arthritis, diabetes, HIV, hepatitis, alcoholic cirrhosis, advanced peripheral vascular disease, headaches, incomplete recovery from surgical procedures (CN, Oct. 2004).
- **Health behavior education** – explanation of health problems and proposed treatment in language the patient can understand; self-management support – explanation of risks associated with health problems for which the patient is being treated and discussion of ways in which he or she can reduce them for him/herself and others (Bonin et al., 2004; Morrison 2007).
- **Motivational enhancement** – client-centered, directive clinical strategies that seek to help people resolve ambivalence and move in the direction of behavioral change, using open questions, affirmations, and reflective listening. Motivational interviewing, a motivational enhancement technique originally developed to facilitate treatment of alcoholism, is also used to support self management of other chronic illnesses and to prevent transmission of communicable diseases (see Morrison 2007, CN June 2000).

Behavioral Health Care

Formerly homeless residents of permanent supportive housing require access to a range of services to address mental health and/or substance use needs, provided by staff with appropriate training, skills, credentials (where appropriate) and supervision.

Behavioral health care should include ongoing, flexible, and individualized community support and recovery support services, provided by LCSWs and MSWs, peers and paraprofessionals, as well as by psychiatrists, psychologists and primary care providers. Psychiatric services should include evaluation, stabilization, and medication monitoring. Substance abuse services should be provided by certified chemical dependency professionals. Some behavioral health services may also be provided by paraprofessionals, including peer counselors, with appropriate training and supervision. Motivational interviewing/enhancement counseling is recommended to help clients with substance dependence resolve ambivalence, reduce health risks, and work toward readiness for behavioral change.

“According to conservative estimates, about one-third of people who are homeless have serious mental disorders, and more than one-half of those with mental illness have co-occurring substance use disorders. The incidence of these disorders is considerably higher among people who have been homeless on a long-term basis. Substance use disorders, in particular, increase risk of exposure to infectious diseases and can cause or exacerbate diseases of the cardiovascular system and liver. Behavioral disorders and cognitive impairments associated with them can interfere with treatment adherence. Clinical practice adaptation and integration of medical regimens with the patient’s regular activities can improve treatment effectiveness.”

– HCH Clinicians’ Network, *Adapting Your Practice: General Recommendations for the Care of Homeless People*

Defining and Funding the Support in Permanent Supportive Housing

Integrated treatment for co-occurring mental illness and substance use disorders is recommended, including psychiatric services, therapy, individual and group counseling, and ongoing recovery support services. Behavioral health care should be coordinated with primary care.

Case Management

The role of case managers includes building trust, knowing where residents are, helping them qualify for and maintain public benefits including SSI/SSDI and Medicaid, assuring access to needed services and mainstream resources, accompanying residents to appointments, teaching them how to use the health care system, assuring care coordination, and identifying/addressing early signs of decompensation – “doing whatever it takes” to resolve behaviors that are likely to result in eviction and to maximize residents’ stability and self-determination.

Intensive case management is required especially during outreach and immediately following admission to supportive housing.

Less intensive services may be required once residents are stabilized. The Assertive Community Treatment (ACT) model of treatment and case management is recommended at least initially for residents with severe and persistent mental illness, as well as for those who may have repeated crises leading to emergency room visits or hospital care for problems associated with chronic health conditions, including behavioral health problems (see p. 20 for description). Ongoing case management services, including primary care case management, should be available to all PSH residents. The intensity and frequency of case management encounters should be determined through regular assessments of client needs.

Optimally, case management services should be provided on site by the organization that is primarily responsible for supportive housing services. Studies indicate that rates of follow-up achieved by the “brokered model” (case management referrals) are relatively low and that this strategy is less effective than providing on-site services directly in permanent supportive housing (Rapp & Goscha, 2004).

Non-clinical case managers are the lynchpins that enable PSH to work, according to Tim Marshall, Director of Residential Services for the Colorado Coalition for the Homeless. They deal with day-to-day stresses in the lives of residents and help them to retain housing. A number of permanent supportive housing residents would be homeless again if it were not for their case managers, he says. For example, one case manager observed that a resident with schizophrenia was decompensating and discovered that she was fearful of living in a large apartment. The client was ultimately able to cope when she was moved to a smaller, SRO unit. Another resident was facing eviction for hoarding large numbers of cans in his room that were becoming a threat to his health and safety and that of other residents (a problem frequently encountered with supportive housing residents who have experienced long-term homelessness). In response to gentle persuasion by his case manager, he finally agreed to store the cans in a locked bin in the garage, which allowed him to retain his room in the housing unit and his can collection.

Life Skills Training

Life skills training encompasses individual and group “stabilizing” interventions which restore functioning that has been impaired by disabling health or behavioral health conditions. Services include:

- Training to enhance activities of daily living (ADL) skills – both basic ADLs (e.g., bathing, dressing, eating) and advanced ADLs (e.g., shopping, managing finances, housekeeping) – including skills needed to maintain residence in a housing unit;
- Vocational and employment services, including training to gain skills needed to manage the challenges of work (attention, focus, and social skills); and
- Other services, including support for family reunification, parenting skills, and educational, recreational, and counseling services for children and youth.

“Although psychotropic drugs may be necessary to control disruptive symptoms [of cognitive and affective disorders], they are not sufficient to enable patients to cope with the life-long challenges presented by severe mental illnesses. Individual and group therapy, life skills training, and ongoing support groups are also recommended to enable these persons to maintain stable housing, regain control of their lives, and re-enter the community.”

— HCH Clinicians’ Network (2000), *Mental Illness, Chronic Homelessness: An American Disgrace*

Life skills training has been shown to be effective at reducing the rates of homelessness in vulnerable young adult populations. Topics for training workshops may include: budgeting, signing a lease, maintaining an apartment, understanding renters’ rights and responsibilities, preparing healthy meals on a budget, and planning for future crises (Ammerman SD et al., 2004).

SERVICE DELIVERY AND STAFFING

Health Centers involved in permanent supportive housing play multiple roles and employ a variety of staffing and service delivery models. This section provides an overview of the different settings in which services are provided and who provides them, obstacles frequently encountered by service providers, and recommendations for PSH providers to make service provision in supportive housing more attractive to Health Centers.

Roles of Health Centers

Health Centers have multiple roles in supportive housing: community building, clinical capacity building, service provision, consultation, and cross-training. Some Health Centers develop and/or manage supportive housing units as well as provide services (e.g., Central City Concern in Portland, OR, Colorado Coalition for the Homeless in Denver, and Project Renewal in New York City). It isn't necessary for one organization to play all of these roles or provide all recommended services.

Sometimes a Health Center employs the entire team of service providers; sometimes it provides part of the team. For example, all service providers in San Francisco's Direct Access to Housing program are employed by or under contract with the Department of Public Health, which administers two Federally Qualified Health Centers – one that serves supportive housing residents exclusively and an HCH grantee that serves only people living in shelters or on the streets. In Chicago, service providers for the same housing unit are employed by several different organizations, which can make service coordination challenging. Residents in supportive housing run by Heartland Health Outreach (an HCH grantee) may be served by a different organization's ACT team, and some people served by Heartland's ACT team live in supportive housing maintained by another agency. The service arrangement depends on where tenants choose to live.

Heartland Health Outreach in **Chicago** serves supportive housing residents with severe and persistent mental illness (primarily schizophrenia) and co-occurring substance use disorders. They use an ACT model of case management. Most residents are on an ACT team which visits them weekly. Each ACT team includes a Bachelor-level case manager, a Masters-level case manager, a "prosumer" (recovering consumer), a certified addictions counselor, a part-time nurse, and a consulting psychiatrist. The intensity of case management varies between regular case management and that of a highly skilled crisis team. Some units have on-site staff (Safe Haven has 24-hour staff); scattered site units (Shelter-Plus-Care) have no on-site staff.

On-site versus Off-site Services

Clinical services are delivered to supportive housing residents in a variety of settings: in on-site clinics staffed by full-time or part-time clinicians, "at the bedside" or in mobile clinics by visiting clinicians, or in off-site satellite clinics. Some housing programs use more than one of these service delivery options. Health Centers see advantages and disadvantages or challenges to mitigate in using each of these options:

On-site services:

Advantages: On-site services are more easily accessible to housing residents, with no waiting period for referrals. Follow-up and service coordination are easier, it's easier to engage vulnerable tenants with complex health and mental health problems who may be unwilling at least initially to go to off-site clinics for care, and clinicians have the opportunity to see their clients' home environment and better understand barriers to and opportunities for managing their medical conditions. In some highly effective program models, such as Assertive Community Treatment (ACT), psychiatrists who work as members of interdisciplinary teams provide services to consumers where they live (as well as in other community settings).

Disadvantages: Services provided at supportive housing sites are usually less comprehensive than those provided in community-based clinics, and productivity may be limited in providing services on site, particularly if the number of tenants served is small. Provision of psychiatric services in supportive housing can be problematic. Residents may be uncomfortable talking about mental health issues with on-site psychiatrists, particularly if the roles of service providers and property management staff are not clearly distinguished, or if confidentiality agreements are not clearly articulated and trusted by tenants. Supportive housing tenants may perceive that psychiatrists who provide services on site will prioritize concerns about managing the housing program over the individual resident's interests.

This problem can be mitigated if staff roles are clearly defined so that psychiatrists are not involved with decisions about evictions or lease enforcement, and if there are well-understood policies and procedures governing confidentiality and privacy. When supportive services and property management roles are separated, the on-site psychiatrist can focus on helping tenants deal with symptoms of mental illness or substance abuse and avoid or reduce problems that could lead to eviction, while property management staff are responsible for imposing lease requirements including expectations about acceptable behavior. If these roles are not clearly distinct, a conflict of interest may arise – e.g., where psychiatrists and property managers are both involved in enforcing restrictions on behavior as a condition of tenancy (to prevent eviction). Some clinicians feel that this potential conflict is better resolved when psychiatric services are provided in an off-site clinic. Residents may also feel freer to be candid about their mental health issues with a psychiatrist or other mental health professional based in an off-site clinic.

Off-site services:

Advantages: Services provided outside the housing site give tenants a greater sense of independence, help them learn how to navigate service systems on their own, and protect personal privacy. As noted, more comprehensive health care services are usually available at community-based clinics, compared to services that can be delivered at the housing site; and services can often be provided more efficiently in off-site clinics, which tend to serve larger populations. For supportive housing programs that don't have sufficient resources to provide on-site services, referral to a clinic located near the housing site or to other community services may be the only feasible alternatives.

Defining and Funding the Support in Permanent Supportive Housing

Disadvantages: Some tenants are too ill to receive services outside the housing site. For these clients, home care may be a better alternative, at least until they are better stabilized. Many Housing First⁵ residents are extremely ill and require a higher level and cost of on-site primary care services than others. There is evidence that families do better with services provided on site, particularly childcare services and Head Start programs (Bassuk EL et al., 2006).

Variables to consider:

- The decision to provide services to tenants at the supportive housing site in an off-site clinic or through referral to other community services depends on program scale, resources, and the severity of residents' health problems. Optimally, clients with greater needs should be admitted to supportive housing that uses an on-site service model.
- Another factor is the proximity of the supportive housing site to an off-site clinic. If the clinic is within a few blocks, it is usually feasible to send PSH residents there for more comprehensive care, once they are engaged and stabilized. Housing programs are advised to begin with home care and move toward clinic-based care as tenants are ready.

Staffing

Supportive housing residents receive services from the following types of service providers:

- Medical providers: physicians, midlevel providers (PAs, NPs), and registered nurses
- Mental health professionals: psychiatrists, psychologists, or psychiatric social workers
- Licensed and unlicensed case managers
- Certified addiction counselors
- Vocational counselors
- Paraprofessionals: peer counselors, lay health workers, “prosumers” or recovery mentors (recovering consumers) who work with skilled case managers as part of an interdisciplinary team

Use of paraprofessional case managers:

Advantages: Paraprofessionals are often able to establish strong rapport with clients. When appropriately supervised by skilled case managers and working within an interdisciplinary team, they are respected by mental health professionals and the criminal justice system. Paraprofessionals require fewer resources to employ than professionals. Nevertheless, Health Centers warn that funding alone should not drive

⁵ Housing First is an approach to supportive housing characterized by barrier-free access to permanent housing directly from shelters or the streets with no pre-requisite to achieve sobriety or attain a level of stability before housing is offered. Housing choice is a key component. This approach is seen as a way to engage individuals with behavioral health problems (substance use disorders with or without co-occurring mental illness) who have been unable or unwilling to accept treatment. Once housed, residents have voluntary access to a range of health and social services designed to promote housing stability and they must comply with normal lease requirements governing rent payment, safety, and behavior. The “housing first” model differs from “housing readiness” models of supportive housing which require individuals with behavioral health problems to receive substance abuse treatment or mental health services as a condition of tenancy. (CN, 2003; Wong, et al., 2007)

the model of case management employed for supportive housing residents; the model should be based on what works best using available community resources.

Disadvantages: Health Centers may not be able to receive FQHC reimbursement for services provided by paraprofessionals (although some states allow some Medicaid reimbursement for these services through the mental health / Rehab option, with appropriate clinical supervision. Some clinicians are concerned about the skill level of paraprofessionals in dealing with clients who have severe and persistent mental illness (but not if they are working closely with an interdisciplinary team). Moreover, there may be recruitment and retention challenges in using paraprofessionals, especially if salaries are low.

In **Hazard, Kentucky**, the Health Care for the Homeless project has used a modified ACT case management model since 1995, featuring paraprofessionals (lay health workers) who work with skilled case managers as part of an interdisciplinary team that includes nurse practitioners, a psychiatrist, a psychologist, and a clinical director. Paraprofessionals are respected by clients, the criminal justice system, and psychiatrists. A roving team does eviction prevention and health education, handles involuntary hospital admissions, and may even help clients clean up their apartment to pass a HUD inspection. The success of this service model may in part reflect the greater intimacy of a rural town (population less than 5,000) and the ability of service providers to be more quickly available when help is needed.

Permanent supportive housing programs that employ paraprofessionals as case managers emphasize the importance of the following key factors to maximize their success: ongoing training, continuity of staffing (which is often dependent upon salary level and cost of living), limiting caseload size, effective and reliable supervision, providing a career track to encourage longevity, and collaboration with mental health professionals.

Roving/Mobile versus On-site Case Management Teams

- One of the factors that may influence whether a Health Center dedicates on-site staff in supportive housing or uses a mobile team approach is whether there is full-time staffing at the housing site.
- It may make more sense to have a mobile model if you are supplementing case management services provided on site by another organization.
- If your agency is the primary service provider, the on-site service model is preferable.

In **San Francisco's** Direct Access to Housing program behavioral health services are provided on site and on-site case managers initiate requests for a roving case management team to help residents avoid eviction due to disruptive behavior, deteriorating medical conditions, or failure to pay rent.

In **Seattle**, the Health Care for the Homeless Network (HCHN) provides services but not housing. They work primarily with three supportive housing agencies that provide various levels of case management to residents on site. One housing agency provides housing, along with licensed mental health and chemical dependency services. HCHN recently developed a team through contractual partnerships to rotate between buildings to provide nursing and chemical dependency services. This mobile team model incorporates flexibility to adapt to the existing service models and strong coordination with on-site case managers.

Obstacles for Health Centers in Providing Supportive Housing Services

Among the greatest challenges that Health Centers face in providing supportive housing services are:

- **Care coordination:** Integrating and coordinating case management services provided by multiple agencies or by case management teams with different skill levels – e.g., coordination of less intensive services with those provided by ACT teams.
- **Financing case management services:** The uncertainty and variability of state policies regarding the inclusion of case management costs in setting reimbursement rates for FQHCs presents serious financial challenges for service providers. While FQHC providers can bill Medicaid for some services provided by Licensed Clinical Social Workers (LCSWs), including services to address mental health or substance abuse problems, in many states they are unable to bill for most services provided by unlicensed case managers. The issue is whether the services provided by case managers are considered as costs in the FQHC reimbursement rate or other forms of reimbursement allowed by the state, such as primary care case management (PCCM).⁶

Recommendations for Permanent Supportive Housing Providers

- **To make service provision in PSH sites more attractive to Health Centers, maximize the productivity of medical services providers.** Health Center dollars are already stretched thin; PSH programs can help to maximize their use in three ways:
 - Select a site where you can assure that CHC or HCH providers will see a significant number of patients.
 - Make sure there is a strong cooperative arrangement with staff in the supportive housing building to identify and contact residents who need health services.
 - Talk about the payer mix – the proportion of supportive housing residents with Medicaid or Medicare.
- **Attend to maintenance and security of supportive housing buildings.** Keep facilities clean, do needed repairs, and protect tenants from violence. Dealing drugs on the premises should be prohibited.
- **Recognize that a strong and resilient partnership between the housing provider and service providers is essential and needs constant tending.** Property management and supportive service provision can be collaborative (provided by different agencies or by different staff units within one agency) or integrated into one team (e.g., Downtown Emergency Service Center (DESC), Seattle), with the goal of helping residents maintain housing.

⁶ Primary Care Case Management (PCCM) is a Medicaid health care delivery system that lies between traditional fee-for-service and risk-based HMO managed care. Under PCCM, consumers are linked to a Primary Care Provider (PCP) who coordinates their health care. Providers are paid on a fee-for-service basis, and receive additional dollars to compensate for care management responsibilities. Providers are not at financial risk for the services they provide or authorize. Thirty states use PCCM in their Medicaid programs, either alone or parallel to HMOs. (Connecticut Health Policy Project, March 2007: <http://www.cthealthpolicy.org/pccm/index.htm> [accessed 10/24/07])

- **Work with PSH property managers.**
 - Be tenacious; a good working relationship with building managers can take years to develop.
 - Show property managers the benefits of regular meetings: help tenants negotiate and follow through on solutions to rent payment problems and help dealing with difficult tenants.
 - Create a formal structure for communication.
 - Designate a lead case manager (LCSW or other skilled staff) to maintain the liaison.
 - Try for a minimum of monthly formal meetings with check-ins once a week or more often.
 - Provide a contact point or phone number with assurance to property manager that a timely response will be provided when concerns arise.
 - Seek out models and promising practices for landlord incentives and protections (e.g., double damage deposits and reliable responses to calls about problems) to encourage landlords to accept tenants who may seem to be poor risks for housing success.
 - Implement a range of housing models (e.g., Alcohol and Drug Free Community Housing and transitional housing) as effective and important components of the supportive housing continuum for homeless chemically dependent populations. (See also WA, 2006.)
 - Include property management staff in staff trainings – e.g., on harm reduction, motivational interviewing, etc. (The Skid Row Housing Trust in Los Angeles trains property managers in motivational interviewing with the goal of helping them better understand stages of behavioral change.)
- **Where property management and services are provided by different agencies, develop interagency partnerships.**
 - Spend time assuring that leadership in various organizations share a common mission: keeping people housed and helping them get the support they need to remain housed. All organizations that provide housing or supportive services should share a commitment and have the capacity to serve homeless people with special needs.
 - Educate one another about the roles each agency is playing.
 - Engage multidisciplinary partners in developing methods to achieve the mission – e.g., involve clinicians and property managers in developing criteria for eviction, considering practice implications of proposed policy.
 - Overall, program strategy should not be an individual or a “turf” decision; it should result from a collaborative process involving all partners. Strong partnerships are based on the articulation of shared goals and policies, how staff roles are different and complementary, and clear and consistent policies regarding communication and the protection of tenants’ privacy and confidentiality.
- **Link service models to populations.** Recognize that high-needs populations (chronically homeless single adults or families dealing with co-occurring disorders) may take longer to engage and require more intensive on-site services. Services with limited barriers can help such clients maintain housing. The type and intensity of services provided should be tailored to client needs (e.g., mental health or chemical dependency services versus non-clinical case management alone).

Defining and Funding the Support in Permanent Supportive Housing

- Consider routing onsite service dollars through other agencies besides the housing provider. This can be more cost effective and result in higher quality of care.
- Develop strategies to promote community acceptance of the PSH project. Although “Good Neighbor Agreements” have helped to promote community acceptance of PSH in some areas, there is evidence that community notification activities can increase resistance to psychiatric residential facilities (Zippay 2007). Long-term public relations and advocacy strategies are often required to achieve community acceptance of permanent supportive housing. “Evidence of supportive housing’s value needs to come before big audiences and small, in public meetings and back corridors, and on terms that may be intellectual in one setting, political in another, and clinical, fiscal, or pragmatic somewhere else. The case needs to be sustained over time, infiltrate many groups and constituencies, and be delivered in a style and tone that befits many different kinds of audience.” (Greiff, Proscio and Wilkins 2003, p. 46).

Initially, efforts to develop permanent supportive housing in Columbus, Ohio, were strongly opposed by the community. The first PSH unit was located in an affluent area. An advisory group of PSH supporters was formed to advocate for residents in the apartment complex and seek help from the community. They utilized Good Neighbor Agreements each time they set up scattered-site housing. The Mayor was a strong opponent during the housing project’s first year; the next year, after learning more about the program, he agreed to provide landscaping for the property. Since then, the PSH program has grown from 12 housing units to 75 units over 8 years. There have been many success stories of residents who eventually reunited with families and gained employment with income high enough to allow them to move to other housing.

RECOMMENDED MODELS OF CARE

Health Centers experienced in serving individuals with a long history of homelessness recommend the following models of care to maximize client stability within the context of permanent supportive housing. These recommendations are supported by some empirical research and by the experience of professionals who provide medical care, behavioral health care, and case management services to formerly homeless residents of supportive housing.

Medical Services

- **Care coordination**, assuring access to secondary and tertiary care, especially for individuals with chronic diseases
- **Interdisciplinary care teams** The preferred service model for permanent supportive housing is having professionals work in interdisciplinary teams comprised of primary care and psychosocial service providers who work together to ensure that an individual's needs are addressed in an appropriate and coordinated manner (CN, May 2006 and Aug 1999; Lenoir G, 2000).
- **Chronic disease management**, featuring service integration, care coordination, and quality improvement and offering a variety of services based on individual need (e.g., the Health Disparities Collaboratives chronic care model: <http://www.healthdisparities.net/>).
- **Adaptation of supportive services to particular resident populations**, such as older adults, persons with HIV/AIDS, and persons with serious mental illness or severe, long-term problems with substance use
- **Education / training of non-medical service providers and peer counselors** who work on site in permanent supportive housing – by HCH clinical teams including medical providers, case managers, and mental health care providers
- **Medical respite services / recuperative care programs** that provide health care and housing through partnerships with local hospital systems (e.g., Recuperation Care Program in Portland, OR, and Interfaith House respite care program in Chicago (Buchanan et al., 2003)

Respite Care for Clients Leaving the Hospitals

The Recuperation Care Program (RCP) in Portland, Oregon is a collaborative project between Central City Concern (CCC), the Oregon Health Sciences University (OHSU), and Providence Health System, initiated in 2005. RCP provides recuperative care for low-income/homeless patients who have received medical services at participating hospitals but need stable housing and continuing medical care to recuperate fully. Hospitals typically have two choices—either discharge such patients to the streets, or continue to provide hospital care until they have recuperated, which can be very expensive. The RCP program has created a new option by bundling quality healthcare, available through providers at the Old Town Clinic (OTC), with stable housing in a CCC building. RCP clients are referred directly from participating hospitals and, after an initial screening, are transported to designated RCP “beds” in CCC’s Henry building. Once there, they receive intensive case management from RCP staff and are able to access primary healthcare services at OTC. RCP marks a new direction for healthcare for the underserved, in which local hospitals contract directly for community-based health services. CCC’s provision of housing and primary care allows participating hospitals to greatly reduce costs associated with caring for uninsured patients, removes the pressure to discharge them promptly, and ensures access to adequate continuing care from a culturally appropriate provider. This approach also minimizes use of emergency departments for follow-up care after former patients’ health has deteriorated further due to inappropriate living conditions.

— Central City Concern, Portland, Oregon

Behavioral Health Services

- **Integration of primary and behavioral health care** provided by mental health professionals, primary care providers, certified substance abuse counselors, paraprofessionals and peer counselors with appropriate training and supervision, and social service providers, working together to provide a broad range of mental health, community support, and recovery-oriented services that include individual and group counseling. The delivery of primary care services should be integrated with the delivery of behavioral health care services. Integrated care presupposes one treatment plan with behavioral and medical elements. Co-location is not sufficient to ensure integrated care (CN, May 2006).
- **Integrated treatment of co-occurring mental illness and substance use disorders** Concurrent, coordinated clinical treatment provided by the same clinician or treatment team has been shown to be more effective than a parallel or sequential treatment approach (Morse, 1999). Supportive housing programs are urged to promote a team approach to mental health care; psychiatrists' work should be team directed.
- **Coordinated treatment of substance use disorders** For substance abuse issues requiring treatment, other services should also be made available directly or through linkages, including the use of peer recovery mentors, AA/NA groups, detox, other recovery services, and for those who chose this option, Alcohol and Drug Free Community (ADFC) housing.
- **Motivational enhancement** (see page 6 for definition) While motivational enhancement and assertive engagement practices can help PSH residents achieve readiness to address health problems, it should be explicit that participation in treatment and other services is optional (not a condition of tenancy). Nevertheless, in many communities it can be very challenging to find (or create) housing for people with addictions and mental illness if there is no requirement that tenants will engage in case management services.
- **On-site and off-site services** PSH providers are encouraged to build trust with residents and respond to crises on site. When clients are ready, some Health Centers recommend provision of psychiatric care in a different setting (off-site clinic), if easily accessible, to avoid a real or perceived conflict of interest and allow access to more comprehensive services. It is important that other health care

Integrated, Interdisciplinary Care

“Integrated care occurs when one clinician or a team of clinicians coordinates health services across multiple disciplines and delivery systems. Service integration can improve the efficiency of health care delivery systems and produces better clinical results, particularly for individuals with co-occurring mental and substance use disorders. Integrated services for homeless people are thought to be most effective when they are broad-based, comprehensive, continuous and individualized, simultaneously addressing clients' medical and psychosocial needs. For example, mental health and substance abuse treatment should be integrated with the provision of supportive housing. Interdisciplinary teams actively coordinate care across disciplines. In that respect they differ from multidisciplinary groups in which practitioners have an awareness and tolerance of other disciplines, but do not share care planning and coordination.”

—HCH Clinicians' Network (1999)

providers maintain a presence at the supportive housing site and be actively involved in helping to facilitate community-building and peer support among tenants. Presence of care providers on site is often crucial to a healthy partnership with the property manager or landlord, and may be necessary to assure consistent service access and utilization. (See p. 10 for discussion of advantages and disadvantages of on-site versus off-site services.)

- **Client and community education about the etiology and treatment of chemical dependence**

Significant scientific advances have been made in understanding the biology of addiction, the neurological effects of addictive drugs, and elements of effective treatment and recovery for individuals with chemical dependence. Nevertheless, misunderstanding of the etiology of addiction and the view of “substance abuse” as a moral and legal issue rather than as a public health issue has resulted in the exclusion of many people with severe impairments related to chemical dependence from disability assistance, housing, and appropriate behavioral health care. PSH service providers should educate themselves, their clients, colleagues, and the community about the scientific basis of addiction and evidence-based practices known to promote recovery. (See: American Society of Addiction Medicine: <http://www.asam.org>; Zerger, 2002; Kraybill and Zerger, 2003; CN, Oct. 2006; O’Connell et al., 2007.)

- **Trauma informed care**

Physical and sexual abuse in family and other relationships is both a cause and a consequence of homelessness. Almost 90 percent of homeless women have been violently victimized at some point in their lives. Persons who are mentally ill or under the influence of alcohol or drugs are especially vulnerable to victimization. Many individuals with exposure to interpersonal violence or abuse have difficulty forming sustaining, trusting relationships. Thus, all interventions including outreach and engagement must be conducted so that clients with post trauma responses are not re-traumatized and programs can more sensitively respond to their needs. Trauma informed care includes gathering information about exposure to traumatic stress, screening for immediate safety and making a safety plan, asking about histories of sexual or physical abuse and other types of traumatic exposure, and understanding physical responses to trauma. (CN, 1999; Bonin et al., 2004; Bassuk EL et al., 2006; Gillis, 2007)

“...the lack of trauma informed and trauma specific services in [supportive housing] programs may contribute to additional difficulties engaging clients and ultimately reduce the likelihood of positive outcomes such as self support among these residents. Trauma informed services avoid program restrictions that clients frequently view as coercive and instead build mutually respectful relationships that address participant’s ambivalence about engaging in services. A trusting relationship rather than coercive rules becomes the leverage for empowering clients to access critical services.”

– National Center on Family Homelessness
Family Permanent Supportive Housing, 2006

Case Management Services

- **Relational Outreach and Engagement Model (ROEM)** Trust is considered to be the cornerstone of successful case management in permanent supportive housing – trust between case managers and clients, and among members of the case management team. Craig Rennebohm of the Mental Health Chaplaincy in Seattle has articulated a theoretical framework for understanding the outreach and engagement process, which seeks to build a relationship of trust and care with those who present unusual challenges and are the most difficult to serve (see Kraybill, 2002: <http://www.nhchc.org/Curriculum/module1/module1A/RP1RelationalOutreachandEngagementModel.pdf>).

- **Assertive Community Treatment (ACT)** – The ACT model has been highly researched and well-established as an effective community-based intervention for non-homeless people with severe mental illness. It differs significantly from many case management approaches, especially in its emphasis on direct treatment and services, shared caseloads, and use of an interdisciplinary team that includes specialists such as psychiatrists and nurses. The ACT model has been adapted in various ways to improve its relevance to homeless people by including assertive outreach and engagement strategies, an increased emphasis on clients’ resource and housing needs, and the addition of adjunct lay citizen community workers and mental health consumers to the treatment team. An advantage to the ACT approach is its clarity and specificity in program principles, functions, and operations. (Morse, 1999)

Recommendations for homeless case management practitioners include focusing service delivery efforts upon:

- Conducting assertive, community-based outreach;
- Nurturing trusting, caring relationships with clients;
- Respecting client autonomy;
- Prioritizing client self-determined needs;
- Providing clients with active assistance to obtain needed resources;
- Maintaining small case loads; and
- Implementing ACT approaches.

— Gary Morse, *A Review of Case Management for People Who Are Homeless: Implications for Practice, Policy, and Research*

- **SSI/SSDI Outreach & Assistance** A national study of homeless assistance providers and their clients conducted in 1996 found that 11 percent of homeless service users and 29 percent of formerly homeless service users received Supplemental Security Income (SSI), and that 8% of homeless users and 16% of formerly homeless users received Social Security Disability Insurance (SSDI) (Burt et al., 1999). Local studies conducted since then suggest that homeless disability claimants are denied benefits at significantly higher rates than other claimants, often for failure to negotiate the arduous application process, rather than for lack of severe medical impairments that meet SSA disability criteria (O’Connell et al. 2007).

Other claimants are determined disabled by SSA but are denied benefits because their substance use is deemed material to their disability.⁷ Case managers working in HCH programs have reported that as many as 80 percent of their uninsured clients should have qualified for SSI or other disability assistance but had not done so (Post 2001, 72-73). SSI/SSDI benefits include cash assistance and eligibility for public health insurance (Medicaid/Medicare). Individuals who have established eligibility for these benefits are more likely than others to obtain available subsidized housing, including supportive housing.

Through aggressive SSI/SSDI outreach and assistance, initial approval rates (without appeals) can be significantly increased and time to initial decision, decreased. Preliminary outcomes of the SSI/SSDI Outreach, Access and Recovery (SOAR) Initiative, a HHS and HUD-sponsored training and technical assistance program provided to more than 24 states and 29 cities since 2006, demonstrate an increase in approval rates from 10-15 percent to 60-95 percent of initial applications and a decrease in time to initial decision from 120 days or longer to 96 days or fewer (Dennis, Mar. 2007). Successful outcomes were attributed to implementation of SOAR critical components:

- focusing on initial SSI/SSDI applications,
- becoming an applicant's representative,
- avoiding the need for Consultative Evaluations (CEs) or collaborating with State Disability Determination Services (DDS) to make CEs more effective,
- working closely with health care providers and educating them about appropriate documentation of impairments,
- reaching out to medical records departments,
- establishing ongoing communication with Social Security (SSA) offices and DDS, and
- using a coordinated rapid benefits acquisition team.

(<http://www.prainc.com/SOAR/about/CriticalComponentsChart.pdf>).

Health Centers and PSH providers should be aware of the following tools to assist homeless adults with applications for SSI/SSDI:

For case managers: *Stepping Stones to Recovery: A Case Manager's Manual for Assisting Adults who are Homeless, with Social Security Disability and Supplemental Security Income Applications:*

<http://www.prainc.com/SOAR/tools/manual.asp>

For medical providers: *Documenting Disability: Simple Strategies for Medical Providers:*

<http://www.nhchc.org/DocumentingDisability2007.pdf>

⁷ Since 1996, persons determined disabled by Social Security have not been eligible for SSI/SSDI benefits if there is evidence that substance use is "a contributing factor material to the determination of their disability." In other words, if there is medical evidence that an individual's impairments would not be severe enough to prevent substantial gainful activity (employment) if s/he stopped using alcohol or drugs, disability benefits are denied. HCH providers and other advocates report inconsistent implementation of this SSA policy nationwide. A number of denials at initial consideration are reversed to allowances on appeal. (O'Connell et al. 2007)

Expediting Access to SSA Disability Benefits

“When Dan Reardon began working as a volunteer at the Colorado Coalition for the Homeless (CCH), he was the benefits acquisition team. In 2004, when CCH received an SSA HOPE (Homeless Outreach Projects and Evaluation) grant, the Benefits Acquisition and Retention Team (BART) program became a full-fledged department. Reardon was appointed project director, and the unit is staffed with medical providers, case managers, an occupational therapist, and a data specialist. The program has an advisory committee that includes representatives from SSA, DDS, the Office of Hearings and Appeals (OHA), and consumers. BART team members help clients with the application, which they complete together and submit to the local SSA office. They also compile a complete medical evidence package, which is sent with the application. The application is flagged and expedited by SSA and DDS. OHA also expedites hearings when an appeal is necessary. Due to relationships BART has developed, the staff has open communication with SSA and DDS, who will contact them when further information is needed to make a determination. This open and expedited communication process has shown great success. In Denver, only 10 percent of homeless applicants were approved on initial application (compared to the national average of 37 percent for all applicants). When DDS dedicated a staff person to focus on applications from homeless adults, the approval rate rose to 20 percent. Since the BART team began assisting applicants, 75 percent of initial applications are approved, and the average processing time is only 40 days.”

– Deborah Dennis et al. (2007), *Promising Practices for People Who Are Homeless*

FINANCING PERMANENT SUPPORTIVE HOUSING SERVICES

While some Health Centers are already involved in supportive housing, a growing number of other supportive housing providers and their funding partners (e.g. local government and community leaders involved in 10-year plans) may seek Health Centers as service partners for supportive housing projects. Health Centers may be attractive service partners because of their capacity to tap Medicaid and other sources of health care funding as well as their clinical expertise and recognized role in the community.

Permanent supportive housing programs rely on multiple sources of funding to keep their doors open and to provide the potentially stabilizing services just described. Requirements of public funders are sometimes at odds with recommended models of care. For this reason, the PSH Working Group's goal was to investigate ways of augmenting and combining federal and state funding streams and aligning them more effectively with services.

Today, funding is scarce for PSH services. Federal funds (from HUD and HHS) are essential but insufficient (and often inefficient) means of financing PSH services. Federal grants and entitlements are supplemented with dedicated funding for supportive housing from state, county, and municipal governments in some jurisdictions. PSH providers also depend on rental payments, corporate grants, philanthropic contributions, and clinical volunteers to make ends meet.

There is tremendous political and community pressure to resolve chronic homelessness in Skid Row. The Mayor of Los Angeles has identified \$100 million to help subsidize permanent supportive housing for 2,000 homeless individuals and families living in shelters and transitional housing. The money comes from reactivation of the Section 8 program, suspended since 1994. The City of LA provides funding for housing development, and the County is responsible for service dollars. Although HCH clinics use their FQHC status to draw down funding for supportive services, most clinics run out of funds within six months.

– Dana Knoll, Skid Row Homeless Health Care Initiative

HUD's McKinney-Vento Homeless Assistance programs represent the largest source of funding for supportive housing operating costs, including rent subsidies. In many communities, HUD's Supportive Housing Program (SHP) is also the largest (but diminishing) source of funding for the supportive services costs of permanent supportive housing. (SHP also provides grants for a wide range of other services and transitional housing for homeless people.) Some of these programs have historically benefited homeless populations that did not require intensive services. In recent years, although HUD funding requirements have increasingly targeted these resources to permanent supportive housing for people living on the streets or in emergency shelters, including chronically homeless people with disabilities, sufficient federal funding has not been provided to cover the cost of supportive services needed by this population.

Under Shelter Plus Care, for example, grantees are required to match HUD funding for housing operating costs (or rent subsidies) with other funding for supportive services. In communities where adequate funding has not been provided for intensive supportive services, this service segment may provide only a case manager who sees clients once a month. This level of service provision is

Defining and Funding the Support in Permanent Supportive Housing

insufficient to meet the needs of people who have experienced chronic homelessness (and may be inconsistent with the match requirements of the Shelter Plus Care Program). Nevertheless, HUD's policy shift away from financing services,⁸ particularly the case management services that are an essential component of supportive housing, to funding "bricks and mortar" severely threatens the sustainability of many supportive housing programs. Moreover, the dramatic decrease in federal support for mainstream affordable housing programs over the past 30 years has undoubtedly increased the numbers of homeless people, many of whom eventually require supportive housing to regain stability.

To date, no federal funding streams large enough to replace lost HUD service dollars have been identified, although the Department of Health and Human Services has the greatest potential to do so, as well as the expertise to administer service dollars effectively. Medicaid reimbursements and HRSA Health Center grants are among the most promising options for financing supportive housing services, but are not without complications and limitations, as working group members made abundantly clear during their discussions. This section focuses primarily on these two funding sources, describes obstacles that PSH programs and service providers encounter in attempting to use them, highlights promising practices, and lists Health Centers' recommendations for financing PSH services.

Medicaid Funding Options for Supportive Housing Services

Medicaid benefits and reimbursement policies differ from state to state, which greatly complicates use of this funding source to finance PSH services. In general, Health Centers can draw down Medicaid dollars for the reimbursement of services provided to supportive housing residents who qualify for Medicaid in the following ways:

Medicaid reimbursement for Federally Qualified Health Centers (FQHC) Most Medicaid reimbursement for Health Centers comes through the FQHC mechanism, while in some states Health Centers also receive Medicaid reimbursement for some services (e.g. rehabilitation services or targeted case management) through coverage for other "optional" Medicaid benefits.

- ***Cost Reports:***

A portion of the cost of some services provided to supportive housing residents who have Medicaid coverage can be reimbursed with Medicaid dollars. **Federally Qualified Health Centers can get enhanced ("cost-based") Medicaid reimbursement rates.** The purpose of the enhanced rate is to enable FQHCs to ensure that grant dollars intended for the uninsured are available for that purpose (HRSA, June 2006). Medicaid reimbursement for FQHC services is based on the clinic's Prospective Payment System (PPS) reimbursement rate. States also have the option of developing an alternative

⁸ While HUD still allows communities to use McKinney grant funding to pay for supportive services, competitive funding incentives established through annual NOFAs in recent years have created very strong pressures for grantees to reduce spending of HUD grant funds for supportive services. In many parts of the country there is little or no funding available from HUD for new grants for supportive services. A large percentage of HUD grant funds for new projects are allocated for housing costs (NOT including the costs of services in permanent housing projects).

payment methodology for Medicaid services. These alternatives are State specific and must be agreed to by the clinic. (Ibid.)

The Medicaid cost reimbursement rate is calculated by dividing the total cost of FQHC services by the number of billable encounters that qualify under state and federal Medicaid programs. Non-billable services may be included among reported expenses in cost statements; but the cost of non-medically necessary services may not be applicable to determination of the reimbursement rate. Cost reporting requirements are state specific.

Every service included in the cost statement must be related to the clinic; workforce education costs may not be included. For HCH grantees, “directly related” services (such as those provided by ACT teams, licensed professionals at sites included within the approved Project Scope) don’t have to be delivered within the walls of the clinic. There are different rules for CHCs.

- ***Billable Encounters:***

Only certain types of provider can bill for services under Medicaid’s FQHC reimbursement rules. Billable services or encounters are defined by federal law and governed by the Centers for Medicare and Medicaid Services (CMS) and the State Medicaid Plan.⁹ In some states additional requirements or procedures may be established by managed care entities.

- ***Can bill for FQHC reimbursement for services:*** licensed medical professionals, including physicians, psychiatrists, physician assistants, nurse practitioners, clinical psychologists, and licensed clinical social workers (LCSWs).
- ***Can’t bill directly for FQHC reimbursement for services:*** paraprofessionals, case managers, other staff who provide mental health and substance abuse services, although some of the costs associated with these staff may be included in FQHC cost reports and recovered indirectly as part of the cost-based rate established for reimbursing “billable encounters” provided by licensed staff (depending in part upon rules established by states).

Only certain types of services are billable, often limited to only one encounter per day; if medical and mental health encounters occur on same day for the same diagnosis, only one encounter is counted (in some states). Costs for many other services / staff are not billed directly, but these costs may be incorporated into the calculation used to establish the rate Medicaid pays for billable encounters. For purposes of FQHC reimbursement, federal law defines billable services by specifying the types of providers who can deliver them. Some aspects of the State’s Medicaid plan also determine which services provided by these licensed practitioners are covered.

⁹ As described in Section 1905(a)(2)(C) of the Social Security Act, Medicaid-covered FQHC services include (1) physician services, (2) such services and supplies as are covered under Section 1861(s)(2)(A) of the Social Security Act (SSA) if furnished as an incident to a physician's professional services and items and services described in Section 1861(s)(10) of the SSA, (3) services provided by a physician assistant or (4) nurse practitioner, (5) a clinic psychologist, or (6) by a clinical social worker, (7) [for (3)- (6)] such services and supplies furnished as an incident to his service as would otherwise be covered if furnished by a physician or as an incident to a physician's service, (8) preventive primary health services that a center is required to provide under section 330 of the Public Health Service Act, and (9) any other ambulatory services offered by a Federally qualified health center and which are otherwise included in the [State's Medicaid] plan. (NACHC Issue Brief # 69: http://www.nachc.com/pubmgr/Files/IB/Medicar Medicaid Technical Assistance_69.pdf)

Defining and Funding the Support in Permanent Supportive Housing

- **Billable services** (in some states): medical, substance abuse, mental health, and wrap-around services that are provided face-to-face by the licensed practitioners listed above.
- **Non-billable services** (in some states): case management provided by an unlicensed social worker and educational wrap-around services

Health centers may not be able to bill for all services or include all of the costs related to staffing for supportive housing services in the FQHC cost report that establishes the Health Centers rate for “billable encounters.” These rules vary from state to state. For example: In Colorado, case management staff is included in the cost report, but case managers don’t generate billable encounters. In Oregon, only case managers on the ACT team providing services to current clinic patients or to transitional housing residents in drug treatment can be included in the cost report. Acupuncture may be included in the Medicaid cost statement, but providers can only bill for substance abuse treatment. In California, case management services previously included in cost reports have been disallowed by auditors as a basis for determining the reimbursement rate; appeals are pending.

Other mechanisms for Medicaid reimbursement for services provided by Health Centers:

In addition to FQHC reimbursement mechanisms, Health Centers in some states may be able to obtain Medicaid reimbursement for some services through “optional” Medicaid benefits. As the name implies, each state determines which “optional” benefits are covered, and the State Medicaid Plan governs coverage, service definitions, and provider qualifications. (CSH is working with the Technical Assistance Collaborative (TAC) to prepare a guide for using some of these other Medicaid benefits to reimburse services in supportive housing. This guide will be available in early 2008.)

Policies for the reimbursement to Health Centers for services that are covered as “optional” Medicaid benefits are complex and poorly understood. Some of the services provided by non-licensed staff may be covered under a state’s Medicaid optional benefits, but there is a lot of confusion about how these services are reimbursed (as part of costs included in FQHC rate determination or billed separately). This is a complicated issue because optional benefits are different in each state, and policies about reimbursing FQHCs for providing these services also vary from state to state.

• **Rehabilitation (Rehab) Option:**

Currently almost all states provide some type of mental health, substance abuse, and physical health services under the Rehabilitation (“rehab”) option. While federal law allows states to provide rehabilitation services¹⁰ for medical, mental health, or substance abuse problems, in many states these optional services are covered primarily for the rehabilitation of people with mental illness

¹⁰ Rehabilitative services are defined as: “Other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.” (§1905(a)(13) of the Social Security Act)

(Smith, 2007; Crowley and O'Mally, 2007; CSH, 2003). The provision of rehabilitative services is not limited to fixed clinic sites; services can be delivered by non-clinicians (including paraprofessionals) in a variety of locations, including a person's home, or in other community settings. The Rehab option may be used for coverage of the following types of services: diagnosis, assessment, treatment planning and coordinating the delivery of rehab services to individuals; individual and group clinic outpatient mental health services; crisis services to prevent hospitalization; family psychosocial education; peer support and counseling; basic life and social skills training (restorative only); intensive Assertive Community Treatment; medication education and management; community residential services that integrate the delivery of mental health services into licensed and supportive housing arrangements; illness and disability management; supported employment (but *not* job training, vocational or educational services). (Smith, 2007, pp. 58-59)

Until recently, the Medicaid rehabilitation services option has been an important source of financing in some states for reimbursing the cost of such services provided to PSH residents. Increased federal spending due to increasing use of the Rehab option has raised questions by policy makers whether this option is being used properly and whether it is appropriately targeted. The Bush Administration believes states are using the Rehab option in inappropriate ways; federal officials are already denying approval of state plan amendments for rehab option services. In 2007, the President reintroduced a plan to place new restrictions on the types of services allowable under the Medicaid Rehab option, to yield federal budget savings of \$2.29 billion over the next five years. A notice of proposed rulemaking outlining proposed changes was recently issued (fall 2007).

Some stakeholders are concerned that the rules will impose new limits on states' ability to deliver rehab option services. (For more information, see comments on these proposed changes by the Bazelon Center for Mental Health Law: <http://www.bazelon.org/takeaction/2007/RehabRules9-20-07.htm>). Even before the proposed regulations were released, CMS has been using audits or other guidance to states to limit state payment flexibility – including efforts to disallow “bundled rates” or other mechanisms some states have used to pay providers with case rate or per diem payments. Mental health service providers prefer such “bundled” payment strategies to fee-for-service payments tied to discrete time units of service, which are difficult to use effectively when operating Assertive Community Treatment (ACT) and other evidence-based practices that use flexible, inter-disciplinary team-based approaches. (Crowley and O'Malley, 2007)

Under some circumstances, costs related to providing vocational / employment supportive services (“soft skills” not job-specific skills) may be covered by Medicaid as rehabilitation services if the State Medicaid Plan includes them, and if the services are clearly linked to rehabilitation goals. (Federal policies in this area have been shifting recently, raising complex issues and uncertainties for states and providers.) In Oregon, for example, vocational services, which are provided outside of the clinic, are not billable, even though provided by credentialed personnel.

Defining and Funding the Support in Permanent Supportive Housing

- ***Targeted Case Management (TCM) option:***

Federal policy changes are also expected that would restrict use of Medicaid reimbursement for Targeted Case Management for services which CMS considers to be within the purview of other programs – i.e., use of the TCM option to fund services to children and families, and services the federal government thinks states should be paying for out of their child welfare funds. Policy changes are expected through audits and eventually through regulations.

In California, billing Medicaid for TCM services is considered “double-dipping” for an FQHC (therefore TCM is not allowed as a reimbursable FQHC service).

- ***Mental health services provided by Assertive Community Treatment (ACT) teams:***

ACT services are reimbursable under Medicaid in some states but not in others. For example:

Services provided by ACT teams are reimbursable in Oregon under a waiver. Reimbursement depends on where the client lives and where he or she is assessed for mental illness. The HCH project in Portland is a subcontractor of the mental health agency that contracts with the State Medicaid program under a behavioral health carve-out. Some funding for ACT teams is available through their managed care contract for behavioral care services, and the state Medicaid office will pay the HCH an adjustment based on FQHC rates.

Most ACT team services are non-reimbursable in Colorado. Currently, services provided by ACT teams working in supportive housing projects are not being reimbursed directly through Medicaid and these costs are also outside the FQHC reimbursement.

Supplementary funds for ACT teams were available to some supportive housing projects through the HUD–HHS–VA Chronic Homelessness Initiative and DOL–HUD Collaboration grants,¹¹ but grants from HHS for services in most of these programs have been discontinued.

- ***Medicaid Administrative Match:***

In some states, Medicaid Administrative Match (MAM) or Claiming (MAC) programs can access federal Medicaid matching funds to support partial reimbursement of specific activities related to Medicaid outreach and coordination for people who are potentially eligible for Medicaid or current recipients.

One example of a health center participating in MAM is the Health Care for the Homeless Network of Public Health of Seattle & King County, Washington. Because the HCH program is part of a local health jurisdiction that participates in its state MAM program, and because the HCH program uses non-federal funds to support health linkage activities in supportive housing, they are able to

¹¹ Four Health Centers received HUD-HHS-VA Chronic Homelessness Initiative grants as lead agencies in October 2003: Central City Concern in Portland, OR; Colorado Coalition for the Homeless in Denver; Project Renewal in New York City; and San Francisco Department of Public Health. Other Health Centers were among the sub-grantees: in Chattanooga, Chicago, Columbus, OH; Fort Lauderdale, FL; Los Angeles and Martinez, CA; and Philadelphia. DOL-HUD Collaboration grants were awarded to workforce development and housing agencies in Boston, Indianapolis, Los Angeles, Portland (OR), and San Francisco. <http://www.hhs.gov/news/press/2003pres/20031001a.html>

request partial reimbursement for certain activities. Examples of *eligible activities* include helping clients through the Medicaid application process and then linking them to medical care, mental health care, and chemical dependency services. Activities that are *not matchable* include direct patient care, health education, or case management for non-health related services.

Arrangements regarding MAM participation vary from state to state and the accountability mechanisms (such as time studies and invoicing procedures) are generally quite complex, but may be worth exploring in cases where substantial levels of potentially matchable activities are taking place and the administrative relationships that make MAM participation feasible are in place.

Obstacles for Health Centers related to Medicaid Reimbursement:

These are the main reasons why Health Centers that provide services to PSH residents have difficulty using Medicaid to fund them:

1. ***Many tenants in supportive housing are not eligible for (or are potentially eligible but not currently enrolled in) Medicaid.*** Medicaid is the largest source of funding for health services provided to people with very low income in the United States. Medicaid reimbursement is generally available only for services provided to individuals who meet Medicaid eligibility requirements, which are determined in part by the states. Unfortunately, many of the impoverished people for whom supportive housing is designed, including those experiencing long-term homelessness, do not qualify for this entitlement program.¹²

A number of individuals experiencing homelessness are categorically ineligible for Medicaid – e.g., adults under age 65 unaccompanied by dependent children whose impairments have not been demonstrated to meet Social Security disability criteria, or for whom a substance use disorder is considered material to the determination of their disability. If they live in states that have not expanded their Medicaid programs through waivers or state-only dollars to cover single adults, they are out of luck. In most states, SSI is the only door to Medicaid for homeless adults unaccompanied by children. Even minimal non-emergency health care, treatment for mental health or substance abuse problems, or other supportive services may be inaccessible to uninsured individuals who have not qualified for SSI or SSDI (which include cash assistance and health insurance coverage under Medicaid and/or Medicare). Lack of resources to obtain medical evidence of impairment and to complete the SSI application process can be a serious obstacle, especially in rural areas. Some homeless individuals with severe mental impairments who should qualify for Medicaid through SSI refuse to apply or cannot complete the application process due to their impairments. Others have

¹² According to a recent HUD report on Housing First for persons with serious mental illness, 45 percent (n = 36) of clients in the study sample (including 3 permanent supportive housing programs) received SSI at enrollment and 23 percent (n = 18) received SSDI; 35 percent (n = 28) of clients received subsidized health insurance at enrollment, including Medicaid, Medicare, and veterans' health insurance (Pearson et al. 2007, p. 76). Of 100 chronically homeless participants in the Denver Housing First Collaborative, 2004–2006, 55% had SSI, SSDI, VA or OAP benefits; 34% of tenants had obtained these benefits through assistance by the program, and 21% entered the program with these benefits in 2004 and continued to receive them, as of March 2006. The remaining 45% of participants had applied for or were in the appeals process for SSI, SSDI, VA or OAP benefits (Parvensky 2007).

Defining and Funding the Support in Permanent Supportive Housing

insufficient medical evidence of impairment due to limited access to health care providers who are authorized by the Social Security Administration to provide this evidence.

- 2. There is a lack of clarity about which costs associated with the delivery of services to supportive housing tenants may be included in FQHC cost reports or reimbursed through other Medicaid covered services. Many of the services provided to PSH residents are non-reimbursable.* Medicaid coverage is limited to certain mandatory and optional services specified in the Social Security Act; the latter are eligible for federal matching funds only if states choose to offer and partially finance them. Some case management services are among the Medicaid benefits designated as “optional” (see Smith 2007, pp. 39–40, 61–62).

While some services that are provided by case managers may be recognized as reasonable costs associated with the delivery of other health services, state policies that govern reimbursement of these costs through FQHC rates are often not clear and generally do not recognize the value and effectiveness of services delivered in supportive housing. Case managers don’t generate billable encounters, although case management staff may be included in FQHC cost reports (subject to limitations that may be imposed by states through program rules or audits). Covering the cost of non-billable case management services has been limited or disallowed in a number of states (e.g., in CO, OR, OH, and CA). Medicaid coverage for Assertive Community Treatment has been provided in some states under the Rehab option (see Smith 2007, p. 58), but ACT team services are not always reimbursable. In some states, Medicaid reimbursement is available for services provided by ACT teams (e.g., Oregon); in other states, ACT services are non-billable and outside the FQHC reimbursement (e.g., Colorado).

- 3. It is often unclear whether and how Health Centers can obtain reimbursement for some case management services which are not included in the FQHC rate but may be covered through other Medicaid billing mechanisms* (such as Targeted Case Management, the Rehab Option, or Medicaid Administrative Activity). Implementing these other billing mechanisms (when available) can be very complex and administratively burdensome. Health Centers feel at risk talking about innovative funding mechanisms used for PSH services, particularly involving Medicaid funding.
- 4. Medicaid reimbursement is an important piece of the funding puzzle, but under current policy it is never enough to cover the full cost of supportive services.* This results in budgetary challenges for Health Centers involved in service provision. For example, despite aggressive entitlement assistance that has resulted in enrollment of more disabled homeless individuals in Medicaid through SSI, the Colorado Coalition for the Homeless is able to cover only about 15 percent of the cost of ACT case management and treatment teams that serve PSH residents through Medicaid reimbursement; the rest is funded through grant resources.

Using HRSA Health Center grants to fund Supportive Housing Services

Three types of HRSA Health Center programs are known to be involved in permanent supportive housing:

- **The Community Health Center (CHC) Program:**

Community Health Centers (CHCs)

Community health centers are local, non-profit, community-owned health care providers serving low income and medically underserved communities. CHCs provide primary care and preventive services, and often provide on-site dental, pharmaceutical, and mental health and substance abuse services. Also known as Federally Qualified Health Center (FQHCs), CHCs:

- are located in high-need areas identified by the federal government as having elevated poverty, higher than average infant mortality, and where few physicians practice;
- are open to all residents, regardless of insurance status, and provide free or reduced cost care based on ability to pay;
- tailor their services to fit the special needs and priorities of their communities, and provide services in a linguistically and culturally appropriate setting; and
- offer services that help their patients access health care, such as transportation, translation, case management, health education, and home visitation.

— Bureau of Primary Care, HRSA: <http://bphc.hrsa.gov/about>

PSH funding issues for CHCs: Community Health Centers (330 (e) grantees) are obligated to serve everyone in the community, not just homeless or formerly homeless persons. Of all HRSA Health Center programs, the CHC program receives the largest amount of funding (81.5% of appropriations for the Consolidated Health Centers Program, \$1620 million in FY 2007). These factors make CHCs potentially important providers of services to supportive housing residents.

However, productivity concerns can present an impediment to on-site service provision in housing units with few Medicaid/Medicare beneficiaries. Productivity is an issue, both perceived and real, for all Health Centers. Contrary to grantees' perceptions and some OPR reviewers' caveats, HRSA imposes no direct financial penalties on grantees that fail to meet a particular productivity standard.¹³

¹³Certain productivity measures based on Uniform Data System (UDS) data (annual number of individuals served, client encounters, and FTE medical practitioners) are used as a starting point when HRSA reviewers are looking at individual Health Centers' performance. For example, when encounters are below 4,200 per physician FTE per year, it is noted – but used to suggest further inquiry, not as a firm standard. UDS numbers are also used in the aggregate to demonstrate productivity of the Consolidated Health Centers Program for budget justifications to Congress.

Defining and Funding the Support in Permanent Supportive Housing

Nevertheless, it is advantageous for all Health Centers to exceed the Baseline Provider Productivity Standard used to calculate FQHC Medicaid and Medicare reimbursement rates.¹⁴ HCH clinics rarely meet this standard, but CHCs may exceed it, resulting in higher Medicare (and perhaps Medicaid) reimbursements. Thus, providing services at PSH sites with relatively high concentrations of Medicaid/Medicare enrollees may be particularly attractive to CHCs.

- **The Health Care for the Homeless (HCH) Program:**

Health Care for the Homeless (HCH) Programs

The HCH program emphasizes a multi-disciplinary approach to delivering care to homeless persons, combining aggressive street outreach with integrated systems of primary care, mental health and substance abuse services, case management, and client advocacy. Emphasis is placed on coordinating efforts with other community health providers and social service agencies. HCH grantees recognize the complex needs of homeless people and strive to provide a coordinated, comprehensive approach to the care they provide their homeless clients, and in such a way that welcomes them as patients. Specifically, HCH programs:

- provide primary care and substance abuse services at locations accessible to homeless people;
- provide around-the-clock access to emergency health services (directly or by referral);
- refer homeless persons for necessary hospital services;
- refer homeless persons for needed mental health services unless these services are provided directly;
- provide outreach services to inform homeless individuals of the availability of services; and aid homeless individuals in establishing eligibility for housing assistance and services under entitlement programs.

Some HCH programs are operated by Community Health Centers, and some “free-standing” HCH programs are not linked to a CHC. HCH programs that are operated by public agencies (e.g. a local health department) are not subject to some of the federal requirements that apply to other FQHCs (e.g. non-profit, community ownership, and governing board participation by consumers).

– Bureau of Primary Care: <http://bphc.hrsa.gov/about/>

PSH funding issues for HCHs:

The HCH Program receives a fixed percentage (8.7%) of the appropriation for Consolidated Health Centers (\$174 million in FY 2007).

¹⁴ Medicaid and Medicare reimbursement rates for all Health Centers are subject to health care practitioner productivity standards. Reimbursement rates can be higher if the ratio of patient visits to FTE health care practitioners (physicians and midlevel providers) is higher than baseline FQHC productivity standards. The Medicare FQHC productivity standard is: 4,200 annual visits per 1.0 FTE physician; 2,100 annual visits per 1.0 FTE MLP, or combined standards for a “medical team.” Medicare reimbursements are also subject to Reimbursement Rate Caps for urban and rural areas. Medicaid Baseline Provider Productivity Standards vary by state and reimbursement caps are clinic-specific. (HRSA, 2006, pp. 25–35). Approximately 35% of clients served by CHCs in 2006 had Medicaid coverage and 7.5% were Medicare beneficiaries, compared to 21.8%/ 3.4% of HCH clients and 46%/4.2% of PCPH clients (2006 National Aggregate UDS Data: <http://bphc.hrsa.gov/uds/2006data/National/NationalTable4Universal.htm>).

Definition of homelessness issue: As a targeted program, HCH grantees are expected to use grant dollars to serve people who are homeless. They can extend services to formerly homeless clients for 12 months¹⁵ (and sometimes longer, based on the broad HRSA definition of homelessness which includes transitional housing residents). But in PSH, services are available to tenants without time limits, and many tenants with disabilities and long histories of homelessness are likely to need health care and supportive services for longer than 12 months – perhaps on a permanent basis.

Waiver of governance issue: Health Centers funded by HRSA are subject to governance requirements, including the expectation that at least 51 percent of governing board members must be patients or “consumers” of the health center. This and other governance requirements can be waived for Health Centers serving special populations – migrant farmworkers and their families, homeless people, or residents of public housing. Community Health Centers, with or without funding for a special population program, are not eligible for a waiver of any part of the governance requirements. (See: <http://bphc.hrsa.gov/governance/> for a description of Health Center governance requirements.) If an HCH grantee expands services by providing care to people living in permanent supportive housing who are not members of these special populations, the Health Center may be required to meet governance requirements previously waived, such as the obligation to form a consumer board.

- **The Public Housing Primary Care (PHPC) Program:**

The PHPC (330 (i)) Program was created under the Disadvantaged Minority Health Improvement Act of 1991. The program provides residents of public housing with increased access to comprehensive primary health care services through the direct provision of health promotion, disease prevention, and primary health care services. Services are provided on the premises of public housing developments or at other locations immediately accessible to residents.

— Bureau of Primary Care: <http://bphc.hrsa.gov/about/>

PSH funding issue for PHPCs:

Definition of Public Housing issue: The Primary Care Public Housing (330(i)) program is not a targeted program. Public Housing clinics, which are located in or adjacent to public housing, are obligated to serve any indigent people in the community who qualify for public housing (just as traditional CHCs are obligated to serve everyone in the community, not just homeless people). The HRSA definition of Public Housing is based on the definition specified in section 3(b)(1) of the United States Housing Act of 1937 (available at: www.hud.gov/offices/ogc/usha1937.pdf). PHPC

¹⁵ Health Care Safety Net Amendments of 2002 (PL 107-251, 107th Congress), 42 U.S.C. §254b. (h)(4): Temporary Continued Provision of Services to Certain Former Homeless Individuals: “If any grantee under this subsection has provided services described in this section under the grant to a homeless individual, such grantee may, notwithstanding that the individual is no longer homeless as a result of becoming a resident in permanent housing, expend the grant to continue to provide such services to the individual for not more than 12 months.” (www.nhchc.org/Publications/REAUTHORIZATION.pdf)

Defining and Funding the Support in Permanent Supportive Housing

grants may be available for supportive housing services provided to formerly homeless individuals through a clinic located in or very near a Public Housing unit which also serves other Public Housing residents. FQHCs working in such a clinic would be obligated to serve all people in the community, not just formerly homeless people.

Funding issue: The PCPH clinic program has a small funding stream (1.2% of the Consolidated Health Centers appropriation, \$24 million in FY 2007). For this funding option to be financially feasible there would have to be a significant number of Public Housing residents at that location requiring supportive services to warrant using limited Public Housing resources for that purpose. It is not financially feasible to use a Public Housing grant alone to provide supportive services – only as a site in conjunction with another Health Center program – a HCH or a CHC.

HRSA anticipates that approximately \$46 million will be available to support approximately 75 new access point grant awards in FY 2008. Applicants may request funding to support one or multiple types of health centers (CHC, MHC, HCH, PHPC). (Information about open funding opportunities for the Health Center Program is available at: <http://www.hrsa.gov/grants/default.htm#primary>.)

(See <http://www.bphc.hrsa.gov/about/> for more information about HRSA Health Center programs.)

Obstacles for Health Centers in Using HRSA Grants to fund PSH Services:

- **Limited HRSA service expansion dollars:** Although appropriations for Consolidated Health Centers have grown significantly over the last several years, most funding has been designated to open new Health Centers in underserved areas. Only a small amount has been designated for service expansions (New Access Points) by already established Health Centers, such as services delivered at permanent supportive housing sites. Moreover, rising numbers of uninsured clients has limited the capacity of FQHCs to stretch their service dollars further. This is one of the reasons why the National Health Care for the Homeless Council finds the use of Health Centers primarily as a safety net for people who lack health insurance to be misguided and ultimately unsustainable. If more adequate and reliable funding for health services through universal health coverage, FQHCs could focus more productively on the delivery of appropriate care to populations that need special services, such as people with disabling conditions. If more Health Center clients had Medicaid or other health coverage, HRSA grant funds could be used for more comprehensive services needed by vulnerable populations which often are not reimbursed under Medicaid (including some of the case management, ACT, and other recovery services that are delivered in supportive housing.)
- **Meeting targeted versus non-targeted requirements:** CHC and PCPH clinics must serve the whole community; HCH clinics target homeless people. As targeted programs, HCH grantees are expected to use grant dollars to serve people who are currently homeless. They can extend services to formerly homeless clients up to 12 months after they are no longer homeless and sometimes longer, based on HRSA's broad definition of homelessness. These HRSA grant restrictions can complicate their use to support the provision of services to permanent supportive housing residents.

Paradoxically, HCH grantees can serve homeless patients for years while they are living on the streets or in shelters, but as a growing number of communities implement “housing first” strategies that target the most chronically homeless disabled individuals, the people who are housed through these initiatives may lose eligibility for HCH services at a time when they are most able to use housing as a stable base for recovery and for managing complex health problems. Where HCH providers have the capacity to provide a medical home and offer continuity of care, they may be in the best position to offer ongoing care and supportive services to PSH residents.

- ***HRSA productivity guidelines:*** It often takes more time to render services at outreach sites than in clinics. The higher acuity of homeless patients and PSH tenants with complex health and social problems can also lower Health Center productivity. Productivity concerns can present an obstacle to providing PSH services on site (as explained on pp. 31-32).
- ***Scope of Project requirements:*** Health Centers find HRSA’s Scope of Project requirements and Change of Project Scope policy unnecessarily burdensome. Because they get malpractice insurance from the federal government (through the Federal Tort Claims Act), FQHCs have to be very clear about their “Scope of Project” – i.e., what services they are providing and where. This can present a huge barrier for HCH projects. For example, Heartland Health Outreach goes to 70 different locations in Chicago and has to notify HRSA every time they stop going to one shelter and start going to another. If Health Center staff are going to ten PSH sites on a regular basis and targeting five sites where the need is greatest, they can’t just decide to go to another site if that changes without requesting permission from HRSA. HRSA policy does not require changing the project scope to do general outreach, however, only to provide new services or to serve new populations at specific locations.

HRSA has released for public comment a draft Policy Information Notice (PIN) (<http://www.bphc.hrsa.gov/draftsforcomment/lookalike/changeinscope.htm>) clarifying some Scope of Project issues. As currently drafted, the PIN would impose additional, burdensome pre-approval requirements for very minor redeployments of grantee resources among Permanent Service Sites where the grantee’s presence is relatively minimal but ongoing (e.g., less than one clinical session per week, but year-round). The PIN does not specifically address the provision of services in recuperative (respite) care facilities or permanent supportive housing sites. In its comments on the draft PIN, the National Health Care for the Homeless Council has proposed that these sites be explicitly recognized by HRSA as appropriate Health Center Sites.

- ***Staff recruitment / retention & cultural competency issues:*** Not everyone is willing to work outside of a clinic, and some health care providers will perceive supportive housing sites as suboptimal environments. Providers who work at housing sites spend more time doing case conferences (more “nonproductive” time) and have to work closely with case managers. They are very involved in psychosocial issues even if they are not directly involved in providing behavioral health or social services. Deficiencies of the physical place and the psychological impact of working in a less secure environment can be obstacles to staff recruitment.

Defining and Funding the Support in Permanent Supportive Housing

The challenge is to identify the right people to do this work and to work on retention issues while also working to establish and sustain a strong partnership with housing providers to address issues related to safety, security, maintenance, and adequate facilities for the delivery of quality care. Some providers working in CHCs have little experience working with homeless and other special populations and lack cultural competency. Nevertheless, these skills can be taught, HCH providers emphasize. It is critical that all PSH service providers and the agencies they represent have the commitment and capacity to serve homeless people who have the most complex health challenges.

Obstacles for Health Center in using HUD grants to fund PSH Services:

- *Loss of HUD funding for supportive housing services* (mental health services, job training) without a clear understanding of how the gap will be filled.
- *Remaining HUD funding is insufficient to provide quality therapeutic services* in supportive housing – especially mental health and addictions treatment services. While HUD may provide some funding for case management services as a component of grants for new supportive housing projects, in most communities there is no new funding available from HUD to provide more intensive health or treatment services for homeless people or supportive housing tenants. HUD is not familiar with mental health services, indicators of quality care, or how to monitor quality care. Some groups using HUD money to provide supportive housing services don't have the expertise to assure a proper therapeutic environment.

Promising Practices in Funding & Administering PSH Services

The most promising PSH service models are receiving financial support from several funding sources – often including state or local funding dedicated to behavioral care, not just Medicaid and HRSA grants.

- **Case rate:** As an alternative to fee-for-service Medicaid reimbursement based on billing for patient visits with certain licensed providers, a number of Health Centers see the need for a single reimbursement rate for all services provided per case or per diem, including primary and behavioral health care, social work, case management, and supportive housing. (See box for description of an initiative to accomplish this in Oregon.) CMS is currently not supportive of this approach.

Team Care Model

Central City Concern in Portland, OR is working with Care Oregon (the state Medicaid program), two managed care entities, and primary and behavioral health care providers to design and implement a team care model—including medical, behavioral health, social work, case management and supportive housing—financed by an integrated compensation method. Still a work in progress, this initiative was driven by the need to identify a more stable funding stream for supportive housing services in the wake of Oregon’s discontinuation of Medicaid coverage for single adults in 2004. They have implemented one team and over the next year will be collecting encounter and cost data with the goal of deriving a single reimbursement rate for all services provided per case, including health, behavioral health, and wrap-around services.

- **Mixed income housing:** Integration of formerly homeless and at-risk PSH tenants with affordable housing tenants who do not require supportive services is a financing strategy that is helping housing providers pay for more highly subsidized supportive housing for formerly homeless or at-risk tenants. (See description of the Renaissance Housing Model developed by Colorado Coalition for the Homeless on page 43.)
- **Mobile health units:** Consistent with HRSA’s current Scope of Project requirements (and draft PIN), all outreach sites can be counted as part of the “main outreach site,” which can be a mobile health unit. That is, the van itself can be considered a service site without requiring the locations at which it stops to be listed, and addition of PSH housing sites as mobile service sites does not require going through the elaborate Change of Project Scope process. This can simplify administrative processes for Health Centers that do outreach to large numbers of SRO hotels (e.g., St. Joseph’s Mercy Care in Atlanta). The National Council has proposed that that Mobile Teams – groups of clinical providers, often accompanied by outreach or other non-clinical staff, who provide primary care services on outreach to homeless people who are unable or unwilling to obtain services at a more traditional service site – be included as permissible sites on the same basis as Mobile Vans.
- **Group visits:** LifeLong Medical Care uses non-therapeutic group interventions to address socialization issues with supportive housing residents. Staff help individual clients with money management, provide vocational and transportation assistance, and promote harm reduction and community involvement. These stabilizing interventions enable clients to negotiate community service systems, hook up with mental health treatment, return to school or work, and feel more

Defining and Funding the Support in Permanent Supportive Housing

connected to the broader community. Such group visits have the potential to increase health center productivity but require collaborative efforts by clinical and support staff to make them work. Aggressive outreach is necessary to invite residents to group sessions.

- **Combining HRSA Health Center grants:**

Many Federally Qualified Health Centers receive more than one HRSA grant, which can improve their capacity to finance PSH services. The combination of CHC (330(e)) and HCH (330(h)) grants is optimal, enabling provision of the broadest range of services to both homeless and non-homeless populations without time limits. In addition, PCPH (330(i)) grants, though typically smaller, can help to support satellite clinics located in or near supportive housing sites that serve all community members (see box).

- **Clinical volunteers:** Use of clinical volunteers from residency and internship programs in academic medical centers saves money and shows medical students the value of working in

FQHCs, but requires a structured program with clear objectives, two-way feedback and mentoring. St. Joseph's Mercy Care in Atlanta is collaborating with medical training programs and nursing schools. The Dean of the School of Health Sciences is on their Board of Directors. (For more information about the use of clinical volunteers in FQHCs, see Post and Martin, 2005).

Combining CHC & PCPH grants

In 2006, LifeLong Medical Care, a consortium of six Community Health Centers (CHCs) in Berkeley and Oakland, California, was awarded a New Access Point Public Housing Primary Care (PHPC) Program grant from HRSA. This grant partially funds a satellite clinic to the Downtown Oakland CHC in the same neighborhood with most of LifeLong's Supportive Housing Program sites, but is located in a separate building. The PHPC clinic serves LifeLong's SHP patients, other residents of supportive housing, county mental health patients who need primary medical care, frequent users of the emergency room, and General Assistance recipients whom LifeLong is trying to get on SSI and Medicaid with the assistance of benefits advocates.

Recommendations for Financing PSH Services:

Based on their experience as permanent supportive housing managers and service providers, Health Centers recommend the following strategies to assure adequate PSH funding streams and to align them more effectively with services for homeless and formerly homeless individuals:

Recommendation for DHHS:

- **Provide grant funding for supportive housing services through existing funding streams or a special program**, and require integration of primary and behavioral health services. This matter should be addressed at the Department level to assure adequate funding and administration.
- **Provide clear guidance about integrating primary care with other stabilizing services that people in supportive housing need, including mental health and substance abuse services.** Clarification is needed about how optional Medicaid benefits can be used to fund case management and other supportive services provided to permanent supportive housing residents.
- **Provide guidance to CMS, HRSA, and SAMHSA to assure more effective interagency efforts to better align programs with funding.** Given that PSH projects operate with a complex mix of funding from federal, state, and local governmental agencies, there is a real need for guidance from the Department level.

Recommendations for the Centers for Medicare and Medicaid Services (CMS), HHS:

- **Clarify Medicaid reimbursement guidelines for supportive housing services** and give clear guidance to states interested in providing supportive housing for homeless people regarding the following issues:
 - How should costs associated with paraprofessional / peer staff be reflected in the FQHC cost structure? What is the appropriate approach for including costs for staff that participate in inter-disciplinary teams and help people with complex health problems or disabilities get into PSH and provide community support services to keep them stable once housed?
 - Can costs of case managers who deliver services to clinic patients, either onsite in supportive housing or as part of an ACT team, be included in the cost report and rate structure?
 - Can FQHC providers obtain reimbursement for some case management services through other mechanisms (including Targeted Case Management, the Rehab Option, or Medicaid Administrative activity)?

Recommendations for the Health Resources and Services Administration (HRSA), HHS:

- **Foster agreement with CMS that costs associated with “community support” services which help homeless patients get and keep housing could be eligible for Medicaid reimbursement**, either as reasonable costs included in FQHC rates (preferably), or through other covered benefits (e.g., the Rehab Option, which can be more complex). Work with CMS to:

Defining and Funding the Support in Permanent Supportive Housing

- Clarify and provide guidance about reasonable costs that could be taken into consideration for Medicaid reimbursement.
- Clarify how Health Centers can use the FQHC cost structure in combination with Medicaid reimbursement for other optional benefits. (In the absence of clear guidance about how to do this without “double dipping,” Health Centers sometimes end up separating services they have worked so hard to integrate.)
- Allow FQHCs to bill Medicaid for case management services at the FQHC enhanced rate.
- Provide direction for states to include cost-based reimbursement for supportive housing services in their State Medicaid Plan.
- **Clarify / update existing federal guidelines for operating different types of Health Centers.** Specify where services can be delivered, to what populations, and for how long – by Community Health Centers, Health Care for the Homeless programs, and Public Housing Primary Care programs.
 - **Explicitly permit HCH grantees to provide services to PSH residents beyond the 12-month limit.** As a growing number of chronically homeless people move directly from the streets or shelters into permanent supportive housing, they need the interdisciplinary service model used in HCH to meet their complex needs. This justifies serving homeless people beyond 12 months after they move into PSH. As more PSH programs use Housing First models and develop services to sustain residents’ housing stability, the issue of how long HCH projects can serve formerly homeless clients becomes more significant. Some people move in and out of homelessness even after they are placed in permanent supportive housing, and HCH grantees can offer continuity of care by sustaining a relationship with patients during these transitions. Consider addressing this issue through guidance which could be provided by Congress through the appropriations process or by HRSA through administrative actions if statutory or regulatory change is not required.
- **Simplify Scope of Project Policy and Policy for Change of Scope.** FQHC status allows HRSA grantees to qualify for enhanced Medicaid reimbursement; among the requirements for an FQHC is the Scope of Services that HRSA defines. Make Change of Project Scope policy less burdensome. Refer to PSH as allowable sites in any revision of the Health Center Scope of Service policy.
 - **Update policy regarding prospective payment / cost-based reimbursement of PSH services.** Specify services provided to residents of permanent supportive housing that are within Health Centers’ Scope of Services
- **Provide more funding opportunities for the provision of services to people who are homeless or at risk of homelessness, including the tenants of permanent supportive housing who were previously homeless.**
 - **Reinstate service expansion (Expanded Medical Capacity) grants as well as site expansion (New Access Point) grants.**

- Reinststate HCH- community mental health center (CMHC) collaboration grants which provided services to homeless people and PSH residents.
- Encourage Primary Care Associations and Primary Care Organizations to educate states about Health Center funding options for supportive housing services.

Recommendations for HUD:

- Continue funding for service coordination including non-clinical case management in supportive housing through programs such as HUD-McKinney, Public Housing, HUD's 202 (senior housing), and other grants, and expand HUD's grant programs that fund service coordinators in assisted housing.
- Require grantees seeking to use HUD funding for supportive housing to demonstrate arrangements for the coordination of medical care, mental health care, and treatment of substance use disorders. In scoring applications, give preference to collaborations that involve Health Center programs.
- Assure continuation of current level of services in PSH now funded by HUD. Continue the unique HUD/McKinney model which provides grants that can be used for capital, operating expenses and services for PSH.
- Develop interagency agreements allowing HHS programs, including the HRSA Health Center program, to administer and oversee services in PSH currently funded by HUD.

Recommendations for State & County Governments:

- Develop more flexible payment methods for the continuum of services homeless people need: housing-related supportive services, case management and employment training, in addition to primary care. Develop a more flexible payment method than fee-for-service based on codes related to primary care alone. Explore options for a *day rate* (such as that used for VA services) or monthly case rates. Consider an *integrated payment system* for behavioral health services, primary care, and social services.

Recommendations for Federally Qualified Health Centers:

- Gather data to advocate for more adequate funding of PSH services. Document percentage of Health Center budget covered by Medicaid and under which approaches – inclusion in FQHC primary care cost report, billing at the FQHC encounter rate, Rehab, Targeted Case Management, Medicaid Administration, etc. Spotlight programs that are using each option successfully.
- Prioritize access to PSH for people with the greatest needs. Specify populations served by PSH according to their service needs. Differentiate residents requiring non-time-limited, housing based services from those who function sufficiently well to secure health care and other assistance off site, in planning for funding and service provision.

Defining and Funding the Support in Permanent Supportive Housing

- Don't extrapolate practices from one state to another without understanding differences among Medicaid programs. Variables include waivers, mental health carve-outs, other funding sources
- In contemplating establishing FQHC status for Medicaid billing at PSH sites, Health Centers should develop a solid relationship with their State Medicaid office and state primary care / community clinic associations. Rules and interpretations vary from state to state.
- Collaborate with FQHCs working in permanent supportive housing in different states to develop policy recommendations on Medicaid reimbursement and what is legally permissible. Identify precedents to help educate states about what works.

Recommendations for Permanent Supportive Housing Providers:

- Maximize HRSA Health Center resources by seeking multiple grants (CHC, HCH, PCPH). Be aware of the advantages and disadvantages of each program as a funding source for PSH:

Community Health Centers (CHCs) receive the largest funding stream under the Health Center program and can serve anyone in the community with no time limit, but service providers may not be experienced in serving homeless/formerly homeless people.

Health Care for the Homeless (HCH) programs: HCH grants and the enhanced Medicaid cost reimbursement rate can be used to finance wraparound services, and HCH providers have expertise in working with homeless and formerly homeless individuals. The statutory limitation on the use of HCH grants to serve formerly homeless clients beyond 12 months may limit service provision in PSH, although HRSA's broad definition of homelessness may provide some leeway in this restriction. HCH grantees may be able to use other funding to serve formerly homeless tenants who are no longer eligible for HCH-funded care.

Primary Care Public Housing (PCPH): The PCPH program receives a fixed percentage of total Health Center funding. Although the funding stream is small, it can be used to supplement other funding. In urban communities, if a primary care clinic is located near conventional Public Housing as well as supportive housing, it might serve both populations using a PCPH grant.

- Approach Health Centers through Primary Care Organizations (PCOs), Primary Care Associations (PCAs), the National Health Care for the Homeless Council, and the National Association of Community Health Centers to encourage their participation in permanent supportive housing.

REFERENCES

- Ammerman SD, Ensign J, Kirzner R, Meininger ET, Tornabene M, Warf CW, Zerger S, Post P. (2004). *Homeless Young Adults Ages 18–24: Examining Service Delivery Adaptations*. National Health Care for the Homeless Council.
<http://www.nhchc.org/Publications/101905YoungHomelessAdults.pdf>
- Bonin E, Brehove T, Kline S, Misgen M, Post P, Strehlow AJ, Yungman J. (2004). *Adapting Your Practice: General Recommendations for the Care of Homeless Patients*. Health Care for the Homeless Clinicians' Network, National Health Care for the Homeless Council, Inc. 44 pg.
<http://www.nhchc.org/Publications/6.1.04GenHomelessRecsFINAL.pdf>
- Buchanan D, Doblin B, Garcia P. (April 2003). Respite care for homeless people reduces future hospitalizations, *Journal of General Internal Medicine*, 18(S1), 203.
- Burt MR, Aron LY, Douglas T, Valente J, Lee E, Iwen B. (1999). *Homelessness: Programs and the People They Serve: Summary Report – Findings of the National Survey of Homeless Assistance Providers and Clients*, HUD Technical Report. Washington, DC: The Urban Institute.
 Summary Report: <http://www.urban.org/UploadedPDF/homelessness.pdf>
 Technical Report: http://www.huduser.org/Publications/pdf/home_tech/tchap-05.pdf
- Grieff D, Proscio T, Wilkins C. (2003). Laying a New Foundation: Changing the Systems that Create and Sustain Supportive Housing. Corporation for Supportive Housing.
<http://documents.csh.org/documents/pubs/LayingANewFoundation.pdf>
- Health Care for the Homeless Clinicians' Network (CN). (Oct. 2006). Addiction on the Streets: Clinical Interventions. *Healing Hands* 10(4).
<http://www.nhchc.org/Network/HealingHands/2006/Oct2006HealingHands.pdf>
- CN. (May 2006). Integrating Primary & Behavioral Health Care for Homeless People. *Healing Hands* 10(2). <http://www.nhchc.org/Network/HealingHands/2006/May2006HealingHands.pdf>
- CN. (Oct. 2004). Pain Management: Reducing Disparities for Homeless Patients. *Healing Hands* 8(5). <http://www.nhchc.org/Network/HealingHands/2004/Oct2004HealingHands.pdf>
- CN. (Dec. 2003). Supportive Housing Helps Break the Cycle of Homelessness. *Healing Hands* 7(6).
http://www.nhchc.org/Network/HealingHands/2003/Final_Healing_Hands_1_04.pdf
- CN. (Oct. 2000). Mental Illness, Chronic Homelessness: An American Disgrace. *Healing Hands* 4(5).
<http://www.nhchc.org/Network/HealingHands/2000/October2000HealingHands.pdf>
- CN. (June 2000). Eliciting Behavioral Change: Tools for HCH Clinicians. *Healing Hands* 4(3).
http://www.nhchc.org/Network/HealingHands/2000/hh.06_00.pdf
- CN. (Aug. 1999). Integrated, Interdisciplinary Models of Care. *Healing Hands* 3(5).
http://www.nhchc.org/Network/HealingHands/1999/hh.08_99.pdf
- CN. (Apr. 1999). Trauma & Homelessness. *Healing Hands* 3(3).
http://www.nhchc.org/Network/HealingHands/1999/hh.04_99.pdf
- Corporation for Supportive Housing. (2003). White paper: Medicaid in Supportive Housing: Lessons for Policy-Makers. <http://documents.csh.org/documents/policy/Med/MedicaidLessons.pdf>

Defining and Funding the Support in Permanent Supportive Housing

- Crowley JS, and O'Malley M. (Aug. 2007). Medicaid's Rehabilitation Services Option: Overview and Current Policy Issues. Kaiser Commission on Medicaid and the Uninsured. <http://www.kff.org/medicaid/upload/7682.pdf>
- Culhane D, Metraux S, and Hadley T. (2002). Public service reductions associated with placement of homeless persons with severe mental illness in supportive housing. *Housing Policy Debate*, 13(1): 107-163. http://www.fanniemaefoundation.org/programs/hpd/pdf/hpd_1301_culhane.pdf
- Dennis D. (Mar. 2007). Preliminary Outcomes from the SOAR Technical Assistance Initiative. <http://www.prainc.com/SOAR/about/SOARPreliminaryOutcomes.pdf>
- Dennis D, Perret Y, Seaman A and Milstrey Wells S. (2007). Expediting Access to SSA Disability Benefits: Promising Practices for People Who Are Homeless. Delmar, NY: Policy Research Associates, Inc. <http://www.prainc.com/SOAR/about/PromisingPractices.pdf>
- Foster LK and Snowdon P. (2003). Addressing Long-Term Homelessness: Permanent Supportive Housing. California State Library. <http://www.library.ca.gov/crb/03/12/03-012.pdf>
- Gillis L. (2007). Understanding Bodily Responses to Trauma. Homeless Resource Center. <http://homeless.samhsa.gov/Resource.aspx?id=26415&AspxAutoDetectCookieSupport=1> (accessed 9/17/07)
- Health Resources and Services Administration (HRSA). (June 2006). Comparison of the Rural Health Clinic and Federally Qualified Health Center Programs. <http://www.ask.hrsa.gov/downloads/fqhc-rhccomparison.pdf>
- U.S. Department of Housing and Urban Development (HUD). (February 2007). Annual Homeless Assessment Report to Congress: <http://www.huduser.org/Publications/pdf/ahar.pdf>
- Kraybill K. (2002). *Outreach to People Experiencing Homelessness: A Curriculum for Training Health Care for the Homeless Outreach Workers*. National Health Care for the Homeless Council. <http://www.nhchc.org/Curriculum/>
- Kraybill K and Zerger S. (2003). *Providing Treatment for Homeless People with Substance Use Disorders: Case Studies of Six Programs*. National Health Care for the Homeless Council. <http://www.nhchc.org/Advocacy/FactSheets/CA05RCasestudies-FINAL5.pdf>
- Lenoir G. (2000). *The Network: Health, Housing and Integrated Services: Best Practices and Lessons Learned*. Corporation for Supportive Housing. <http://www.csh.org/html/hhisn-final.pdf>
- Martinez TE, Burt MR. (2006). Impact of permanent supportive housing on the use of acute care health services by homeless adults. *Psychiatric Services* 57:992-999.
- McMurry-Avila M. (2001). *Organizing Health Services for Homeless People: A Practical Guide*, 2nd Edition. Service Delivery Strategies/Outreach: 166 - 179. <http://www.nhchc.org/Publications/Pagesfrom2ndedition-101901.pdf>
- McMurray-Avila M, Gelberg L, and Breakey WR. Balancing Act: Clinical Practices that Respond to the Needs of Homeless People. In: Practical Lessons: The 1998 National Symposium on Homelessness Research, Fosburg LB and Dennis DL, Editors. <http://aspe.hhs.gov/progsys/homeless/symposium/8-Clinical.htm>

- Morrison S. (2007). Self Management Support: Helping Clients Set Goals to Improve Their Health. HCH Clinicians' Network. <http://www.nhchc.org/SelfManagementSupport052907.pdf>
- Morse G. (1999). A Review of Case Management for People Who Are Homeless: Implications for Practice, Policy, and Research. In: Practical Lessons: The 1998 National Symposium on Homelessness Research, Fosburg LB and Dennis DL, Editors. HUD & DHHS. <http://aspe.hhs.gov/homeless/symposium/7-Casemgmt.htm>
- National Association of State Medicaid Directors (NASMD). (Nov. 2006). Medicaid Reform Initiatives and their Relationship to Health Centers. <http://www.nasmd.org/resources/docs/Medicaid-Reform-Initiatives-and-their-Relationship-to-Health-Centers-A-NASMD-Report.pdf>
- O'Connell JJ, Zevin BD, Quick PD, Anderson S, Perret YM, Dalton M, Post PA (Ed.). (2007). *Documenting Disability: Simple Strategies for Medical Providers*. Nashville: Health Care for the Homeless Clinicians' Network, National Health Care for the Homeless Council, Inc. <http://www.nhchc.org/DocumentingDisability2007.pdf>
- Parvensky J. (June 2007). Providing Health Care in Permanent Supportive Housing – presentation at National HCH Conference. <http://www.nhchc.org/PSHParvenskyHCH2007.pdf>
- Parvensky J and Perlman J. (December 2006). Denver Housing First Collaborative Cost Benefit Analysis and Program Outcomes Report: 1–15. <http://www.shnny.org/documents/FinalDHFCCostStudy.pdf>
- Pearson CL, Locke G, Montgomery AE, and Buron L. (July 2007). *The Applicability of Housing First Models to Homeless Persons with Serious Mental Illness*. Prepared for the Department of Housing & Urban Development. <http://www.huduser.org/publications/homeless/hsgfirst.html>
- Post PA. (2001). *Casualties of Complexity: Why Eligible Homeless People Are Not Enrolled in Medicaid*. National Health Care for the Homeless Council. <http://www.nhchc.org/Publications/CasualtiesofComplexity.pdf>
- Post PA and Martin LA. (2005). *Clinical Volunteers in Homeless Health Care*. National Health Care for the Homeless Council. <http://www.nhchc.org/Publications/ClinicalVolunteersinHomelessHealthCare.pdf>
- Rapp CA and Goscha RJ. (2004). The principles of effective case management of mental health services. *Psychiatric Rehabilitation Journal* 27(4): 319–333.
- Rosen J and Perret YM. (2005). *Stepping Stones to Recovery: A Case Manager's Manual for Assisting Adults who are Homeless, with Social Security Disability and Supplemental Security Income Applications*. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. DHHS Pub. No. SMA 05-4051. <http://www.prainc.com/SOAR/tools/manual.asp>
- Rosenheck R, Kaspro W, Frisman L, et al. (2003). Cost-effectiveness of supported housing for homeless persons with mental illness. *Archives of General Psychiatry*, 60(9), 940–951.
- Smith G. (2007). *A Primer on How to Use Medicaid to Assist Persons Who are Homeless to Access Medical, Behavioral Health, and Support Services*. Centers for Medicare and Medicaid Services. <http://www.cms.hhs.gov/HomelessnessInitiative/Downloads/HomelessPrimer2007.pdf>

Defining and Funding the Support in Permanent Supportive Housing

- Smith G, O'Keeffe J, Carpenter L, Doty P, Kennedy G, Burwell B, Mollica R and Williams L. *Understanding Medicaid Home and Community Services: A Primer* (October 2000). George Washington University Center for Health Policy Research, prepared for the U.S. Department of Health and Human Services. <http://aspe.hhs.gov/daltcp/reports/primer.htm>
- State of Washington (WA) Department of Community, Trade and Economic Development. *Landlord Incentives and Protections: Encouraging Landlords to Rent to Recovering Substance Abusers*. Report to the Legislature, December 2006. <http://www.cted.wa.gov/DesktopModules/CTEDPublications/CTEDPublicationsView.aspx?tabID=0&ItemID=3983&Mid=870&wversion=Staging>
- Wells S, Williams F, Dennis D. (2003). *Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illnesses and/or Co-Occurring Substance Use Disorders*. Substance Abuse and Mental Health Services Administration, DHHS. Pub. No. SMA-04-3870. <http://mentalhealth.samhsa.gov/publications/allpubs/SMA04-3870/UsingthisReport.asp>
- Wong YI, Hadley TR, Culhane DRp, et al. (March 2006). *Predicting Staying in or Leaving Permanent Supportive Housing That Serves Homeless People with Serious Mental Illness*. University of Pennsylvania Center for Mental Health Policy and Services Research. Prepared for HUD Office of Policy Development and Research. <http://www.huduser.org/Publications/pdf/permhsgstudy.pdf>
- Zerger S. *Substance Abuse Treatment: What Works for Homeless Individuals*. (2002). National Health Care for the Homeless Council. <http://www.nhchc.org/Publications/SubstanceAbuseTreatmentLitReview.pdf>
- Zippay AL. (Jan. 2007). *Psychiatric Residences: Notification, NIMBY, and Neighborhood Relations*. *Psychiatric Services* 58:109–113. <http://www.psychservices.psychiatryonline.org/>

OTHER RESOURCES:

Centers for Medicare & Medicaid Services (CMS)
FQHC Center

www.cms.hhs.gov/center/fqhc.asp

Corporation for Supportive Housing
Services Financing Sources

www.csh.org/index.cfm?fuseaction=Page.viewPage&pageId=533&nodeID=81

Department of Housing & Urban Development (HUD)
Homeless Assistance Programs

www.hud.gov/offices/cpd/homeless/index.cfm

Health Resources & Services Administration (HRSA)
Consolidated Health Centers Program
HRSA Medicaid Primer
Health Disparities Collaboratives

<http://bphc.hrsa.gov/chc/>
www.hrsa.gov/medicaidprimer/
www.healthdisparities.net/hdc/html/home.aspx

National Health Care for the Homeless Council,
HCH Clinicians' Network
Supportive Housing
Clinical Resources

www.nhchc.org/supportivehousing.html
www.nhchc.org/clinicalresources.html

Substance Abuse & Mental Health Services
Administration (SAMHSA)
Homelessness Resource Center
SSI/SSDI Outreach, Access & Recovery (SOAR)
initiative:

<http://homeless.samhsa.gov/>
www.prainc.com/soar/

Social Security Administration (SSA)
Service to the Homeless

www.ssa.gov/homelessness/

PROFILES OF SELECTED PSH PROGRAMS

Central City Concern, Portland, Oregon

Central City Concern (CCC) is a nonprofit organization with 27 years of experience in development, ownership, and management of housing for very low-income men, women and children. CCC began operating in 1979 as a property management and service entity to address the problem of homelessness in Portland, Oregon. In 1980, CCC began managing housing and two years later purchased and renovated its first building.



Hotel Alder

CCC currently operates 1,453 units of supportive housing in Portland, including a range of transitional and permanent housing for people with special needs. CCC operates both Alcohol and Drug Free Community housing and low barrier housing for a variety of tenant populations. Each building CCC operates is specialized in some fashion to meet the unique needs of the homeless population:

- Housing for families in recovery
- Housing for individuals in recovery
- Housing for people with mental health issues
- Housing for people living with HIV/AIDS
- Housing linked to employment
- Fair market low-income housing
- Section Eight housing

CCC's goal is to not only get people into housing, but to help them stay housed; so they also provide a variety of residential services including, but not limited to: advocacy, childcare, conflict resolution, eviction prevention, food, mental health services, rent assistance and transportation. The program's successes come from experience in financial management as well as an appreciation for the complexity of operating low income housing:

Affordable Housing: Since 1980, CCC has been managing low-income housing in and near downtown Portland. Today, the agency owns or manages 1,453 units of housing in 20 buildings throughout the metropolitan area. The housing ranges from refurbished units in older former hotels in Portland's Old Town to the single-story garden apartments of Taggart Manor. In all of this housing, rents are kept affordable for those most in need.



Taggart Manor

Special Needs Housing: To address the problem of homelessness at its roots, Central City Concern offers supportive housing to people with special needs. It is the firm belief of Central City Concern that these special needs, such as being in recovery from alcohol and drug addiction, being diagnosed with HIV/AIDS, suffering from a mental illness, or being on parole or probation largely contribute to a person's homelessness. The housing is managed to facilitate the development of positive relationships and provide links to needed services. This greatly increases residents' success.

Alcohol and Drug Free Community (ADFC) Housing: Recognizing that everyone in recovery from substance abuse and/or mental health issues faces similar problems as they work to stabilize their lives, alcohol and drug free housing is intended to provide a common living environment where individuals can obtain the peer support that is necessary to succeed. There are four basic goals in ADFC Housing:

1. Assist the resident to gain safe and secure housing.
2. Provide an environment where an individual can maintain abstinence from alcohol and other addictive drugs.
3. Encourage the resident to continue to participate actively in an ongoing program of recovery.
4. Permit the growth of a positive support network that can assist the resident in the process of recovery and constructive involvement in society.

Factors considered essential to PSH program success:

- **Mission:** Health centers serving people who are homeless should be in the business of ending homelessness, not just stabilizing health. Doing otherwise ultimately achieves neither residential nor health stability.
- **Housing choice for people with special needs:** CCC's experience over the last 25 years supports a continuum of supportive housing, ranging from transitional housing with recovery-driven (not "treatment-driven") services to permanent supportive housing (housing with comprehensive supportive services that has no arbitrary time limit). Ideally, a continuum of housing would be available through partnerships between health centers and housing providers. The type of supportive housing used should be population driven—a function of client choice as well as behavioral stability. People whose special needs include alcohol and/or drug addiction should have access to clean and sober living environments in supportive Alcohol and Drug Free Community (ADFC) housing if they choose. There is a high prevalence of alcohol and/or drug addiction particularly among single adults who are homeless. To address this, housing and healthcare programs should be based on demonstrated best practices for this population, including ADFC housing. Transitional housing is also an important part of the housing continuum. Many people with special needs may not need permanent support, and the shorter term support available through transitional housing meets their needs. Transitional housing can also serve as a bridge to permanent housing, either PSH or non-subsidized, non-supportive housing in the community, depending on the needs of the individual.

One of Central City Concern's permanent supportive housing programs (43 units of the Hotel Alder) uses a supportive housing model; most tenants have substance use disorders and may have concurrent depression or anxiety, but do not have severe and persistent mental illness. Most CCC clients with serious mental illness (Axis I disorders) are referred to PATH providers working out of a community mental health clinic. CCC Executive Director Richard Harris is not convinced that Housing First is necessarily the best option for individuals with chemical dependence who do not have a co-occurring serious mental illness. The Housing First model was originally designed for individuals dually diagnosed with severe and persistent mental illness and co-occurring substance dependence, he observes. According to Harris, Housing First may decrease use of urgent or emergent services and save money for the government over the short run; but if residents do not receive recovery supportive services, they are likely to lose their housing and/or die of their addictions (an end result no different from that experienced by people who were placed in traditional "flop houses" (SROs). "Permanent subsidized housing for this population without supportive services is not financially sustainable and does not result in greater self-sufficiency or recovery," contends Harris. "This just amounts to giving up on people with chronic addiction, many of whom do have the potential to recover and live stable, happier lives in places other than supportive housing." The goal for many PSH residents is to move on to other housing options (Section 8 or private) and greater self-sufficiency, he says.

Defining and Funding the Support in Permanent Supportive Housing

- **Peer mentoring:** Central City Concern's Recovery Mentor Program employs recovering addicts with several years of successful sobriety to serve as role models for ADFH tenants. Mentors are available 24 hours a day to help these tenants build relationships with new friends who are living sober lives and accompany them to counseling and other services. The Mentor Program has been demonstrated to increase the percentage of clients with heroin dependence who participate in and complete outpatient treatment following detox, vastly improving their chances of long-term recovery.
- **Workforce Program:** Tenants living in the 62-unit Shoreline Building and the 19-unit King Manor live in alcohol and drug free communities and engage in a specialized program of job skills building. CCC's Workforce Program has been designated as a one-stop employment center under the federal Workforce Investment Act. Workforce customers meet individually with case managers to identify job goals and develop an individualized employment plan. They take classes and participate in support groups on job hunting, creating a resume, and interview skills. Workforce also features a successful and growing employment program for homeless veterans, providing case management, housing, training, and optical and dental care. The Workforce Program enrolls over 2,000 clients per year, and between 400 and 700 of them are assisted in obtaining employment as a result of CCC's services.

Colorado Coalition for the Homeless, Denver

The Colorado Coalition for the Homeless (CCH) is a non-profit organization whose mission is to work towards the creation of lasting solutions for homeless families and individuals throughout Colorado. CCH provides a range of housing, emergency assistance, health care, mental health counseling, and other supportive services to more than 12,000 homeless families and individuals in the state each year.



Renaissance Housing Development Corporation (RHDC) is a subsidiary of the Colorado Coalition for the Homeless. CCH and RHDC have developed more than 1,200 housing units in the Metro Denver area in the past 10 years. The Renaissance Housing Model is focused on integrating formerly homeless families and individuals into mixed income housing developments that enhance the neighborhoods in which they are located. At each Renaissance housing site, one-third of tenants have special health needs and are formerly homeless or at risk of homelessness; two-thirds of tenants pay higher but affordable rents and do not require supportive services. This financing strategy helps CCH provide more highly subsidized housing with supportive services to PSH tenants.

Renaissance at Civic Center Apartments, located in a building renovated by CCH that formerly housed the downtown YMCA, provides affordable housing in the heart of Denver's expensive "luxury loft" market. Completed in 2004, this housing site currently has 216 affordable rental units with 72 of these providing critical housing to both homeless and at-risk individuals with chronic mental illness and other difficulties. The units also provide housing to residents of Denver who could not otherwise afford to live downtown. In 2004, Renaissance at Civic Center Apartments received the Downtown Denver Partnership's Celebration of Achievement Award.



Off Broadway Lofts

Renaissance Off Broadway Lofts, completed in 2002, were the first newly-constructed, affordable rental lofts in Denver's history. Located adjacent to CCH's Stout Street HCH Clinic, the 81 unit complex is a mixture of studio, one and two-bedroom units over a two-story parking garage. Twenty-four of the units are targeted for individuals who are formerly homeless and the remaining units are rented to downtown workers who otherwise could not afford to live near their jobs. Off Broadway Lofts also houses CCH's Housing First program. (More information about CCH's housing properties for homeless individuals and families is available at: http://donate.coloradocoalition.org/housing_development/properties%20list.htm)

CCH uses a range of housing models as a part of substance abuse treatment for clients in recovery: a Housing First (low-barrier, non-ADFC) program and "sober" (ADFC) housing for clients actively engaged in treatment. Scattered-site as well as congregate housing units are served by mobile Assertive Community Treatment (ACT) teams. The Housing First program is based on the harm reduction housing model pioneered by Sam Tsemberis' Pathways to Housing program in New York. Residents are required only to meet twice a month with a case manager, have a representative payee if they have SSI/SSDI, and focus on modifying their behavior if they are at risk of eviction (which may require daily intervention involving motivational interviewing/engagement).

Defining and Funding the Support in Permanent Supportive Housing

CCH has found that Housing First results in better outcomes for people for whom treatment services cannot be mandated, including dually diagnosed individuals with primary mental illness: improved health and mental health status, less substance use, and better engagement (which occurs within approximately 18 months post admission to the CCH Housing First program). (Rosenheck, Kaspro, and Frisman (2003) reported similar data in response to research questions about health, mental health status, and substance use.)

Outcomes of the Denver Housing First Collaborative (DHFC), 2 years following inception:

DHFC, one of 11 programs funded nationally through the Ending Chronic Homeless Initiative program, is a partnership between CCH, Denver Department of Human Services, Denver Health and Hospitals Association, Arapahoe Housing Substance Treatment, the Mental Health Center of Denver, and the Denver VA Medical Center. The following outcomes have been documented for the first two years of the program (Jan. 2004 – Mar. 2006):

- Overall reduction of emergency services costs by 72.95%; average emergency services cost reduction of \$31,545 per person
- 77% of program participants initially housed are still housed in the program
- 50% of participants have improved their health status
- 43% improved mental health status
- 15% decreased substance abuse
- 64% improved overall quality of life
- 34% obtained SSI, SSDI, VA or OAP disability benefits through assistance by the program
- 15% are employed or seeking employment
- Ave monthly income increased from \$185 at entry to \$431 currently
- ER visits decreased by 34%
- Inpatient visits decreased by 40%; inpatient nights decreased by 80%
- ER costs decreased 34%, inpatient costs decreased 52%; outpatient costs increased by 51% (ave. cost increase \$894 per person); total health costs decreased by 44%
- 81% reduction in average detox costs
- 76% reduction in days incarcerated and incarceration costs
- Shelter cost savings for 150 participants: \$4.7 million over 2 years
- Average cost change per person (pre-post program entry): \$4,745; projected savings for 150 participants: \$711,734

Whether permanent supportive housing is developed by direct service providers or by affordable housing developers, the key factor is that the program be mission driven, according to CEO John Parvensky — i.e., that there be a commitment to serve the most vulnerable populations as a matter of social justice. Successful PSH programs are also personality driven; success is partially explained by the passion of their founders. Most of the differences among PSH programs derive from historical differences in their program mission, he says. For example, CCH was initially a housing initiative; Central City Concern in Portland began as primarily a substance abuse treatment and recovery initiative; Project Renewal in New York began as an alcohol detoxification program for public inebriates.

Tim Marshall, Director of Residential Services, stresses the importance of having “many tools in your toolbox” to meet the many different needs of homeless individuals. It is difficult, if not impossible, to say which model of PSH works best for particular disorders or demographic groups, he says. Client choice and case manager preference help guide the assignment of particular individuals to CCH housing units, but individual outcomes are unpredictable. Some people suddenly do well after many unsuccessful attempts at recovery.

LifeLong Medical Care, Berkeley, California

LifeLong Medical Care (LMC), which currently provides a broad range of health and social services to people of all ages, began in 1976 when the Gray Panthers, a senior citizens' advocacy organization, opened the storefront Over 60 Clinic on San Pablo Avenue. In 1996, the organization merged with Berkeley Primary Care Access Clinic and rapidly grew into a community health center (CHC) with five clinic sites and a variety of special programs. LMC is known as the primary "safety net" provider of medical services to the uninsured and those with complex health needs in Berkeley, Albany, Emeryville, and parts of Oakland. LMC has been involved in permanent supportive housing since 1998.



C.W. Dellums Apartments,
Oakland



U.A. Homes, Berkeley

Supportive Housing Program: The LifeLong

Supportive Housing Program (SHP), also known

as the Alameda County Health, Housing, and Integrated Services Network, is a collaboration of public and private agencies that provide permanent housing as well as social and health services to formerly homeless people with disabilities. SHP provides on-site, multidisciplinary support services to over 600 tenants living in eight subsidized housing sites scattered throughout Berkeley and Oakland. Services provided by SHP are optional and available to all tenants living in these housing sites. LMC does not own or operate any of the housing sites, but collaborates with several nonprofit

housing development corporations which create and operate affordable housing in Alameda and Contra Costa Counties.

Intensive supportive services are provided to SHP tenants and include: outreach, intensive case management, housing stabilization and eviction prevention, benefits advocacy and money management, medical care, mental health and substance abuse services, community building and social activities, and employment/vocational support. SHP staff also provides outreach and case management services to currently homeless individuals to help them obtain and maintain permanent affordable housing.

In 2006, LMC was awarded a New Access Point Public Housing Primary Care (PHPC) Program grant by HRSA. This grant partially funds the Downtown Oakland which is in the neighborhood of most of LifeLong's SHP sites, but located in a separate building. The PHPC clinic serves LifeLong's SHP patients, other residents of supportive housing, county mental health patients who need primary medical care, frequent users of the ER, and GA recipients whom LifeLong is trying to get on SSI and Medicaid.

Project RESPECT, the Frequent Users of Health Services Initiative project in Alameda County, aims to create cost-effective and coordinated systems of care to address the overuse of medical and psychiatric emergency services, and to improve the health and psychosocial status of frequent Emergency Department users. LifeLong Medical Care, the Homeless Action Center, the Alameda County Medical Center (ACMC), and the Alameda Health Consortium are collaborating to provide intensive case management services and to participate in system change efforts to achieve this goal. Most frequent users of the emergency room have serious, chronic health conditions as well as psychosocial issues such as homelessness, substance abuse, and a lack of social support systems.

Defining and Funding the Support in Permanent Supportive Housing

Project RESPECT's multidisciplinary team, including a social worker, case manager, nurse, attorney and psychiatrist, provides access to the following services for indigent patients who regularly use the Highland Emergency Department: primary care, housing, mental health services, benefits assistance (Medicaid, SSI, Food Stamps), substance abuse services, and transportation assistance. Services are provided through office, home and community based visits. Project RESPECT serves people who have had 10 or more visits to the Emergency Department during one year or four or more visits a year for at least two consecutive years. Services are not time limited. The Project has provided intensive case management services to more than 70 people in the past year. This model has had the following positive impact:

- 75% of clients have shown a reduction in Emergency Department visits.
- 85% of project clients have received increased primary care services.
- 50% of project clients have received advocacy services for SSI, MediCal and other benefits.
- 30% of clients are either housed or in process of receiving permanent housing

Much of this success is a result of collaboration and coordination of services across the primary care, housing, benefits advocacy, mental health, and hospital systems.

Factors to which Supportive Housing Program success is attributed:

- **Benefits advocacy:** Lifelong contracts with a benefits advocacy agency to provide legal representation for SSI/SSDI applicants. They have been very successful in getting clients SSI/SSDI benefits, including health insurance. Benefits advocacy has also been an important way to engage clients in services.
- **Integrated primary and behavioral health care:** Psychosocial and medical teams are well integrated; primary care and mental health service providers meet regularly with case management teams. Four supportive services teams—each comprised of case managers (some with BA degrees, others not), MSWs and LCSWs—provide individual case management and organize and lead a variety of groups. LCSWs serve as team leaders; they supervise case managers, provide expertise in working with seriously mentally ill clients, and are the only members of the case management team who can bill for services provided to FQHC clients. A mid-level [NP or PA] and an MD provide clinical services at 5 hotel sites. When clinic is in session, they are usually supported by a MA psychologist and a case manager who provides psychosocial referrals, support, crowd control, etc. A psychiatrist from the county mental health department serves on one of the teams for 4 hours each week. All case managers and MSWs are full-time employees; 3 of the 4 LCSWs are part-time (60% – 80%); the MD and mid-level who work at the housing sites and at the Downtown Oakland Clinic are both part-time providers (55% and 75%, respectively).
- **Linkage with property management:** Weekly meetings with property managers focus on pending evictions, identifying who hasn't paid rent and who is ready to move on to a better housing situation, and determining what help is needed to prevent eviction/promote readiness for better housing. Working with property managers helps keep people housed and makes the atmosphere in supportive housing buildings safer. This has taken years to achieve.
- **Individual and group “stabilizing” interventions:** Non-therapeutic group interventions have been particularly important to help address socialization issues; women's support groups are especially popular. Aggressive outreach to residents is necessary; a well-known case manager goes door-to-door in the housing units to invite residents to group sessions. Staff help individual clients with money management, provide vocational and transportation assistance, promote harm reduction and community involvement. These stabilizing interventions enable clients to negotiate community service systems, hook up with mental health treatment, return to school or work, and feel more connected to the broader community. Half of the groups are led by social service staff (case managers, MSWs, LCSWs), and half are led by medical providers on physical health topics.

Defining and Funding the Support in Permanent Supportive Housing

- **Intensive case management:** The most intensive work is done at the point of engagement with street dwellers and during the transition from the street to housing. Many new PSH residents feel isolated and “penned in”; home visits and office visits help these clients feel more comfortable. Caseloads are 1:20 (“a bit high, but funding demands it”). Flexibility and the development of trusting relationships are important for recruitment and retention of case managers, as well as for clients. Two of the case management teams provide services exclusively at 4 hotels; the other two teams provide services out of the Downtown Oakland Clinic, through home visits (combination of Shelter + Care clients and others), at two hospital ERs, on the street, at shelters and other social service agencies and at two SROs near the clinic where full-time services are not available on site. Active outreach is provided to those sites to bring people to the clinic for primary care and to participate in group sessions.

Direct Access to Housing Program, San Francisco

Established in 1998, the San Francisco Department of Public Health's (SFDPH) Direct Access to Housing (DAH) program provides permanent housing with on-site supportive services for approximately 1,000 formerly homeless adults, most of whom have concurrent mental health, substance use, and chronic medical conditions. Another Housing First program funded by San Francisco's Human Service Agency (HSA) houses an additional 3,000 formerly homeless people. DAH is a "low threshold" program that accepts single adults into permanent housing directly from the streets, shelters, acute care hospitals or long-term care facilities. Residents are accepted into the program with active substance abuse disorders, serious mental health conditions, and/or complex medical problems.



Plaza Apartments



Central YMCA

Currently the DAH program has 13 housing sites ranging in size from 33 to 106 units each. One DAH site is a licensed residential care ("board and care") facility designed to house individuals with chronic medical problems who have spent most of their adult lives in locked psychiatric institutions. Another site has an Adult Day Health Center on site serving about 100 disabled clients, 52 of whom have been chronically homeless. Four sites are restricted to frail elderly (age 55 or over 62, depending on the building). The Plaza Apartments, one of the largest sites, has 106 studio apartments. Approximately 500 more housing units are expected to be opened by 2010, including 174 units of supportive housing in the Central YMCA, to be renovated, which will also house the new Health Center that serves all residents of supportive housing facilities in San Francisco.

Medical services: All DAH sites have some medical staff on site, ranging from once-a-week public health nurses to sites with full-time nurses, psychiatrists and part-time nurse practitioners. Most on-going care is provided at the Housing and Urban Health (HUH) clinic, located on the ground floor of one of the supportive housing sites. Many of the DAH program residents receive primary care services at the HUH clinic which serves about 1000 clients each month. Licensed staff at the supportive housing sites usually are able to engage clients at the bedside and then move them on to longitudinal care at the HUH Clinic. About three-fourths of clinic patients have Medicaid. The Health Center is a Federally Qualified Health Center with a per visit billable rate of \$202. The clinic is staffed primarily by nurse practitioners but also supports 5 full- and part-time psychiatrists and a full-time medical director.

At the RCF, there are around the clock nursing services. One residential hotel has five-day-a-week nursing services, and three-day-a-week urgent care medical services provided by an on-site nurse practitioner and a full time on-site licensed social worker. An additional two sites staffed by nurses offer residents directly observed therapy for psychiatric and HIV medications, as well as other medications, five days a week. The other sites have access to an on-call nurse practitioner for urgent care home visits. At all sites, staff meet at least monthly with the medical director for the DAH program to assist with medical treatment plans and to strategize on how to access appropriate medical and psychiatric care in the community.

Defining and Funding the Support in Permanent Supportive Housing

Behavioral Health services: Most psychiatric care for permanent supportive housing residents is provided in the Health Department's Housing and Urban Health clinic or at other city funded mental health treatment facilities. A Roving Team serves residents of the HSA Housing First Program, engage people at the bedside, and then provide ongoing care in the clinic. The primary goal of the Roving Team is to prevent eviction resulting from exacerbation of mental health and substance use disorders. Medical Director Josh Bamberger, MD says he wishes the Roving Team had more staff so that they could engage the high-needs clients among the 3000 people living in HSA housing earlier through brief, intensive interventions by primary care providers.

Case management services: All sites have between three and six on-site case managers as well as a site director. Most of the on-site case managers are employees of contracted community based agencies. Case managers are usually Bachelor or Masters level social workers. Site directors are generally Masters-level, licensed social workers or registered nurses. Case managers help residents obtain and maintain benefits, provide individual case management for substance use and mental health problems, life skills and family counseling, assist in accessing medical and behavioral health treatment, assist with accessing food and clothes, and interface with property management to assist in preventing eviction.

Project Renewal, New York City

Project Renewal, one of the early pioneers of supportive housing, converted old, deteriorating Single-Room-Occupancy hotels into safe efficiency apartments with offices where caseworkers offer tenants help with behavioral health problems and assistance with life skills and employment on an as-needed basis. Project Renewal's permanent supportive housing program provides services to formerly homeless individuals with chronic illnesses, many of whom have co-occurring substance use disorders. The PSH program offers a range of housing-plus-services options – from supportive housing in congregate settings and scattered-site Shelter-Plus-Care apartments to more supervised housing for homeless people with mental illness.



Holland House

Clinton Residence: The Clinton Residence in Manhattan provides housing and round-the-clock comprehensive supports to 57 tenants, many of whom have spent many of their adult years in psychiatric institutions. Initially, the Clinton Residence was imagined as permanent housing, because the severity of residents' illnesses suggested they would never live any more independently. But many residents who received closely coordinated comprehensive services including psychiatric and medical care, case management and employment assistance were able to establish social networks, gradually assume more responsibility, and even pursue employment. As a result the program increased its emphasis on employment, which has improved clients' self-esteem and ability to live with greater independence. One floor of the 7-floor residence was converted into a "transitional" floor, where residents take on much greater responsibilities. As a result, since the program's inception, 73% of residents have moved into more independent housing and all continue to succeed in these new settings; and 75% of current Clinton residents are involved in some type of employment activity.

Holland House: In 1995, Project Renewal completely renovated the decrepit Holland Hotel, turning it into safe and attractive supportive housing for 307 men and women, making it one of the largest supportive housing complexes in the country. It was renamed the Holland House. Tenants are either formerly homeless or have a very low-income. Of those who have a history of homelessness, 40 apartments are reserved for individuals living with a mental illness, 40 for people living with HIV/AIDS, with the remainder available for other homeless individuals - including those in recovery. The award-winning project has proven a success for both tenants and the community. Tenants stabilize and don't return to homelessness; 86% have remained housed for at least a year.

St. Nicholas House: Project Renewal's newest affordable/supportive housing complex, which provides housing and support services to 94 formerly homeless and very-low income residents in Harlem, opened in 2004. Modeled on the Holland, the new building features a computer lab, a library and on-site recreational services in addition to comprehensive support, medical and employment services. Project Renewal worked extensively with the community and Community Board 9 to ensure that all neighborhood concerns about the project were met.



St. Nicholas House

LeonaBlanche house: This site includes 53 units of supportive housing in the Bronx for people living with chronic mental illness. It was opened in 2004. Less supervised than the Clinton but providing more support than the Holland, the LeonaBlanche houses people ready to live more independently, but not totally so.

Lease on Life: 36 apartments leased by Project Renewal to provide safe, affordable housing with some ongoing support to help formerly homeless or addicted men and women complete their recovery. The apartments are made affordable through subsidies from the state's Office of Alcohol and Substance Abuse Services.

In Homes Now: In 2003, Project Renewal was awarded one of 11 Chronic Homelessness Initiative grants nationwide. The grant helped create In Homes Now, a Housing First program that identifies chronically homeless individuals whose primary disabling condition is a substance use disorder, places them in scattered site apartments, and provides comprehensive health, support, addiction, and employment services. Most services are provided onsite by project staff: a nurse, a part-time psychiatrist, maintenance and security staff, and staff who provide meals for people with AIDS. Tenants are referred to some community services: 5 primary care clinics, specialty care, and dentistry. PSH services are provided to tenants in 2 fully independent buildings. Under New York law, leases can't be terminated except for failure to pay rent or behavioral issues. Program activities are designed to promote treatment adherence for residents with mental illness.

Important for program success: According to Executive Director Ed Geffner, the following factors ensure the success of this and other permanent supportive housing programs:

- **Maintenance & security of buildings:** Keeping facilities clean, doing needed repairs, and protecting tenants from violence are very important. Those who deal drugs are evicted.
- **Entitlements:** Currently there is an effort in New York to get homeless people who are not receiving treatment for substance abuse into permanent supportive housing. All residents of supported housing come with SSI and public assistance; enrollment is accomplished at the referral source.
- **Case management:** Case managers contact all tenants immediately after intake; they don't compel anyone to participate in services, but try to persuade them to do so. Case managers keep up with tenants' appointments and health needs; help people with mental illness with treatment adherence (taking meds in timely manner, understanding medication side effects and benefits).
- **Psychiatric services:** stabilization and evaluation of tenants not yet evaluated (services offered, not required); crisis management for those who stop taking medications (refuse to come out of rooms or admit anyone; if these tenants won't agree to see psychiatrist, outside crisis management team is called in). Staff negotiate with tenants and do everything possible to avoid compulsory hospitalization. Titration of medications is used to minimize side effects (a common obstacle to adherence). When a tenant sees a provider outside the agency, the psychiatrist follows up with treating physician to assure integrated service plan and continuity of care.
- **Health promotion & chronic disease management:** Onsite wellness management program: diet/nutrition, exercise, symptom management (especially for mental illness), stress reduction, smoking cessation, other behavioral change to promote health. Staff work hard to persuade people to participate in these programs, to help them manage chronic disease and increase life expectancy. A nurse does basic screens and triaging, makes referrals to 5 primary care clinics, specialty care, and dentistry.
- **Substance abuse treatment:** Substance abuse is a major issue in NYC and for this population; 60-70% of tenants have a history of substance abuse. Project Renewal maintains its own detox unit and outpatient clinic for short- and long-term treatment of substance use disorders; clients also have access to rehab units. "But it's not easy to persuade tenants to utilize these services." Harm reduction is practiced, but drug trafficking in the building is not tolerated. Nonpayment of rent is usually an indicator of relapse in recovery.
- **ADL skills training:** Activities of daily living/life skills training is provided to tenants to promote stabilization.

About The National Health Care For The Homeless Council

Founded in 1985, the National Health Care for the Homeless Council is a membership organization comprised of health care professionals and agencies that serve homeless people in communities across America. The National Council works to improve the delivery of care to homeless people, and to reduce the necessity for dedicated health care for the homeless programs by addressing the root causes of homelessness. www.nhchc.org

About The Corporation For Supportive Housing

The Corporation for Supportive Housing (CSH) is a national, nonprofit organization that helps communities create permanent housing with services to prevent and end homelessness. CSH advances its mission by providing high-quality advice and development expertise, by making loans and grants to supportive housing sponsors, by strengthening the supportive housing industry, and by reforming public policy to make it easier to create and operate supportive housing. CSH delivers its core services primarily in ten states (California, Connecticut, Illinois, Indiana, Michigan, Minnesota, New Jersey, New York, Ohio, Rhode Island) and in Washington, DC. CSH also operates targeted initiatives in 6 states (Indiana, Kentucky, Maine, Massachusetts, Oregon, and Washington) and provides limited assistance to many other communities.

About This Publication

If you have questions or comments regarding this publication, please contact the CSH Resource Center at info@csh.org. This publication is available to download for free at www.csh.org/publications, and please see www.csh.org for additional on-line resources and materials, including information regarding the communities in which we currently work.

We encourage nonprofit organizations and government agencies to freely reproduce and share the information from CSH publications. The organizations must cite CSH as the source and include a statement that the full document is posted on our website, www.csh.org. Permissions requests from other types of organizations will be considered on a case-by-case basis; please forward these requests to info@csh.org.

Information provided in this publication is suggestive only and is not legal advice. Readers should consult their government program representative and legal counsel for specific issues of concern and to receive proper legal opinion regarding any course of action.

Cover: St. Nicholas House in Harlem run by Project Renewal. Photo by Bob Zucker/Corporate Graphics. For more information on this project, please see page 57.

