

Healthy Aging in Place: Integrated Service Models Making Impact

Tuesday, October 10, 2017



Overview

Today's Learning Objectives:

- Participants will learn about the unique health and housing partnerships to deliver enhanced services to their aging and elderly clients/residents
- Participants will have a deeper understanding of the different financing structures providers have leveraged to deliver services

Special Thanks to the Mizuho Foundation and The Fan Fox and Leslie R. Samuels Foundation, Inc. for making today's webinar possible.

Today's Panel

Pascale Leone, Associate Director, CSH



Scott Walker, Director of Residential Services, CaringWorks



Bob Theil, Government Affairs Manager New Courtland.



Molly Dugan, SASH Program Director in Vermont



Robin Wagner, Deputy Assistant Secretary of Louisiana Department of Health



Integrated Health Care Addressing Social Needs for Aging Adults in Supportive Housing

- **Housing is Health**
 - 85% of surveyed Primary Care Providers & Pediatricians believe that unmet social needs lead directly to worse health for all Americans.
 - Most older and elderly adults (89%) want to remain in their homes for as long as possible
- **Trends in Integrated Care Settings**
 - Older adults are living longer, with less social supports and more complex care needs
 - Previous CSH webinars highlighted:
 - Brooklyn Community Housing & Services Oak Hall Program ~ 96% Reduction in in-patient hospital stays for medical issues
 - Breaking Ground's Elder Care Health Outreach (ECHO Pilot) ~ 109 reduced ED & Hospital days in Yr 1
- **Today's Webinar**
 - Health Center + Supportive Housing Partnership
 - PACE program serving frail elders in Affordable Housing
 - SASH Enhanced Service Model
 - Leveraging Medicaid to Provide Services in Supportive Housing



Housing. Help. Hope.
One person at a time.



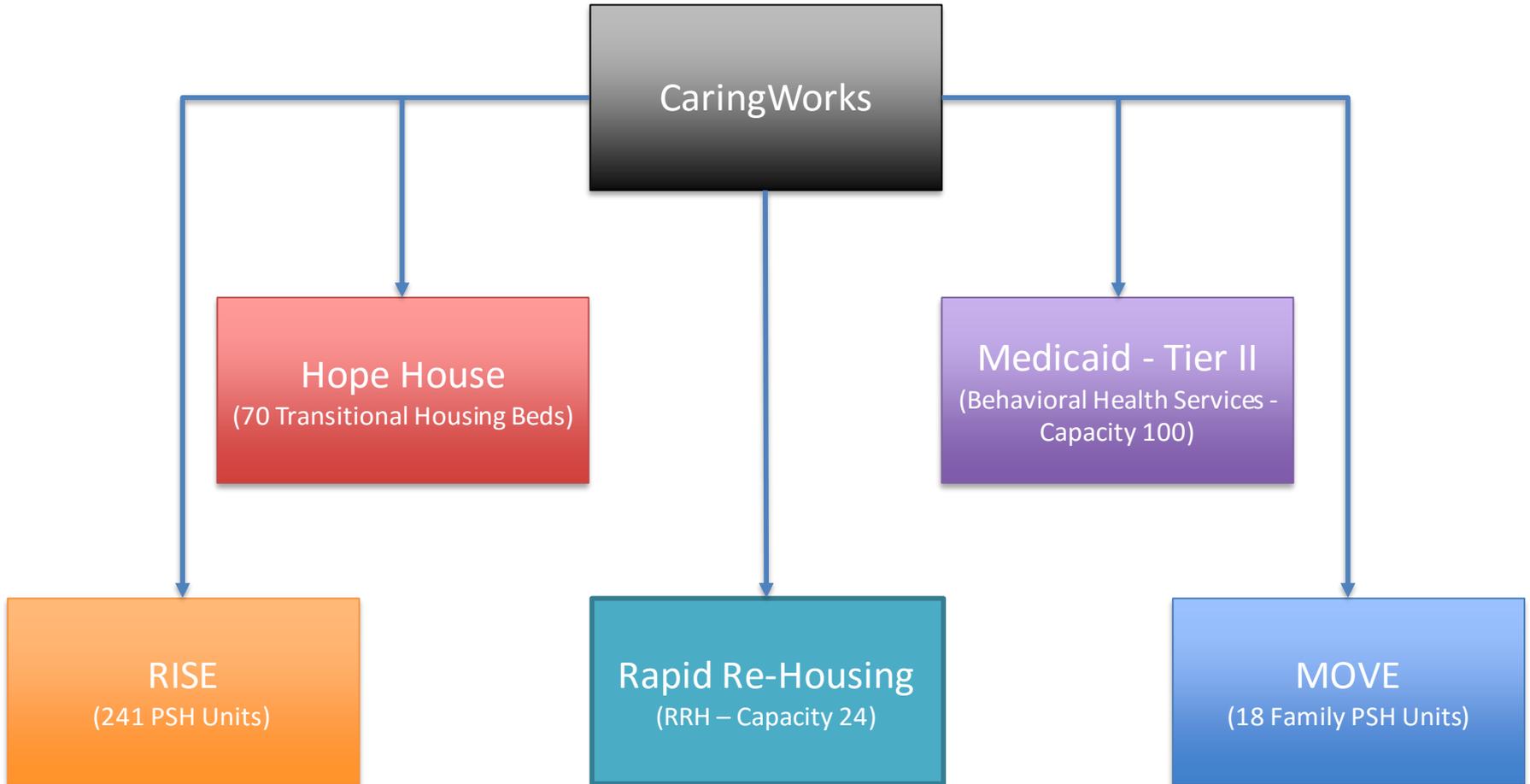
CaringWorks

HOUSING • HELP • HOPE

Healthy Aging Webinar
Scott Walker, MSW

- Founded in 2003
- Permanent Supportive Housing (PSH) Provider
 - 268 Units Over 3 Continua of Care (Atlanta, DeKalb, & Fulton)
- Progressive Hope House Opened in 2005
 - 70 Bed Transitional Housing Facility
 - Men recovering from substance use disorders
 - Deaf HOH, Re-Entry, HOPWA, & VA Programs
- Rapid Re-Housing with DCA Balance of State
 - Rockdale, Henry, & Newton Counties
 - Served XX Families in 2016
- CORE Medicaid (Tier II)
 - Behavioral Health Services
 - Serving up to 100 Medicaid clients





RISE Program Description – Clients



- Chronically Homeless Individuals with Disabling Conditions
 - Physical Disability
 - Severe and Persistent Mental Illness (SPMI)
 - Co-Occurring (Substance Use Disorder)
- Hardest-to-serve clients
 - Diminished physical ability
 - Multiple hospitalizations
 - Chronic relapses
 - Multiple incarcerations
 - Resistance to engagement in services
- Demographics
 - 70% are 45 and older (Single/Unattached)
 - 67% are Male
 - 90% are African-American

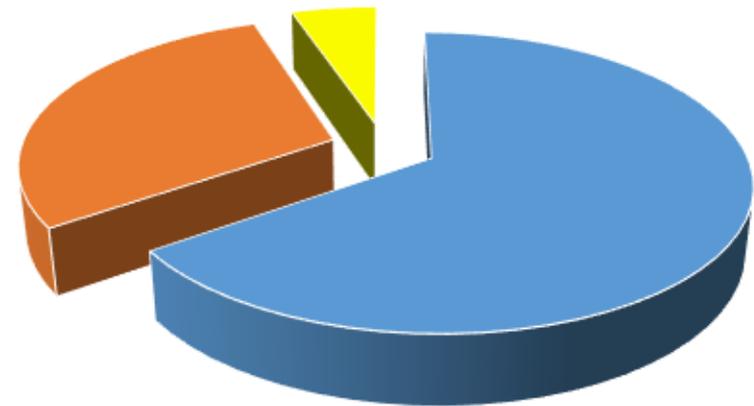
- Housing Placement
 - One or Two Bedroom Apartment in Mixed Communities
 - Rent & Utilities subsidized for 30% of client's adjusted income
 - 151 Units in 11 properties
 - Safe communities with amenities and access to community resources (MARTA, shopping, retail, medical centers; etc.)
- Support
 - Case Management
 - Community Linkage (Mainstream benefits, employment, support groups, etc.)
 - Crisis Intervention Funds (MARTA, medication, food, toiletries; etc.)
- Need for Integrated Services
 - Limited engagement with mainstream benefits
 - Hardest-to-serve, most service resistant
 - Less service dollars to manage this population

- Industry Best-Practice
 - 151 total clients in program
 - 7 direct service staff
 - No more than 25 clients per case manager
- Staff composition
 - Traditional case managers
 - Harm Reduction Case Manager (versed in Substance Use Disorder counseling)
 - Program Director
- Caseloads are determined by need/stability
 - Four times per month (For SPMI or new clients needing stabilization)
 - Two times per month (Harm reduction for Substance Use Disorder clients)
 - Once monthly (More stable, service-connected clients)



- Seven funding sources support the program
 - Housing and Urban Development (HUD)
 - Department of Behavioral Health and Developmental Disabilities (DBHDD)
 - Georgia Department of Community Affairs (DCA)

- Total Funding \$1,918,890



■ Rent & Utilities ■ Services ■ Other

- Gap in services was not addressed for the population
- Established Medicaid provider status in 2014
 - Peer Support led by Certified Peer Specialists (CPS)
 - Did little to provide the additional support needed
 - Difficult to administer services
- Established Tier II (CORE) Status in 2015
 - Planned to layer services with those provided by PSH
 - Service gaps addressed by robust service offerings
 - Goal was to ensure housing stability through collaboration between PSH and Tier II staff

- Tier II offers an array of Behavioral Health Services
 - Psychiatric Services
 - Medication Monitoring
 - Therapy
 - Mental Health Case Management
 - Substance Abuse Counseling
 - Peer-led groups
 - Group Counseling
 - Nursing Services



- When paired with our established PSH, we have sustained current outcomes but have increased the overall quality of life of engaged clients.
- 40 clients are engaged in the layering of Tier II services with-in CaringWorks PSH
- Many have transitioned from PSH to independent living via Housing Choice vouchers/FLOW

- Sustained active engagement is important.
- Team Coordination/Collaboration
- Tri-Morbidity identification -> prolonged life expectancy
- Collaborate with other agencies when able
 - Fills gaps
 - Expands services reach
- Layering services stretches resources; more quality & more clients
- Revenue streams allows CaringWorks to provide services to its indigent/uninsured clients in our housing/communities
- Lean on the strengths/skill sets of clients
 - Pair services with level of need
 - Match clients with clients (peer-to-peer support)

- Georgia has not expanded Medicaid Services
- Clients in need of Tier II services have not been approved for Medicaid
- Excessive delays in obtaining Medicaid services & other mainstream benefits – new clients
- Clients who are...
 - Older
 - Service resistant
 - Have chronic medical conditions
 - Vulnerable
- Property owners are less willing to offer housing to population
 - Market shift
 - Increased cost

- PSH Metrics
 - Served 174 Clients in 2016
 - 78% housing stability
 - 91% remained stably housed in 2016
 - 71% housing tenure 365 days or longer
- Tier II Metrics
 - Served 85 clients in 2016
 - 40 clients reside in CaringWorks PSH
 - 15 clients attend daily groups
 - 33 clients connected to psychiatric services
 - 30 appointments (nursing, prescriptions, etc.)
 - 25 clients have made progress with goals



NEWCOURTLAND
SENIOR SERVICES

The NewCourtland Model of Housing with Supportive Services

Bob Theil
Government Affairs Manager
October 10th, 2017



- Organization dates back to the Civil War with the start of the Presbyterian Hospital in Philadelphia. In 1995, the hospital was sold to the University of Pennsylvania Health System and NewCourtland Senior Services was created with the purpose of improving the quality of life for the elderly in Philadelphia.
 - The first goal was to improve the quality of life and care seniors received in nursing homes.
 - Began investing in housing in 2006.
 - Opened first LIFE Center in 2007.
 - Opened first apartments in State dedicated to Nursing Home Transition (NHT).
 - In 2011, sold 6 of 7 nursing homes to shift focus to housing and home and community based services.
- In 2013 we started to fully develop our 15 year plan which focuses on building housing with supportive services.



NEW COURTLAND
SENIOR SERVICES

LIFE program

- Living Independently for the Elderly (LIFE) is an all inclusive health care program. Known nationally as the Program for All Inclusive Care for the Elderly (PACE).
- LIFE's comprehensive features help make it possible for seniors to remain in their homes. For most participants who are eligible for Medicaid or dually eligible for Medicaid and Medicare this means:
 - generally no costs for services provided by LIFE
 - no costs for prescription drugs
 - a LIFE care team dedicated to addressing your health care and social support needs
 - comprehensive medical services
 - as directed by your LIFE care team, home services such as meals, help with bathing and dressing, light housekeeping, laundry, chores, home modifications, and medical equipment and supplies
 - a day center at which members can eat, receive medical care, and participate in activities
 - free transportation to doctor appointments, the LIFE day center, and medical destinations outside your home



Facts about Our Model

- Based in North, Northwest and Northeast Philadelphia our model creates a community which combines the LIFE program with affordable senior housing and allows seniors to stay in a place they call home for as long as possible.
- We asked for and received a preference from HUD which allowed our LIFE and NHT participants to move to the top of our waiting lists.
- We fund our projects through a number of sources and partnerships including:
 - PA Housing Financing Authority Tax Credits
 - PA Redevelopment Assistance Capital Program Grant
 - Philadelphia Office of Housing and Community Development Grant
 - Loans
 - NewCourtland Investment
 - Philadelphia Housing Authority vouchers
 - This working partnership with PHA is one of the main reasons our housing model is so successful.



- We offer three categories of housing to ensure that the needs of our seniors are always met:
 - One bedroom and studio apartments designed for independent living
 - Housing for seniors transitioning out of nursing homes
 - Cottages for the memory-impaired and their caregivers
- This model falls in line with two of Pennsylvania Governor Tom Wolf's top priorities:
 - PA's Five Year Housing Plan- just as it is stated in the plan, we connect seniors with affordable and supportive housing that keeps them out of nursing homes.
 - Community Health Choices (CHC)- beginning in 2018 PA will implement MLTC across the state for eligible seniors. Housing is a central part of CHC in that the MCO's must provide and have an understanding of housing needs of seniors. Our model is already there and, as you will see, is moving forward with new developments to meet the constant need for senior housing.



In 2013 we embarked on a 15 year plan with the goal of developing and maintaining 2000 affordable senior housing units in Philadelphia. The following slides will show where we are now and where we are going.



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Our Communities

NewCourtland Senior Community at Allegheny North Philadelphia



- 105 housing units
- 15,000 square foot LIFE Center on the same campus
- Room to build up to 100 additional units on lot

NewCourtland Senior Community at Germantown in Northwest Philadelphia



- 115 housing units including
 - 60 apartments
 - 18 cottages
 - 37 NHT units
- 8,000 square foot LIFE Center is on the same campus



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Our Communities

NewCourtland Apartments at Cliveden in Northwest Philadelphia



- 62 units
- There is not a LIFE Center on site but there is a Services on Site coordinator to assist seniors living in this building

Future NewCourtland Developments

Currently we are in the process of planning three more campuses which will be comparable to Allegheny and Germantown in that they will have housing and a LIFE Center on the same site

NewCourtland Senior Community at St. Bart's



- Located in Northeast Philadelphia
- 2.5 acre site
- Phase 1 construction is 60% complete
- When completed there will be:
 - 138 apartments
 - 15,000 square foot LIFE Center



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Future NewCourtland Developments

NewCourtland Senior Community at Henry Avenue



- Located in Northwest Philadelphia
- 13 acre site
- Construction is slated to start in the winter of 2017
- Multi phase project with room for up to 600 apartments
- Phase 1 will include:
 - 78 apartments
 - 15,000 square foot LIFE Center
 - 6,000 square foot of commercial space
 - Community amenities include a dog park



NewCourtland Senior Community at Pennypack

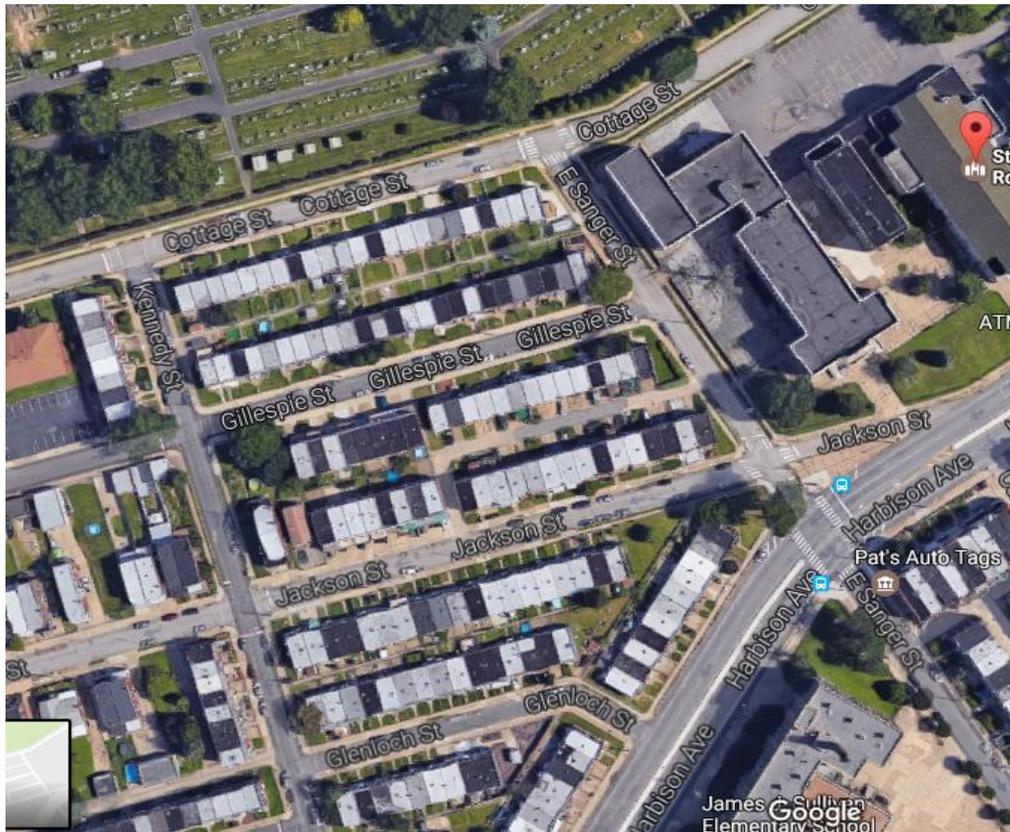


- Located in Northeast Philadelphia
 - Formerly known as Liddonfield Housing Project
- 33 acre site
- Construction slated to start within in winter of 2017
- 1/3 will contain 250 apartments and a 15,000 square foot LIFE Center
- 1/3 will be made into athletic fields and donated to Holy Family University
- The last third will be land banked for future use



Future NewCourtland Developments

We are in the process of obtaining scattered site housing to further meet the growing need for senior housing in Northeast Philadelphia



- Located in Northeast Philadelphia in close proximity to our St. Bart's development
- We are purchasing one story, 700 square foot homes and rehabbing them into senior housing
- The goal is to purchase 200 over the next two years
- To date we have purchased over 40
- The cost to purchase and rehab these units is well under the cost to build one apartment in a multi unit building



Successes

- To date we have transitioned over 150 seniors out of nursing homes and into safe, stable housing through our NHT program.
- We have been able to leverage funding sources at both the local and state level to make our housing model a reality and we are well on our way to achieving our goal of 2000 units over the next 15 years.
- Our LIFE program saves the state over \$27,000.00 per participant, per year, by keeping seniors out of nursing homes. With almost 600 participants in our program, and growing, that equates to a total of over \$16,000,000.00 in savings per year.
- Through our partnerships with HUD and the Philadelphia Housing Authority we created a preference on our waiting lists for seniors that are eligible for the NHT program or in need of supportive services which helps prevent unnecessary nursing home placements. This substantially cuts down the time a senior has to wait for housing.
- We have been able to gain the full support of elected officials and the local community organizations by working with them from the first step of project development and by adding a community benefit to all of our projects.



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Conclusion and Contact Information

- As you can see we are well on our way to realizing our goal of drastically increasing the number of affordable senior housing apartments in Philadelphia over the next 15 years.
- We believe this model will allow us to best serve the needs of the senior population both as a healthcare and housing provider.
- If you have any questions, or would like any other information about our model or our future developments, please feel free to contact me:

Bob Theil

Government Affairs Manager

215-965-2385

rtheil@newcourtland.org



SASH *a caring partnership*
SUPPORT AND SERVICES at HOME

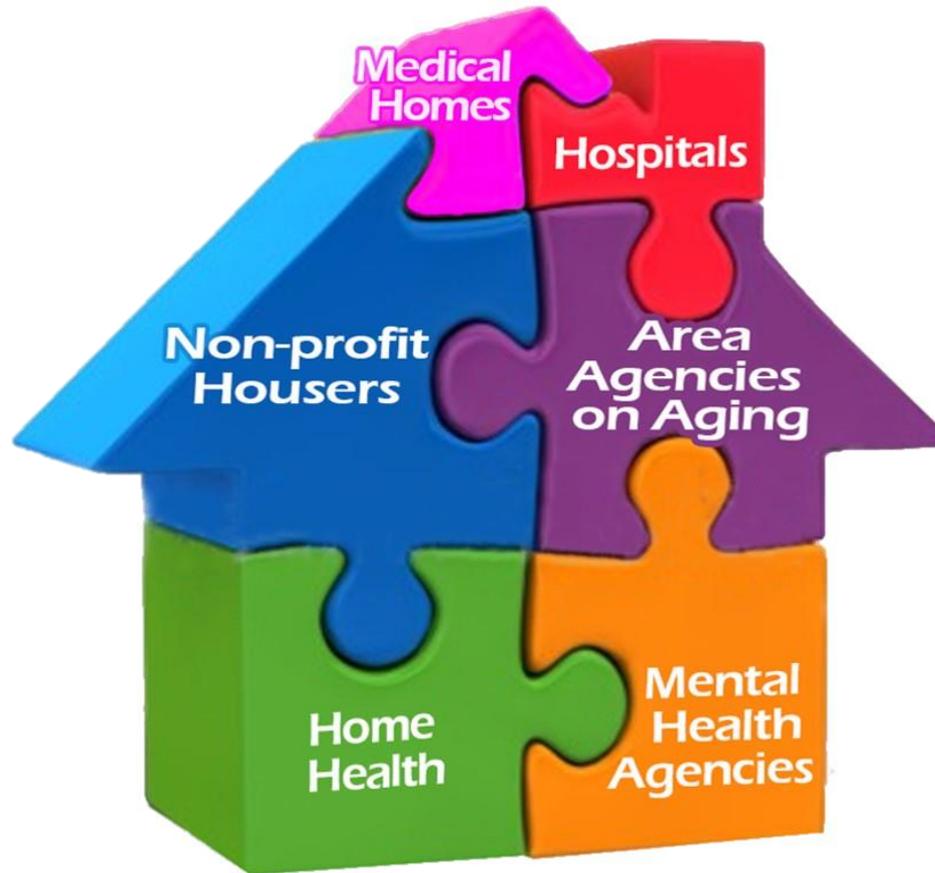


Healthy Aging in Place: Integrated Service Models Making Impact

The SASH[®] Model

A caring partnership to help seniors and individuals with special needs stay at home and healthy

SASH[®] Housing- A Platform for Population Health Based on Partnerships



WHY HOUSING?

- ▶ A ready-made network
- ▶ Allows scale and replication
- ▶ Integrates primary care, acute care, mental health, behavioral health and LTSS at home



Social Circumstances and Health

 U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

**PICTURE OF
HOUSING AND HEALTH:
MEDICARE AND MEDICAID USE
AMONG OLDER ADULTS IN
HUD-ASSISTED HOUSING**

March 2014

- Medicaid costs 32% higher
- 55% had 5+ chronic conditions
- Medicare costs 16% higher

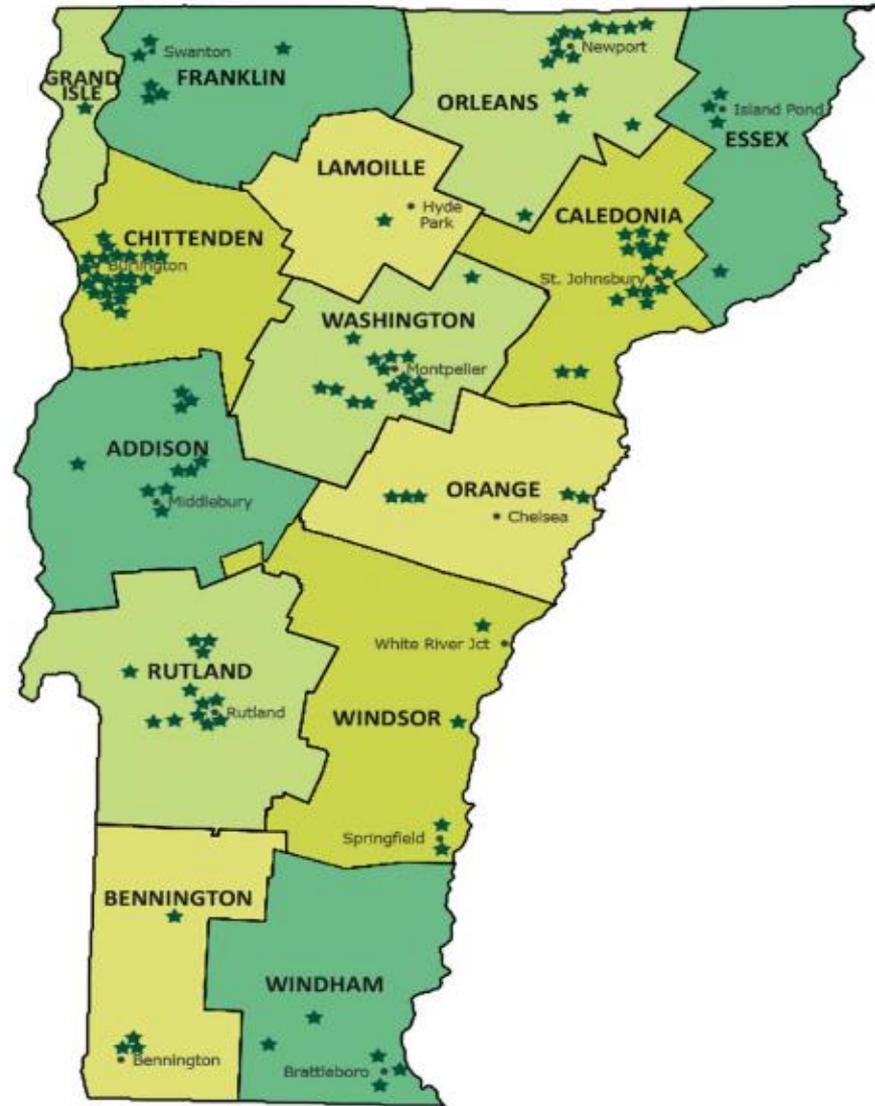
Who SASH Serves In VT

- 5,000 Participants
- 80% Medicare
- 25% live in a community setting
- 73% 65 +
- 27% under 65
- Participants span all health care needs
- We have a “no discharge” policy



SASH STATEWIDE LOCATION MAP

**SASH is
available in
140
Affordable
Housing Sites
Across Vermont**



What does it mean to be in SASH?

SASH participants become part of a defined community supported to focus on being healthy at home.



The SASH Model Focuses on the Three Components of Care Management

- Conducts wellness assessment
- Convenes SASH team
- Understands participants needs and preferences
- Coordinates individual/community healthy living plans

Care
Coordination

- Develops healthy living plan
- Coaches SASH Participants
- Provides reminders and in person check ins
- Organizes presentations and evidence based programs

Self
Management

- Coordinates with discharge staff, family and neighbors
- Personal visit to review discharge instructions
- Helps ensure a safe home transition

Transitional
Care

What are the Essential Elements of the SASH Model?

- Person-centered
- SASH Staff
in housing hubs
- Partnerships
- Information Sharing
- Prevention and Wellness through Healthy Living
Planning- Evidence Based Practices



SASH Staff = Trusted Guides

Consistent presence of SASH Staff and SASH Team builds knowledge and trust.



The SASH Team

- The SASH Team consolidates advocacy and support efforts of multiple agencies (it takes a village!) into one concerted and coordinated system that is both population based and person-centered.
- Monthly Meetings.

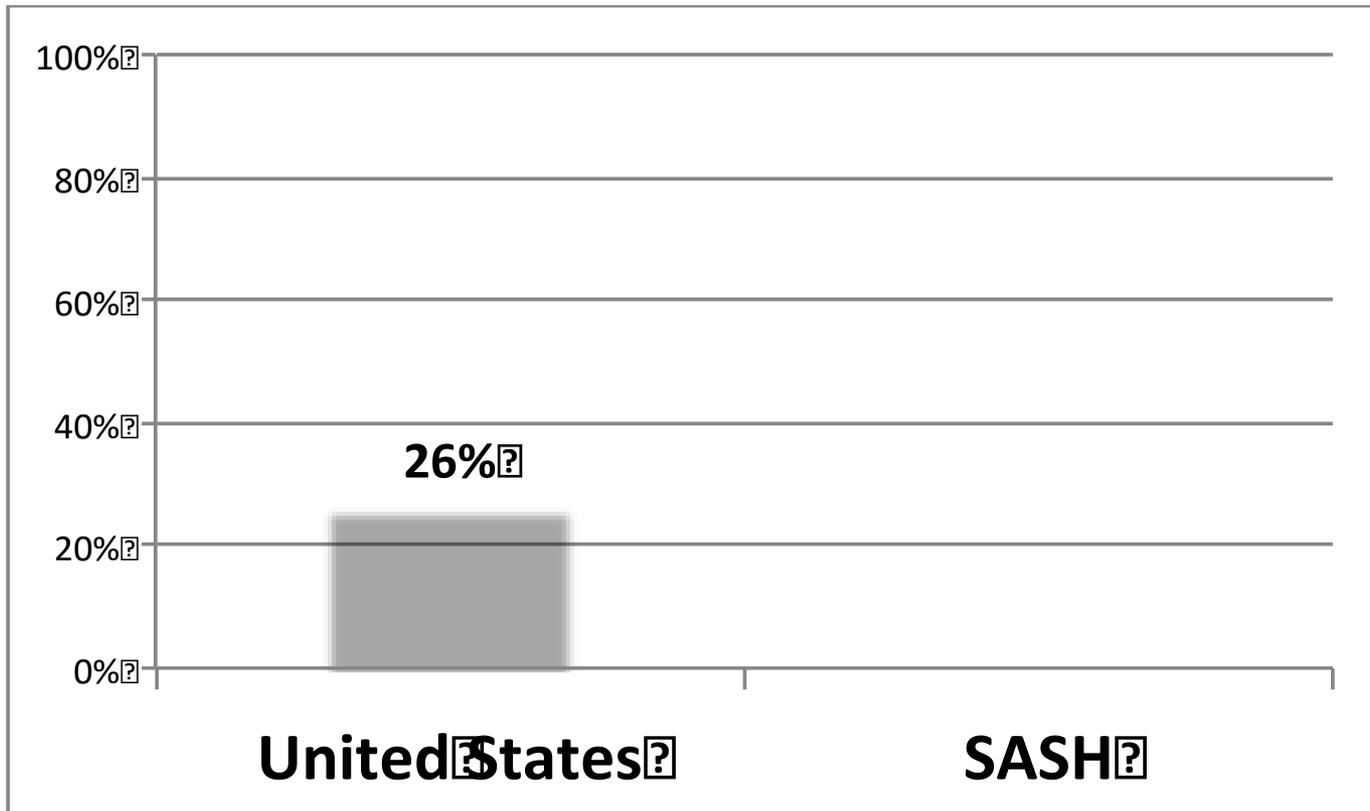


Does the SASH model benefit Health Outcomes?

4 Selected Measures

1. Documented Advanced Directives
2. Shingles Immunization
3. Annual Falls Rate
4. Controlled Hypertension (BP < 140/90)

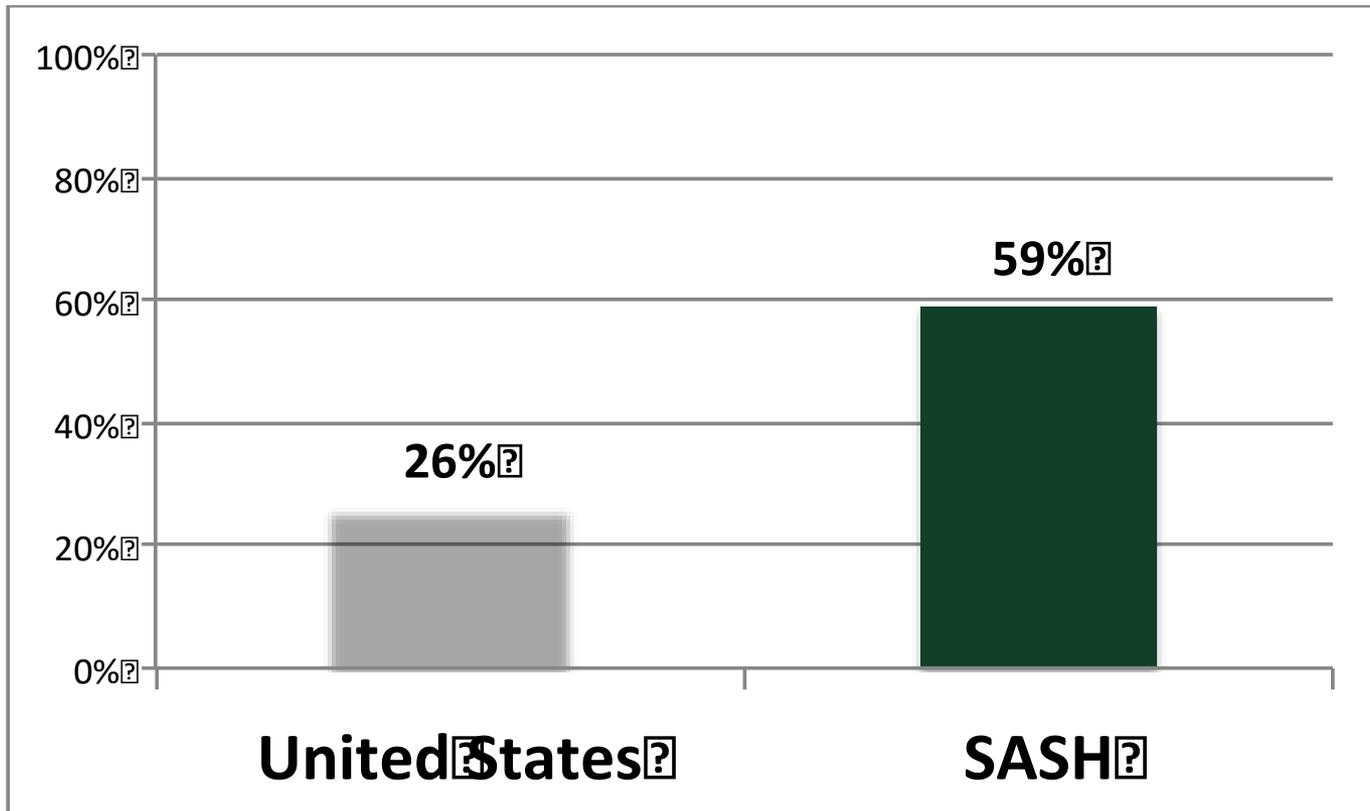
Documented Advanced Directives



Source: 2014, American Journal of Preventative Medicine

<http://www.nhpco.org/press-room/press-releases/new-study-advance-directives>

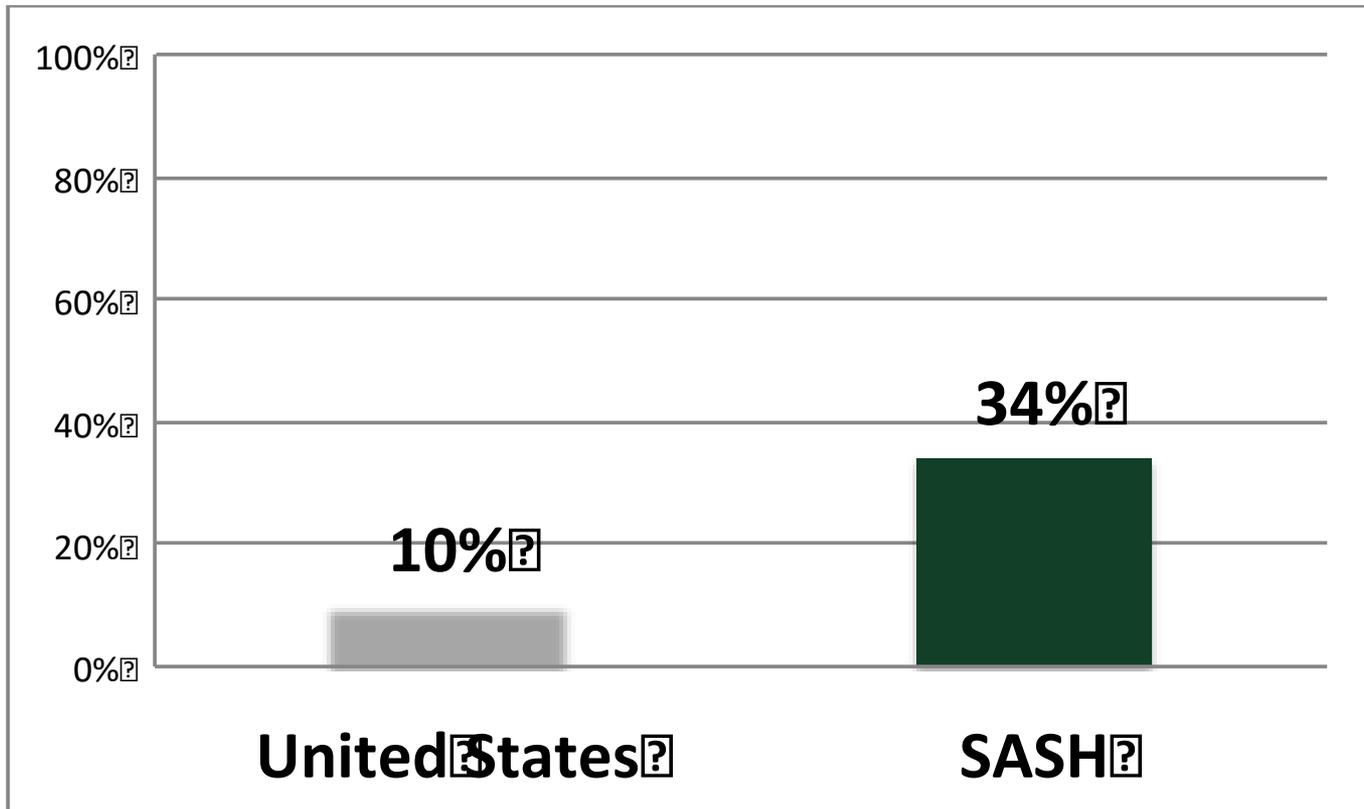
Documented Advanced Directives



Source: 2014, *American Journal of Preventative Medicine*

<http://www.nhpc.org/press-room/press-releases/new-study-advance-directives>

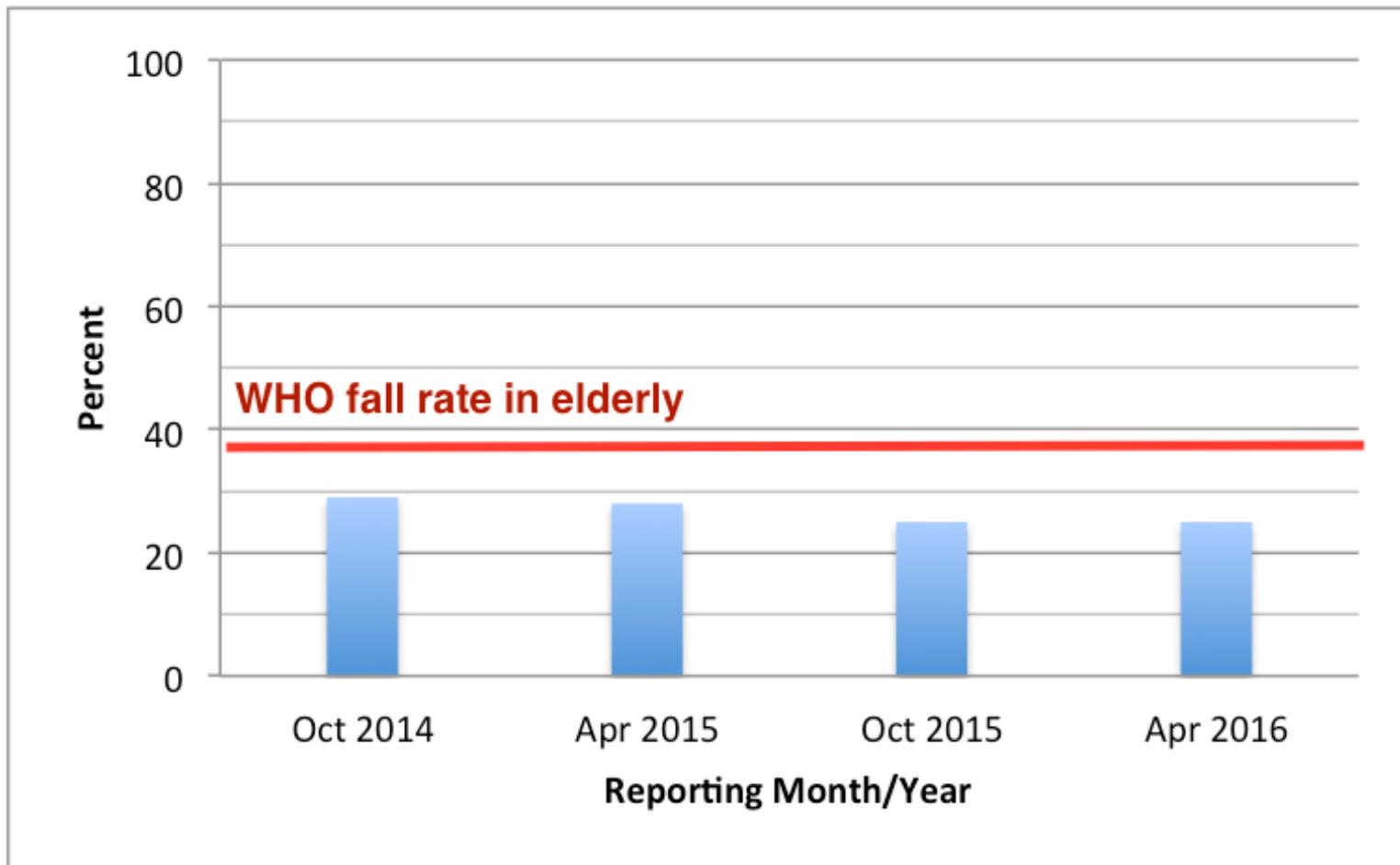
Shingles Immunization



Source: 2011, Journal American Medical Association

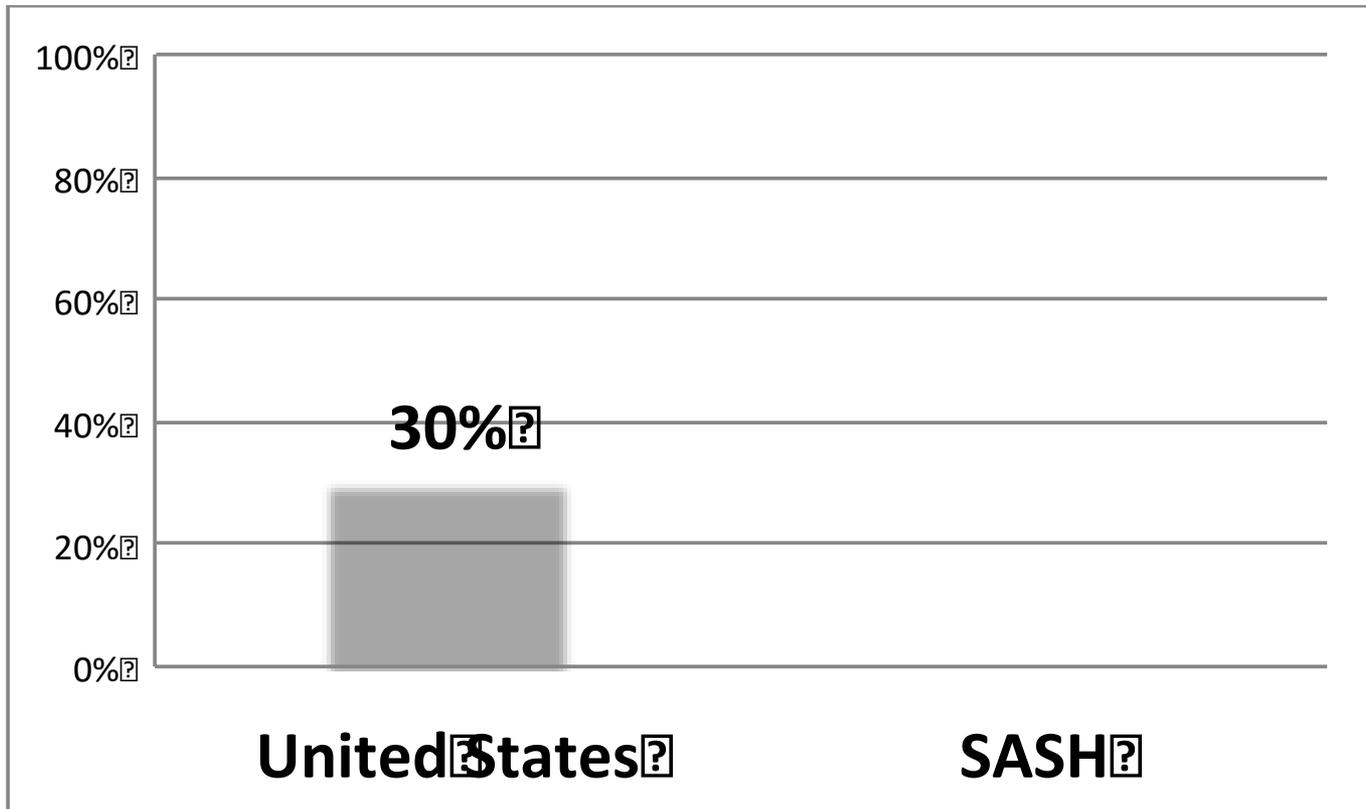
<http://jama.jamanetwork.com/article.aspx?articleid=645044>

Percent of SASH participants who have fallen in the past 12 months



Source: World Health Organization (WHO)
http://www.who.int/ageing/projects/falls_prevention

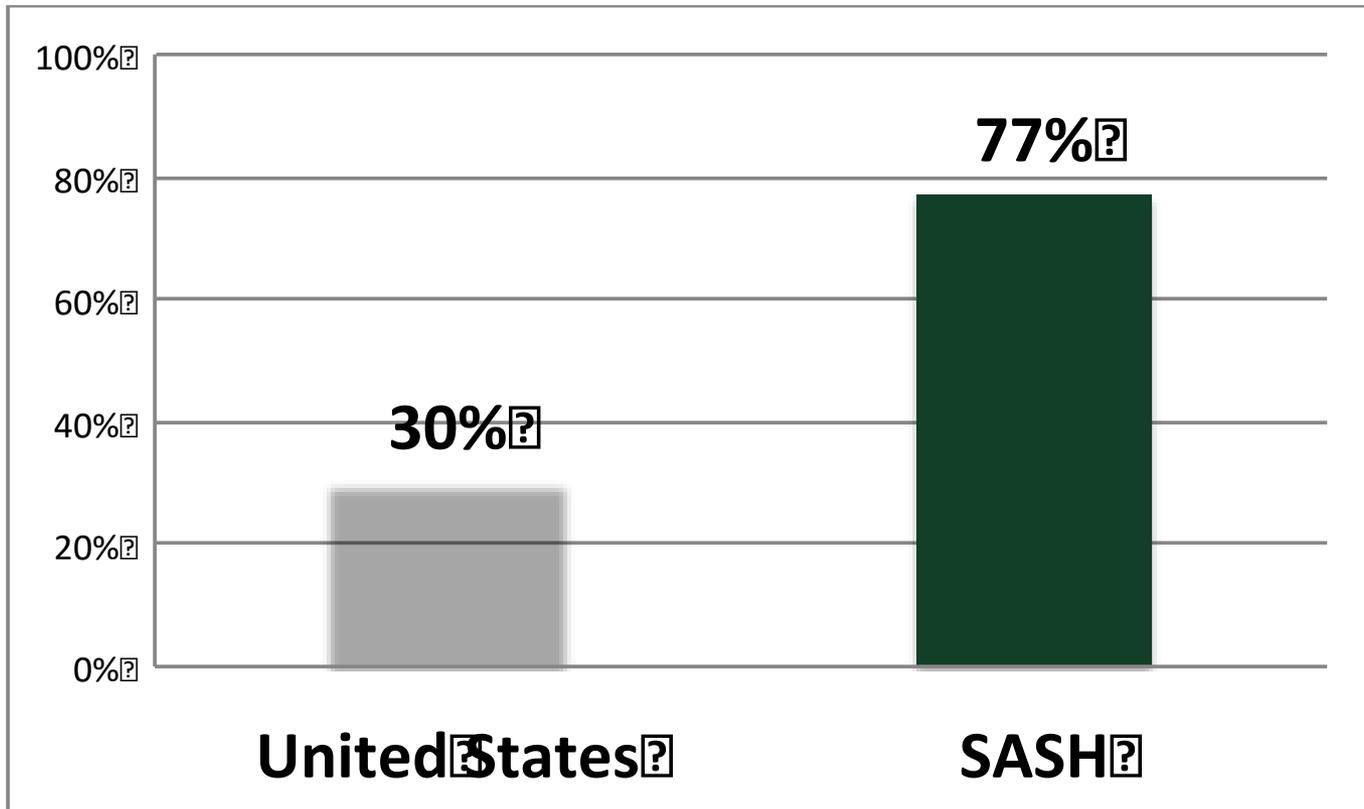
Controlled Hypertension



Source: 2012, *American Health & Drug Benefits*

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4046467/>

Controlled Hypertension



Source: 2012, American Health & Drug Benefits

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4046467/>

Major Findings: 3rd Party Evaluation

- Released in January 2016
- SASH sample size = 1602
- 3 years of implementation

SASH continues to slow the growth of total annual Medicare Expenditures

*Growth in annual Medicare expenditures was statistically significantly lower, by an estimated **\$1,536** per beneficiary, in early panels*

How is SASH[®] Funded?

- Medicare Demonstration Funding (MAPCP Demo) in 2011 through 2016.
- State general fund and Medicaid match provides funds for administration.
- Medicare funded through 2022 by the “All Payer Model” negotiated between the State of Vermont and CMS.
- Other grants, housing organizations, fill in the gaps.

Primary Challenges

- Finding sustainable funding source
- Getting partners on board
- Short on administrative funding
- Information sharing – IT systems, HIPAA
- Capacity for mental/behavioral health services
- Multiple funding sources=multiple applications, reports, outcomes, etc.

Success Drivers

- Housing sector included in statewide health care reform discussions/initiative
- Population-based approach with focus on social determinants of health
- Medicare Demonstration funds allow flexible spending to match need – capitated payment model
- SASH designed *with* participants not *for* them
- Real-time data and ability to regularly share outcomes
- Statewide platform to build upon

What's Next?

- Spread our Success- Replicate! In Rhode Island as of May 2017.
- Use SASH Platform for specific public health initiatives:
 - Hypertension control
 - Zero Suicide Initiative
 - Diabetes Management
 - Dementia Care
 - And many more....

Questions?

Thank you!

Molly Dugan, SASH Director

www.sashvt.org

dugan@cathedralsquare.org

Phone: (802) 859-8803

Healthy Aging in Louisiana

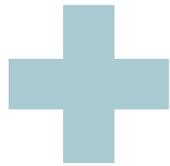
Permanent Supportive Housing

10 October 2017

Robin Wagner, Deputy Assistant Secretary
Louisiana Department of Health, Office of Aging & Adult Services
robin.wagner@la.gov

Permanent Supportive Housing – Housing First

Deeply
Affordable
Rental
Housing



Voluntary
Flexible
“Tenancy
Supports”



Permanent
Supportive
Housing

Overview of Louisiana's PSH Program

- ▶ Planning started in 2005; first household housed 2008
- ▶ Statewide and state operated
- ▶ Cross-disability in focus
- ▶ Currently housing approximately 2,700 households
- ▶ Additional 400 plus households receiving pre-tenancy services
- ▶ On target to house 3,545 households based on rental subsidies obtained so far

Policy Goals

- ▶ Dual Policy Goals:
 - Prevent and reduce homelessness among people with disabilities
 - Prevent and reduce unnecessary institutionalization of people with disabilities
- ▶ Closely tied to Money Follows the Person

Eligibility & Priorities

- ▶ Very low-income
- ▶ Substantial, long-term disability *of any type*
- ▶ Priority given to:
 - Individuals transitioning from institutions
 - Homeless individuals/households

Medicaid (& Medicare) Eligibility Among PSH Participants (June, 2017)

Status	HH w/ Medicaid	Individuals w/Medicaid	HH with Dual Coverage	Individuals w/ Dual Coverage
Housed	96%	94%	25%	15%
Pre-tenancy	92%	92%	23%	22%

- 28% of program participants are 55 or older
- Overlap between homelessness and nursing home placement

A Partnership Between Agencies

LA Department of Health

- Single State Medicaid agency
- Provides/manages services funding Medicaid & non-Medicaid
- Works internally & with community partners to identify individuals in need of PSH housing & services

LA Housing Corporation/ Housing Authority

- Works to recruit & identify housing providers through Low-Income Housing Tax Credit Program
- Rental subsidy administrator for Louisiana PSH

Housing Strategy

Low Income Housing Tax Credit Program

- Incentives for developers to “set aside” 5-15% of units for PSH within mixed-income, multi-family projects

Rental Subsidy

- Makes the unit affordable at 30% of household income

Subsidy Type	Eligibility
LIHTC Subsidy	Households with Adequate Income
Project Based Voucher	All Program Participants
Continuum of Care (Shelter Plus Care)	Homeless Individuals/Households
811 PRA Demonstration	Participants Up to Age 62
Section 8 Match for PRA Demo	All Program Participants
Other Rental Subsidy (VASH, FUP, HOME)	--

PSH Housing – Community Integrated

- ▶ Majority of units are in large, multi-family LIHTC projects with no more than 15% of units set aside for PSH. Some houses and smaller projects.
- ▶ Couple of projects operated by Homeless Continuum of Care with higher set asides.
- ▶ The housing provider is **not** the service provider.



Services: Tenancy Supports

Pre-Tenancy

- Housing application
- Eligibility requirements & addressing housing barriers
- Understanding the role of tenant
- Engagement & planning for support needs
- Housing search & choosing a unit

Move-In

- Arrangement for actual move
- Ensuring unit & individual are ready for move in date
- Initial adjustment to new home & neighborhood

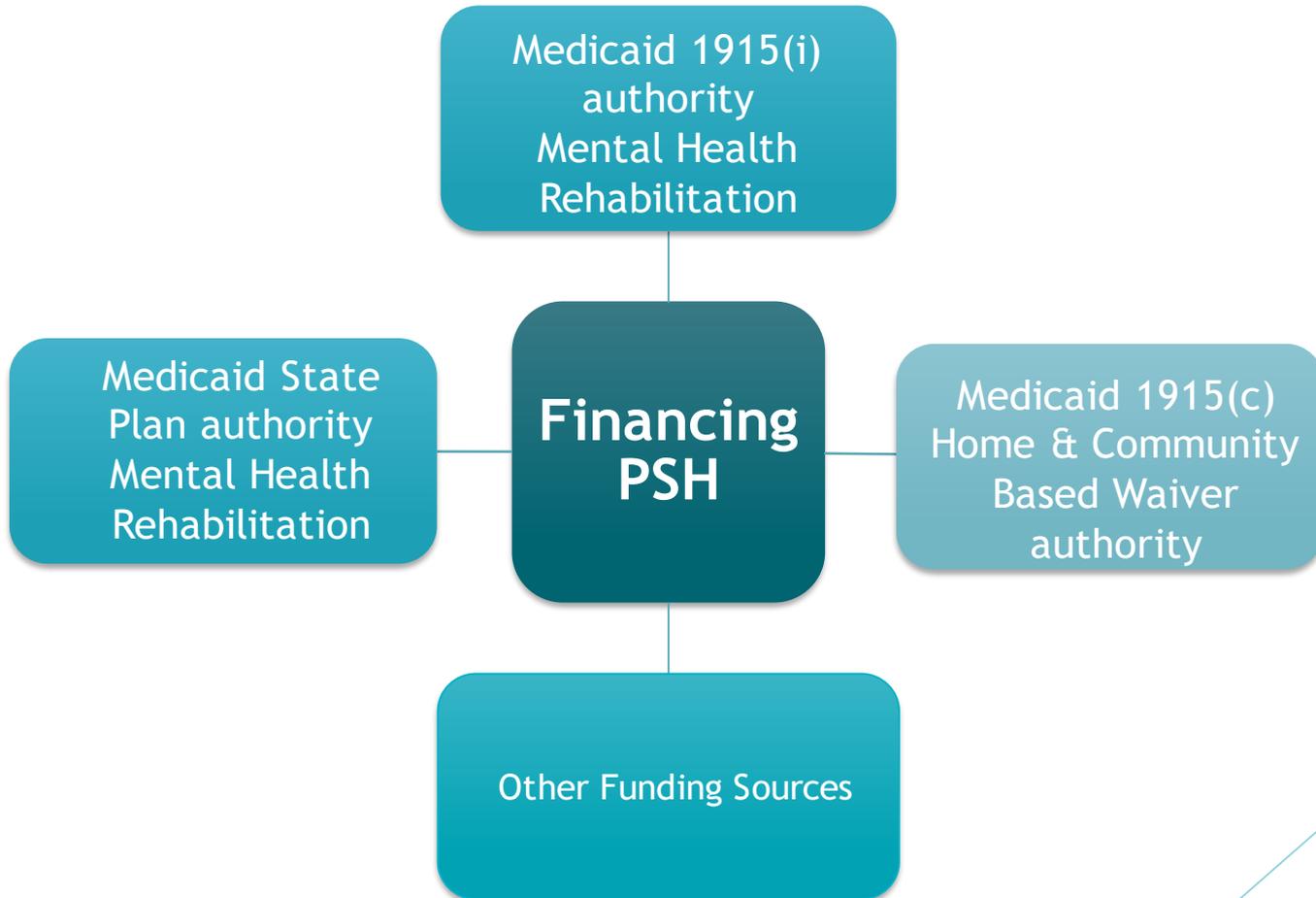
On-going Tenanc

- Sustained, successful tenancy
- Personal satisfaction: relationships, employment, education
- Flexing the type, intensity, frequency & duration of services based on needs & preferences

Services Funding

What it is	What it pays for	Source
Medicaid 1915(c) Home and Community-Based Services Waivers	Long-term services and supports, including tenancy supports	CMS
Medicaid State Plan	Mental health rehabilitation services, tenancy supports, habilitation services previously covered under a 1915(i) waiver	CMS
Ryan White	Security deposits, utilities, medical care, health education, legal support, nutrition support, and other services	HRSA
Cooperative Agreement to Benefit Homeless Individuals	Housing support, treatment for substance abuse and/or serious mental illness, peer support, and other services.	SAMHSA
Veterans Services	Health care for eligible veterans	US VA
Community Development Block Grant	Local community development such as affordable housing, anti-poverty programs, and infrastructure development	HUD

Funding Tenancy Supports: Use of Medicaid Authorities



Medicaid Reimbursement of Tenancy Supports

1915(c) Waivers

- Z0648 Pre-Tenancy &/or Tenancy Crisis
- Z0649 Tenancy Maintenance
- Billing not limited to time spent face-to-face

Mental Health Rehabilitation

- H0036TG Community Psychiatric Supportive Treatment (CPST)
- H2017TG Psychosocial Rehabilitation (PSR)
- **TG** modifier pays a higher rate
- Billing limited to time spent face-to-face

PSH Service Providers

- ▶ 15 provider agencies around the state
 - Provider agencies drawn from Continua of Care for the Homeless but also from behavioral health and other social service agencies
- ▶ Receive specialized training, technical assistance, and monitoring to provide tenancy supports
- ▶ Must be **accredited** and **credentialed** as Mental Health Rehabilitation providers, but
- ▶ Must work with **all disabilities** and enroll/contract to be reimbursed under **all funding streams**
- ▶ Service providers do **not** provide housing

PSH Program Staff

- Take and process applications
- Place applicants on appropriate housing wait list(s)
- Assure adequate outreach through partners
- Receive and oversee resolution of critical incidents
- Provide Tenant Service Management (e.g., facilitate lease up, housing inspection, provide support if Medicaid lapses, landlord mediation)
- New Unit Development
 - Work with La. Housing Authority to reach out to and recruit property managers; facilitate contracting with property managers for the kinds of units and locations most needed for PSH tenants.
- Deliver initial and annual certification training for all PSH service providers, and technical assistance

Program Results

Population

- 45% of households were homeless
 - More than half were chronically homeless
- 10% of individuals/households served were in institutions
- 37% of households in tenancy & pre-tenancy have 1 or more members with a SUD

Housing Outcomes

- 94% retention rate (only 6% with negative outcome)
- 54% of households have improved income
- 68% reduction homelessness between 2010 and 2016)

Health Outcomes

- Initial 24% reduction in Medicaid acute care costs (2011-2012)
- Statistically significant reductions in inpatient and ER for adult tenants post-housing (2016)

Integration with Other Medicaid Services

- ▶ Money Follows the Person
- ▶ HCBS waivers include services such as personal care attendant; home modification; transition services; assistive technology; home-delivered meals; limited PT, OT, nursing; etc.
- ▶ Medicaid State Plan personal care attendant services for persons with significant ADL limitations
- ▶ Medicaid behavioral health including licensed mental health professionals, assertive community treatment (ACT), and other MHR
- ▶ PSH service providers facilitate access to primary and preventive care

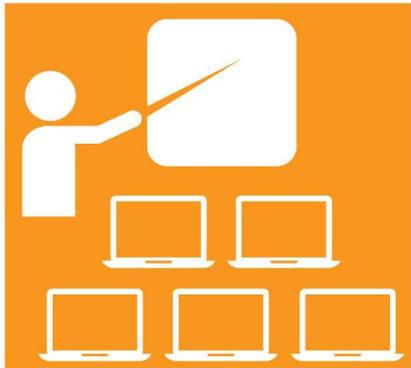
Why has it worked?

- ▶ Joint advocacy of homeless and disability advocates
- ▶ State Medicaid agency involved starting with initial planning
- ▶ Creation of state-level housing authority to administer PSH rental subsidies
- ▶ Combining of LIHTC and rental subsidy to produce a community integrated strategy
- ▶ Appropriate role distinctions for housing and service providers
- ▶ Success has earned buy-in from developers and property managers
- ▶ Braided funding
- ▶ State staffing of “Tenant Services Liaison” function



Supportive Housing TRAINING CENTER

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Solutions**

csh.org/training