Systems Changes to Maximize the Impact of Supportive Housing on Ending Homelessness

Matthew Doherty, Director of National Initiatives

August 14, 2014

Roles of USICH

- **Coordinates** the Federal response to homelessness
- **Maximizes** the effectiveness of 19 Federal agency partners
- **Shares** best practices
- **Drives** collaborative solutions

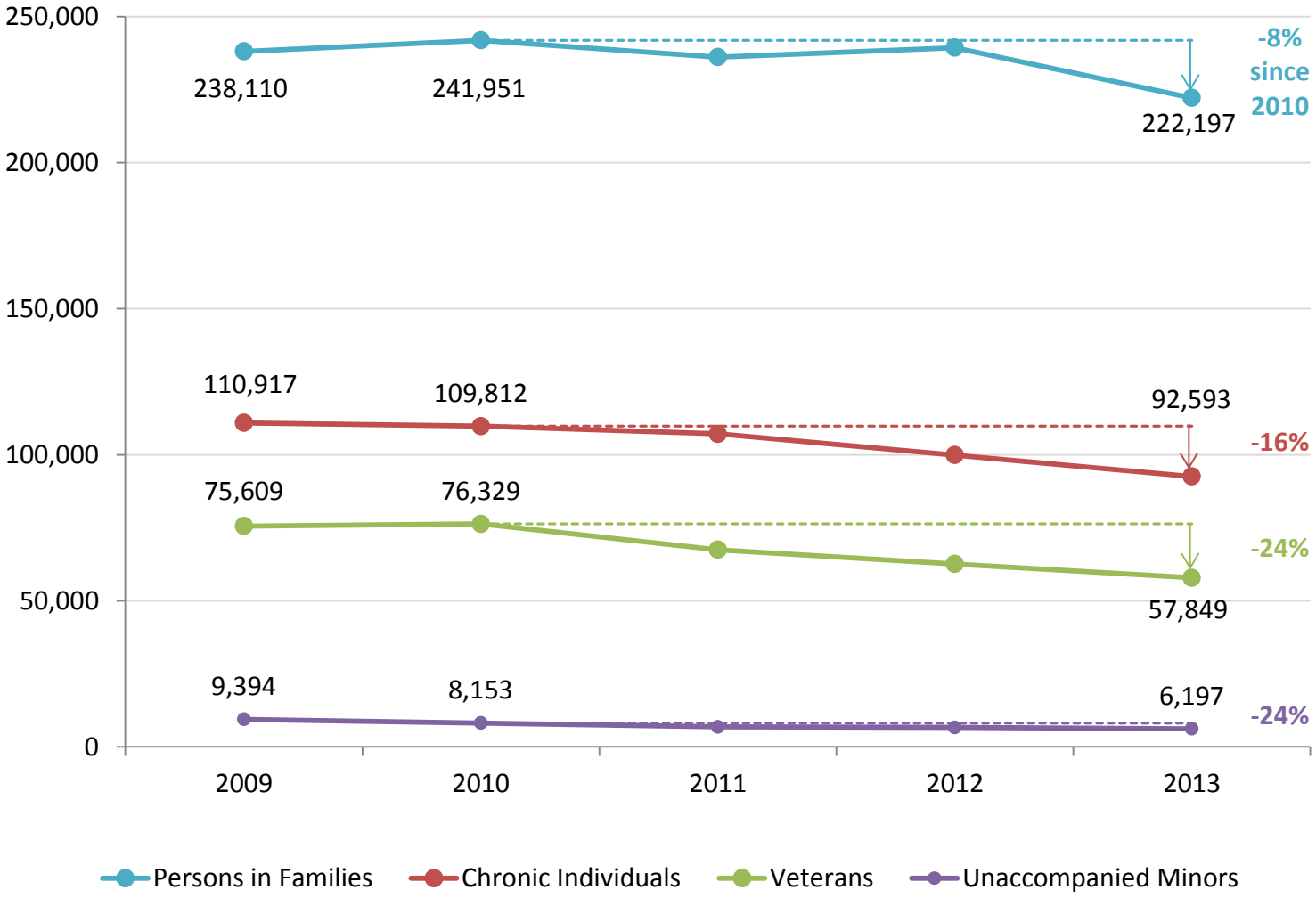
Opening Doors

- ***No one*** *should experience homelessness*
- ***No one*** *should be without a safe, stable place to call* ***home***

Opening Doors

1. Finish the job of ending chronic homelessness by ***2016***
2. Prevent and end homelessness among Veterans by 2015
3. Prevent and end homelessness for families, youth, and children by 2020
4. Set a path to ending all types of homelessness

Point-in-Time Count Progress



Turning Sets of Programs into Efficient Systems

Critical Questions & Decisions

- Is the system **reducing the number of people experiencing homelessness**?
- Are **resources targeted effectively to those with the greatest needs**, including those who are unsheltered?
- Does the **community have the right balance of interventions** (permanent supportive housing, rapid re-housing, etc…) to respond to local needs?

Critical Questions & Decisions

- Is the system **exiting people from homelessness to permanent housing quickly** and using the right size of intervention based on their needs?
- How can the community **align resources and design its system most strategically**?
- Do strong connections exist **between the homeless response system and intake processes for mainstream services**?

Five Key Strategies

1. **Use Data to Drive Results:** Use data to **measure system and program performance** and inform resource allocation decisions
2. **Be Frugal – Target Wisely:** Provide the **right intervention at the right time** to the right individual or family through a coordinated assessment system
3. **Be Smart – Use Evidence:** Adopt **Housing First practices** to offer individuals and families experiencing homelessness immediate access to permanent affordable or supportive housing, without clinical prerequisites or other barriers

Five Key Strategies

4. **Expand the Pie Strategically:** Use existing resources in smarter ways to help **make clear case for new investments** of Federal, State, local, and private sector resources to scale the practices and innovations that work

5. **Leverage Mainstream Resources: Engage mainstream systems and integrate those resources**— housing, job training, child care, health care, etc …

Coordinated Systems

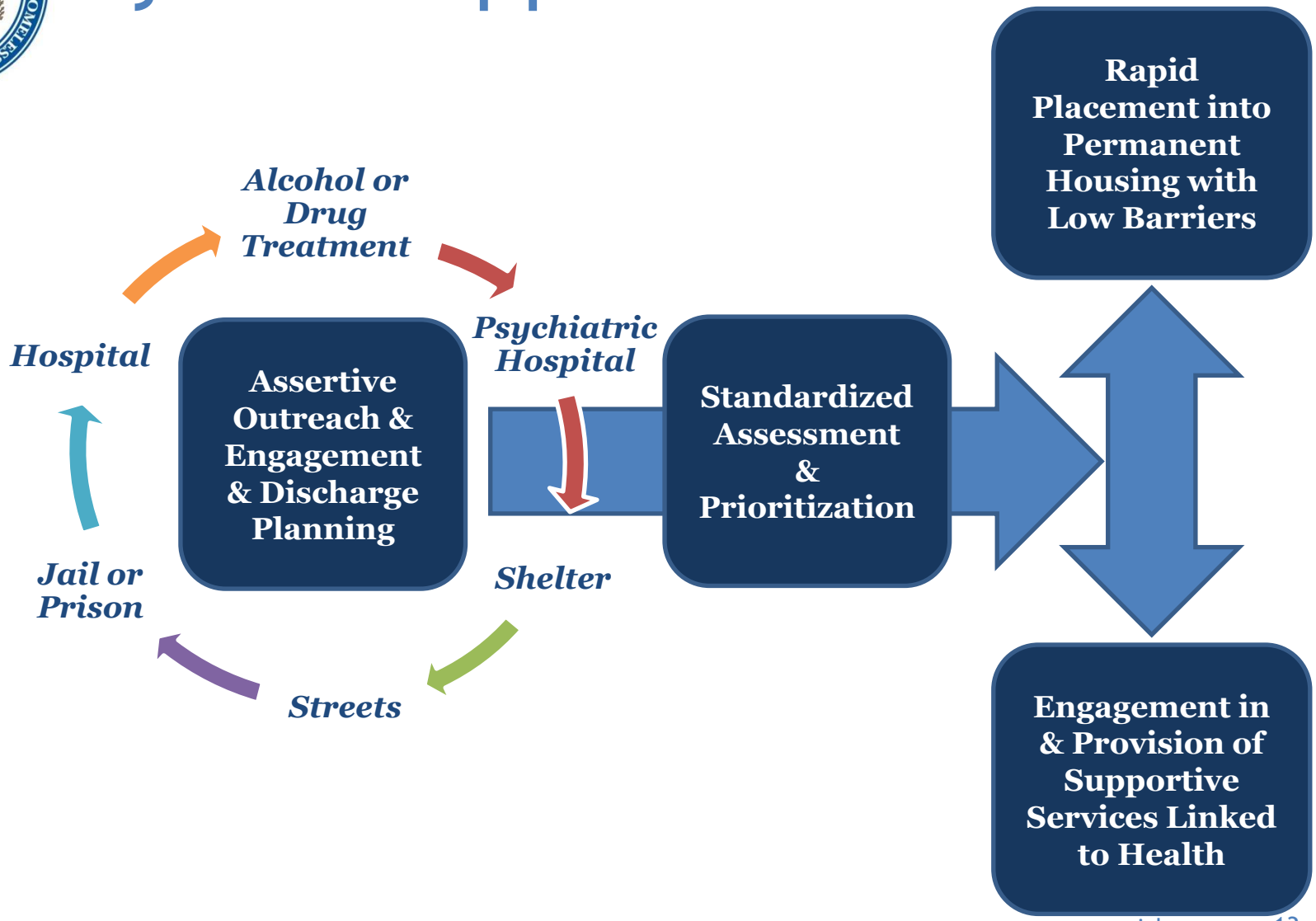
- **Access to services:** broad access in community, coordinated street outreach, integration with mainstream systems
- **Assessment of individual/family situation and needs to right-size the intervention:** prevention, diversion, admit to shelter
- **Align housing interventions:** prevention, rapid re-housing, affordable housing, and permanent supportive housing

Reorienting our Systems

"In order to **bend the curve**, we must first **abandon the line**."

- Richard Cho, USICH
blog at www.usich.gov

Systems Approach



Retooled System

- **Design an approach that recognizes that people take many paths to assistance,** and intake processes for mainstream systems (e.g., cash assistance, health care) can serve as front doors.
- **Effective, assertive outreach is essential,** especially for people who are unsheltered, since the system only works if people get connected.
- **System design must reflect local community context**, including HMIS, geography, and many other factors

Community-Level Actions

- **Develop systems for aligning housing and services interventions** based upon assessments
- **Adopt Housing First** approaches that reduce barriers to and streamline housing entry
- **Provide supportive services** that place low demands on clients, but engage frequently
- **Prioritize people experiencing chronic homelessness for PSH** as part of coordinated assessment implementation

Prioritizing for PSH

Shift away from:

- Passive role of housing agencies and providers in identifying prospective tenants
- First come, first served approach to allocating affordable and supportive housing

Prioritizing for PSH

Shift towards:

- Proactive, assertive outreach that identifies, engages, and rapidly connects people with the highest needs to permanent housing
- Prioritization of people based on objective measures of need, vulnerability, and cost

Expectations Under HEARTH

- Covers the Continuum's of Care (CoC's) **geographic area**
- Is **easily accessible** by households seeking housing or services
- Is **well-advertised**
- Uses a comprehensive and standardized **assessment tool**
- Responds to **local needs & conditions**
- Covers ***at least*** **all CoC & Emergency Solution Grant (ESG)** programs

Engage Mainstream Systems

- Physical and behavioral health care systems
- Medicaid-funded services and Federally-Qualified Health Centers
- Workforce development system
- Benefits and income supports

Encouraging Key Strategies

Encouraging Key Strategies

1. **Use Data to Drive Results:** Use data to **measure system and program performance** and inform resource allocation decisions
2. **Be Frugal – Target Wisely:** Provide the **right intervention at the right time** to the right individual or family through a coordinated assessment system
3. **Be Smart – Use Evidence:** Adopt **Housing First practices** to offer individuals and families experiencing homelessness immediate access to permanent affordable or supportive housing, without clinical prerequisites or other barriers

Encouraging Key Strategies

4. **Expand the Pie Strategically:** Use existing resources in smarter ways to help **make clear case for new investments** of Federal, State, local, and private sector resources to scale the practices and innovations that work

5. **Leverage Mainstream Resources: Engage mainstream systems and integrate those resources**— housing, job training, child care, health care, etc …

Listening to Communities: Input for *Opening Doors* Amendment

Stay Connected

United States Interagency Council on Homelessness

No one should experience homelessness. No one should be without a safe, stable place to call home.

An Energizing Council Meeting & New Ideas on Ending Homelessness Among Families

July 17, 2013

Cabinet Secretaries Advance Efforts to End Family Homelessness

On July 9th, the Obama Administration convened a meeting to push forward its agenda to end homelessness. USICH Chair, VA Secretary Eric K. Shinseki, and Vice Chair, HUD Secretary Shaun Donovan, met with other Council leaders including ED Secretary Arne Duncan and DOL Acting Secretary Seth Harris, USICH Executive Director Barbara J. Poppe, Chief Executive Officer of the Corporation for National and Community Service Wendy Spencer, Director of the White House Office of Faith-Based and Neighborhood Partnerships Melissa Rogers, and representatives from 11 other member agencies. The group discussed ways to leverage opportunities created by the Affordable Care Act and ways to better serve families who are experiencing homelessness. Donna Seymour, Acting Deputy Assistant Secretary for Warrior Care Policy at the Department of Defense, also updated the Council on DoD's efforts since the last Council meeting to coordinate transitions from active service to Veteran status for our

SIGN UP NOW

FROM THE SOLUTIONS DATABASE

Home Free is a program of the Volunteers of America - Oregon designed to expand access to services among survivors of domestic violence facing housing instability.

READ THE REST

EXPLORE MORE SOLUTIONS

IN CASE YOU

Sign up for our newsletter
www.usich.gov/signup

and join us on

facebook & twitter

For more information:

Matthew Doherty
Director of National Initiatives
matthew.doherty@usich.gov
202.754.1586
(Based in San Diego)

www.usich.gov

HOUSING IS HEALTHCARE: USING MEDICAID IN PERMANENT SUPPORTIVE HOUSING

Carol Wilkins

Medicaid's role in supportive housing for chronically homeless people

HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) study began in 2010

- Literature Synthesis and Environmental Scan (2011)
- Four papers published in 2012 – available at ASPE.hhs.gov
  - Health, Housing, and Service Supports for Three Groups of People Experiencing Chronic Homelessness (2012)
  - Medicaid Financing for Services in Supportive Housing
  - Establishing Eligibility for SSI
  - Public Housing Agencies and Permanent Supportive Housing

Case study: Medicaid's changing role

- Case study sites:
  - Los Angeles
  - Chicago
  - New Orleans
  - Washington DC
  - Minnesota
  - Connecticut
- Coming soon!
  - Case study final report: Emerging Practices from the Field
  - Primer on Using Medicaid for People Experiencing Chronic Homelessness and Tenants in Permanent Supportive Housing

Case study focus

- Expansion of Medicaid eligibility to include more homeless people
- Changes in health care finance and delivery systems
  - impacts on chronically homeless people and health care providers who serve them
- Roles of HCH and other FQHCs
- Medicaid benefit design and implementation
- Increasing role of Medicaid managed care

Medicaid and solutions to homelessness

- Medicaid is a partnership between state and federal government with shared costs
  - States make choices about optional benefits and waiver requests
- Medicaid services can help people get and keep housing
- Some Medicaid services can be provided in supportive housing
- Other Medicaid services can help meet the needs of people who are homeless or supportive housing tenants

California: Medi-Cal and counties

California counties play important roles

- Medi-Cal eligibility and enrollment
- “Specialty Mental Health” and “Drug Medi-Cal” services
- County hospitals and clinics deliver care – in some counties
  - Counties may face costs / financial risk for avoidable hospitalizations and ED visits
  - Counties may be competing and/or collaborating with FQHCs to serve people who experience homelessness

Medi-Cal changes and impacts for people who experience homelessness

- Medi-Cal eligibility expanded January 2014
  - Single adults with incomes up to $16,105
  - Low Income Health Plans were a “bridge to reform”
- Enrollment in Medi-Cal managed care
- Changes in Medi-Cal benefits

Medicaid managed care

- Enrollment in Medicaid managed care is rising
  - People newly eligible for Medicaid
  - SPD: seniors and people with disabilities (SSI)
  - Expansion of managed care in many rural counties
- Plan and provider selection
  - Big implications for HCH/FQHC
  - Big implications partnerships to integrate primary care & behavioral health and link services to supportive housing

Helping people enroll in Medicaid

- CA provided outreach and enrollment grant funds to counties for hard-to-reach groups of people, including people experiencing homelessness
  - Counties partner with community-based organizations
- Providers of supportive housing and homeless services can assist with enrollment and access to care
  - Tips at www.hcd.ca.gov/LetsGetEveryoneCovered.pdf
  - Engage and enroll people – and help with plan / provider selection
- No deadline for Medicaid enrollment
  - People can enroll now - and any time
- Health Care Options for help with selecting (or changing) a health plan and provider in CA (800) 430-4263

Medicaid benefit changes – impacts for the people you serve

- More access to mental health and substance use treatment services for adults
  - In CA (and many other states) substance use services only in qualifying treatment settings
- Managed care plans may be responsible for some mental health services – in CA:
  - For people without serious mental illness
  - Coordination with county for “specialty” MH services
- Other optional benefits may be under consideration
  - Health homes
  - Home and Community-Based Services (HCBS)

Medicaid for services in supportive housing – current practices

- Most often Medicaid is covering mental health services connected to supportive housing
  - To be eligible, a person must have a serious mental illness
  - Service provider contracts with County Mental Health in CA
- Some Federally Qualified Health Centers (FQHC) also provide services in supportive housing
  - Payment for visits with doctors (including psychiatrist), mid-level practitioners (NP, PA), LCSW
- Integrated primary care and behavioral health services
  - Often partnerships use both Medicaid payment models
- Funding from federal, state, county, local sources to cover what Medicaid doesn't pay for

HCH / FQHC services linked to supportive housing

- Satellite clinics in supportive housing buildings
- Clinic located close to supportive housing
- Home visits to people living in scattered site supportive housing
- Collaborations with mental health service providers to create interdisciplinary teams linked to housing resources
- HCH programs can continue to serve homeless people after they move into supportive housing

Challenges and gaps

- Costs for some members of inter-disciplinary teams are not reimbursed in FQHC PPS rates
  - Nurses do not provide billable encounters
  - Case management costs may not be included in rates
- Productivity concerns
  - Fewer visits per day when working outside of clinics
- Limits on reimbursement for same-day visits
- Managed care:
  - Difficult to get reimbursed if people enrolled in and assigned to other primary care providers
  - PMPM rates not adjusted to reflect acuity / complexity of needs
  - Provider networks may not facilitate continuity of care
- Some FQHCs do not adapt service delivery approach to meet needs of people experiencing chronic homelessness
  - May have limited capacity for serving people with serious mental health or substance use disorders

Medi-Cal for mental health services

- CA's MHSA Full Service Partnerships = "whatever it takes"
- Medi-Cal = documentation must link every service to diagnosis, goals, and plan
- Clinical loop
  - Start with assessment including symptoms, behaviors, impairments
  - Care coordination plan has goals based on symptoms and interventions to effect impairments
  - Progress notes document goal-based interventions

Community Support Teams and ACT covered by Medicaid in IL, DC, LA*

- For persons with serious mental illness who meet additional criteria:
  - Recent and/or multiple hospitalizations, ED visits, contacts with law enforcement
  - Inability to participate or remain engaged in less intensive services; inability to sustain involvement in needed services
  - Inability to meet basic survival needs, homeless
  - Co-occurring mental illness and substance use disorder
  - Lack of support systems
- Teams are mobile and interdisciplinary
  - Assertive engagement, individualized and flexible approach
  - Frequent home visits, face-to-face contact in range of settings
  - Small caseloads

* LA = Louisiana

Challenges and gaps

- Services and goals must be related to diagnosis, symptoms and impairments related to mental illness – not (directly) related to substance use problems or medical needs
  - Providers can make the connection to mental illness (social isolation, substance use to manage symptoms of mental illness, anxiety about medical conditions or treatment) – but it isn't always easy
  - In most states Medicaid benefits cover limited array of services to address substance use – only in approved settings, making it hard to integrate
- Provider requirements often not designed for mobile, team-based models of service or electronic records
- These are <u>state</u> policy decisions – not federal requirements

Challenges and gaps (continued)

As people recover, they may not be eligible for ongoing support from intensive mental health service models

- Other less intensive services may not be mobile with capacity to do “whatever it takes”
- It can be hard to return to more intensive services during a crisis that could lead to losing housing
- Responsibility for mental health services may shift to managed care plans
- Changes may disrupt trusting relationships

What's working?

- Mental Health departments allow outreach teams to assess homeless people who are not engaged in the mental health system and determine eligibility for services
- Some CA counties provide training for Medi-Cal billing with focus on services in supportive housing and other settings outside of clinics
- MHSA FSP and Innovations funding for partnerships create integrated teams linking MH and primary care services
- Mental health providers help consumers navigate managed care enrollment, provider selection, access to care
- Experienced providers help others who are new to Medicaid
- County / state staff involved with providers and billing understand mobile, team models and help reduce obstacles
- Medicaid managed care plans contract with behavioral health providers for risk assessment and care management

Some CA counties are investing in supportive housing as health care

- Housing for most vulnerable and high cost homeless people reduces avoidable hospital costs and improves health
- Los Angeles DHS Housing for Health program
  - Launched with funding to pay nonprofit partners for case management and housing-related services
    - Linked to housing developed with city funding and vouchers administered by housing authorities
    - Permanent and interim / respite housing options
  - Public-private partnership provides $18 million for Flexible Housing Subsidy Pool
    - Evidence of savings justifies county health department investment

Medicaid for services in supportive housing – what's happening in other states?

- Medicaid managed care plans in some states are paying for services in supportive housing
  - Care coordination delivered face to face by trusted service providers
  - Diversionary services to reduce avoidable hospitalizations by providing community support
  - Case management services linked to housing assistance for homeless plan members
- Monthly rates for some covered mental health / behavioral health services

Medicaid for services in supportive housing – more options for state policy

- Home and community-based services for people with disabilities
- Health homes – an optional Medicaid benefit
  - For people with multiple chronic health conditions and/or serious mental illness
  - Whole-person, comprehensive and individualized case management
  - AB 361 (enacted) = opportunity for CA to develop this benefit