

NATIONAL
HEALTH CARE
for the
HOMELESS
COUNCIL

August 17, 2015

The Joint Commission
Standards and Survey Methods
Proposed BHC Standards for Permanent Housing Support Services
One Renaissance Blvd.
Oakbrook Terrace, IL 60181

RE: Proposed Standards for Permanent Housing Support Services, Behavioral Health Accreditation Program

Dear Ms. Pierre:

Thank you for the opportunity to comment on the Joint Commission's Proposed Standards for Permanent Supportive Housing Services. The National Health Care for the Homeless Council (NHCHC) is a membership organization representing federally qualified health centers (FQHCs) and other organizations providing health services to homeless populations. Recent data shows that the 268 Health Care for the Homeless (HCH) health center grantees served over 850,000 patients at more than 2,000 locations across the United States in 2014.

There is a plethora of evidence demonstrating that *housing is health care*. We believe that housing should be affordable and accessible, with low-barrier support services available where needed. We value consumer-driven choices with regard to housing and services, and appreciate seeing these principles reflected in the proposed standards. We do, however, recognize that there are challenges in delivering services to a very vulnerable group of individuals, and have provided comments on areas we believe can help ensure high quality care while still remaining true to a client-oriented model.

Comments

CTS.04.03.37: The organization offers individuals served housing that is affordable and readily available.

- 4. The organization requires individuals served to pay no more than 30% of their income for housing costs.* We understand the goal to ensure affordable housing, but we are concerned that health service organizations are not always in charge of establishing or enforcing housing-related rules, often set by another entity. We also believe a cap would have the indirect effect of prohibiting organizations from providing services to people who need support, but who happen to pay more for housing.
- 6. The organization assesses the needs of the individual served to determine whether transitional housing options should be utilized to help prepare individuals to move into permanent housing.* We are concerned that this element of performance may suggest preference for the transitional housing model—

typically a time-limited, recovery-first program--as a superior program and set up a housing pathway that does not ensure long-term sustainable housing. This line of thought, that “readiness” must precede housing, is generally inconsistent with a Housing First model, which has a strong evidence base supporting its use with individuals experiencing homelessness. Transitional housing can be disruptive and often forces people back to the streets or shelters if permanent solutions are not available once residents reach the end of their time-limited stay. Additionally, many transitional programs have many strict guidelines under which a continued stay is contingent and, given this, may not be positioned to honor a client’s stage of change. Indeed, HUD is moving away from financing transitional housing with preference going to communities who offer more permanent housing solutions. While an assessment is important to determine the level of services needed once in supportive housing, it is not efficient or necessary for supportive housing candidates to first go through transitional housing (given few would meet the rigorous requirements). We would suggest this performance element instead be phrased as follows:

For organizations providing transitional and permanent housing support services to homeless individuals: The organization completes a needs assessment of each individual to determine which services are needed and has a care plan in place that reflects those needs.

CTS.04.03.39: The organization offers individuals served housing with a minimum of contingencies.

- 1. The organization requires individuals served to meet with staff face-to-face on a regular basis, as determined by the individual’s needs and preferences. We agree that face-to-face visits are the ideal for providing services and ensuring stability; however, it is not always possible for staff to insist upon face-to-face visits, and we posit this requirement is not in keeping with a supportive housing/housing first approach, which espouses voluntary participation in services. We recommend the element of performance be reworded to focus on the efforts staff makes to achieve face-to-face visits (e.g., documented in the care plan and progress notes). In addition, we suggest that the definition of these meetings more clearly ensures that tenants are included in developing their own service/care plan.*
- 6. The organization provides individuals served with a written agreement (such as a lease or occupancy agreement) that specifies the rights and responsibilities of typical tenants in the community. We agree that there should be a written agreement specifying tenant rights and responsibilities, however we recommend that the Joint Commission narrows this definition to require a lease or sublease rather than an occupancy agreement. A lease or sublease, as opposed to an occupancy agreement, carries the weight of being a legal document with clearly defined roles, responsibilities and enforcement mechanisms. Leases are essential for housing stability. Additionally, leases or subleases should look like those found in the community, and should not have any additional requirements (such as participation in services) that are tied to housing.*
- 7. The organization helps individuals served to adhere to a standard lease. We agree that it is a primary goal to ensure that tenants are afforded all of the rights under a lease, however we believe that providers should have the flexibility for subleasing units if necessary. Some supportive housing programs have arrangements in place where a provider holds the lease and subleases to their clients. This offers more opportunities to access housing where landlords may have reservations in leasing directly to clients. Since the goal is to ensure individuals are quickly housed and many communities have low vacancy rates and limited housing options, it might be necessary to sublease for a client. If this does occur, agencies should ensure that individuals have consumer choice wherever possible, services are not a requirement for*

housing, and individuals have similar rights and responsibilities that a standard lease or sublease would provide. We recommend simply adding the words “or sublease” to this standard.

8. *The organization offers individuals served who have lost their housing due to eviction another unit.*

While we greatly anticipate the day when there is a sufficient capacity of affordable housing available to everyone, very few (if any) providers can ensure that a housing unit is available at any given time. There are also times when it is just not possible to re-house someone immediately after an eviction or other traumatic event (to include client refusal to be re-housed). While we support the intent of this standard, unfortunately the availability of housing units is often well out of the control of the organization providing the support services. We recommend that the standard be re-written to say: *The organization demonstrates immediate and good-faith efforts to rapidly re-house individuals who have been evicted.*

9. *The organization continues to offer individuals served access to social, behavioral, or physical health care, treatment, or services even if they lose their housing due to eviction or short-term inpatient treatment.*

We agree that access to social, behavioral and/or physical health care services are vital to achieving health improvements, but our members must also consider the safety and security of their staff and the other individuals they serve. Clients who are violent and have posed a direct threat to others may require a break in service until they can be safely re-engaged in care. We understand that outreach or other limited services could remain active to continue the relationship with the individual, but we are concerned that mandating access to the full range of services could potentially be unsafe for others in certain circumstances. We recommend adding the clause “, to the extent consistent with provider safety” to the standard

CTS.04.03.41: The organization offers an array of services to individuals who are receiving housing services.

1. *The organization provides assistance with move-in and securing furniture and appliances, as needed.*

We agree that helping a client set up their new housing unit is an important step to stability, however, we are unclear what “assistance” means in this standard. Does it mean physical assistance moving furniture and unpacking boxes, financial assistance to purchase items such as bedding and dishes, or that the organization will purchase these items to have available for every individual receiving services? Likewise, how does this standard define “as needed” in this regard, and how should an organization distinguish between a client need and use of limited agency funds? Certainly we would agree that a bed and bedding are fundamental needs, but what about a television, a DVD player, a blender or other common household items? Where does this standard begin and end regarding the items to be furnished to every individual, understanding that these items are typically donated or purchased through donated funds? We recommend that, in addition to making the provision of physical items a highly recommended service, the Joint Commission stress Home and Community Based Services (HCBS) as part of this element of performance. These services include case management, homemaker and other transitional services, that can help to stabilize health and housing status and are able to be provided in an individuals’ home.

2. *A psychiatrist is available to provide the following care, treatment, or services:*

- *At least monthly, assess individuals’ symptoms and responses to medication*
- *Monitor individuals’ non-psychiatric medical conditions and non-psychiatric medications*
- *If individuals are hospitalized, communicate directly with each individual’s inpatient psychiatric prescriber*
- *Provide medication education*
- *Conduct home/community visits*

- *Make referrals as needed*

While we recognize the value of home/community visits, we believe that a lower credentialed staff person can adequately conduct such visits. Many community-based organizations may not be able to afford a psychiatrist for home visits. We recommend removing this provision, or amending the staff credentials needed to provide this service.

5. *For organizations providing permanent housing support services to homeless individuals: The organization facilitates inpatient care, treatment, or services as follows:*

- *Initiates admission as necessary*
- *Consults with inpatient staff regarding need for admission*
- *Consults with inpatient staff regarding an individual's care, treatment, or services*
- *Consults with inpatient staff regarding discharge planning*
- *Receives notification of an individual's discharge from inpatient care, treatment, or services*

While we agree that coordinating care with an inpatient team would be an ideal situation, we are very concerned that many of our members could not meet this standard for the simple reason that each of these requirements falls outside their authority or ability to control. Supportive housing service providers do not often initiate inpatient admission, but rather, will call in response to a mental health crisis or other health care emergency. Clinical decisions about inpatient admission are typically made within an emergency department or other urgent care setting, and not in consultation with supportive housing services staff. Likewise, our members have little ability to ensure inpatient hospital staff consult them over any aspect of the individual's admission, care plan, or discharge plan, and we envision circumstances where inpatient staff could refuse to share information. We recommend changing this standard to reflect an attempt to contact inpatient staff over these aspects of care, or standing interagency agreements to collaborate on clinical and case management.

6. *The organization's social and clinical services are based off-site from the housing. We strongly disagree with this standard as it introduces barriers to care for many clients receiving supportive housing services. Having medical, behavioral health and/or support services co-located with housing enables more frequent contact with clients, facilitates relationship building, and helps create efficiencies in service delivery. Because of our history serving this population, we know that even a service location one or two blocks away can serve as a barrier to seeking care, hence there are many initiatives working with the specific goal of ensuring the availability of services onsite where vulnerable people are living. Often supportive housing services are delivered by Health Centers that receive federal funding to co-locate services in housing complexes; this provision would undermine those efforts. We also recognize the concern with ensuring the most integrated setting for consumers, in accordance with the Olmstead decision. It is our understanding that providing onsite services will not conflict with this ruling so long as residents maintain the right to choose their provider and the building makeup complies with the state's Olmstead settlement, if applicable. We respectfully recommend the Joint Commission consider removing this standard from the program.*

8. & 9. *The organization educates the individual served about its policies and practices regarding housing opportunities; the array of care, treatment, or services provided by the organization; and how to contact the organization 24 hours a day, 7 days a week. & The organization is able to respond to individuals served 24 hours a day, 7 days a week by phone and can link individuals to emergency services as needed. We appreciate the intent to ensure responsiveness to those receiving supportive services, but are concerned that the requirement to provide 24 hour/7-day-a-week coverage and/or communication is*

not possible to sustain given the staffing models used by most supportive housing programs. We believe that a goal of being responsive and accessible can be satisfied without requiring 24/7 availability. When possible, assisting clients with developing skills to manage and reduce crisis that would otherwise warrant immediate intervention is a worthy treatment goal and consistent with a recovery-oriented philosophy of care. When such goals are not possible, there are other community-based services that provide this level of care, to which a client could be referred should it be deemed appropriate. We recommend that these standards require that provisions be in place for after-hours emergency care, and that residents be informed of those arrangements.

CTS.04.03.43: A multidisciplinary care, treatment, or services team coordinates the provision of care, treatment, or services.

1. *The organization has a multidisciplinary care, treatment, or services team that consists of at least the following:*

- *Physician, advanced practice nurse, or physician assistant*
- *Nurse*
- *Social worker*
- *Case manager*

We agree that ideally a supportive housing program has an integrated team of clinical and support staff. However, to accommodate the varying roles that a provider may assume, we recommend that the Joint Commission identify roles rather than positions. For example, social workers and nurses may have dual roles in delivering both clinical and support services. We are also concerned about the all-too-common scenario whereby a supportive housing client receives case management and behavioral health supports from one organization, but primary care from another organization—hence not receiving all services from one organization. Given that the client has the right to choose his/her service provider(s), we believe it would be difficult for one agency to fully staff across all disciplines. We suggest revising this standard to require supportive housing service organizations to document how they are coordinating care across multiple disciplines and/or to supply the memorandum of understanding used between agencies to provide these services.

3. *At each meeting the multidisciplinary care, treatment, or services team does the following:*

- *Conducts a brief, clinically relevant review of all individuals served and any contacts with them since the last team meeting*
- *Documents the status of all individuals*
- *Develops a staff schedule based on individuals' schedules and emerging needs, and the need for proactive contact to avert future problems*

We agree that regular case conferencing with an interdisciplinary team of providers is essential to provide high quality, coordinated care; we are concerned that it is not feasible to discuss all individuals at every meeting. It is often most beneficial to discuss more complex cases in greater detail, requiring a greater allotment of time to cover. Should this time be restricted in order to provide a brief update on every individual served by the care team, it may reduce the quality of care and the level of coordination provided to the more complex clients. We recommend that this performance element be revised to allow for cases to be discussed on a rotating basis, in which an update on each individual is provided regularly, but not necessarily at each meeting.

Additional Comments

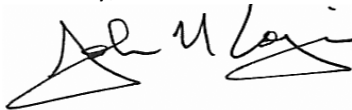
In addition to the above comments, we believe that the Joint Commission should consider including the following as part of their proposed standards.

1. Require standards related to coordination between service delivery staff and housing management staff. A key practice in supportive housing is that supportive services staff — charged with advocating for tenants and linking them to essential services — work in partnership with property management staff to meet the needs of consumers. Effectively coordinating supportive services and property management functions requires careful planning, including clear delineation of roles and responsibilities, policies and procedures, and communication and confidentiality guidelines, among other considerations.

In successfully coordinated programs, property management staff will be able to contact supportive services staff with concerns regarding the consumer, such as late rent or behavioral concerns, giving them the opportunity to work with the client to address unmet needs and therefore retain housing. Likewise, the supportive services staff can make property management aware of when to expect groups on site, what types of services are available, and they can refer additional clients to the property when vacancies occur.

Thank you for the opportunity to comment on these proposed standards for Housing First programs. Please contact us if you should wish to discuss any aspect of these comments further. I can be reached at jlozier@nhchc.org or at 615-226-2262.

Sincerely,

A handwritten signature in black ink, appearing to read "John N. Lozier". The signature is fluid and cursive, with a large initial "J" and "L".

John N. Lozier, MSSW
Executive Director