SEPTEMBER 2015

Improving Care for Medicaid Beneficiaries Experiencing Homelessness: Handout #3 - for state agencies and health plans

A CUSTOMIZABLE LOCAL HOUSING RESOURCE TEMPLATE

HOW TO USE THIS TEMPLATE:

This document is provided as a guide to help you develop a profile that will organize information that can inform local Medicaid providers, health plans, and other stakeholders about opportunities to better assist Medicaid beneficiaries who are experiencing homelessness. The questions included here are intended to guide conversations and data collection. At the end of this handout is a sample of a completed local housing handout for Santa Clara County in California.

WHERE TO FIND THIS INFORMATION:

Some of this information is available from the U.S. Department of Housing and Urban Development (HUD) on the HUD Exchange website at *https:// www.hudexchange.info*.

For example, to find Continuum of Care contacts for your state or community, and reports that summarize information about homeless populations and subpopulations, an inventory of housing and shelter programs, and a list of recent federal grant awards, see the link below *https:// www.hudexchange.info/grantees/?granteesaction=main.searchresults&programid=3*.

Use the drop-down menus to find your state and select a program: CoC: Continuum of Care Program. Each CoC is identified with the abbreviation for the state name, a number, and the CoC name. For example, GA-500 is Atlanta County.

To answer many of these questions, you will need to have conversations with CoC leaders and you may need to talk to other people who are familiar with local homeless assistance and supportive housing resources. The CoC leader can help to identify these people, and you may find them in state or local government agencies that are responsible for housing, mental health, or social services, or in a local non-profit organization, foundation, or coalition. One way to find more information or to identify community leaders with expertise about these questions is to search for "end homelessness in (insert the name of your state or city)" using your favorite internet search engine.

For more ideas, please read: **Handout #2**

Understanding the Homeless Assistance System and Leveraging Resources for Medicaid Beneficiaries

Carol Wilkins, MPP is a nationally recognized expert on integrating health care, social services, and housing assistance for persons with disabilities, with a focus on persons who experience homelessness. She conducts research and provides technical assistance to develop and support the implementation of evidence-based policy solutions for people with complex health needs and vulnerabilities. She has worked with several states to support the use of Medicaid financing and delivery systems to provide the services and supports needed for homeless people with complex health needs to get and keep housing, and to reduce avoidable hospitalizations and other costs.

Big Picture

- How many people in the state / county / region are experiencing homelessness?

  - How many people were staying in emergency shelters or transitional housing programs at the time of the last Point in Time (PIT) count of homeless people?

  - How many people are unsheltered (sleeping on the streets, in cars, or other places not meant for human habitation)?

- What are the housing resources available for homeless people with disabilities/complex health needs?

  - How much permanent supportive housing is available?

  - How much emergency shelter, transitional housing, or other temporary beds are available for people experiencing homelessness?

  - How much of current capacity in supportive housing and homeless assistance programs is for single adults? For families with children? For youth?

- Are there local programs that offer medical respite or recuperative care for homeless people who are being discharged or diverted from hospitals? Are there programs that offer intensive case management services for people with frequent and avoidable hospitalizations or emergency room visits? Are there other promising program initiatives that focus on homeless people with complex health needs?

  - Are these programs linked to permanent housing resources?

- Is there a local, regional, or statewide public-private partnership or coalition committed to ending homelessness?

  - Does this partnership have specific goals that focus on particular groups of people who experience homelessness, such as veterans, chronically homeless people, youth, etc.?

Permanent Supportive Housing

- What types of supportive housing are available in the state/county/region?

  - Is there a mix of site-based housing apartment buildings and residential hotels that have

been renovated and converted to permanent housing) and scattered site programs that use tenant-based rent subsidies, or only some of these types of supportive housing?

  - What types of supportive services are available in or connected to this supportive housing? Are health services connected to some housing?

  - Are any Medicaid providers involved with supportive housing?

- How much of this supportive housing is designated for persons who meet specific eligibility criteria – e.g. veterans, persons with serious mental illness, persons experiencing chronic homelessness?

  - Are there gaps in the availability of supportive housing for some groups of homeless people?

- Are all or most of the supportive housing providers and funders and the leaders in the local homeless assistance system committed to using a Housing First approach? Are programs working to help homeless people move into permanent housing as quickly as possible, and eliminating requirements that people obtain income, participate in treatment, or achieve sobriety before they get housing assistance? Or do most supportive housing programs require people to engage in treatment and/or achieve sobriety before they can get housed?

Who is likely to have priority for permanent supportive housing?

- Is there a system in place to prioritize some homeless people for housing assistance, or are most housing resources made available on a first-come, first-served basis (with long waiting lists)?

  - For example, some housing programs are prioritizing chronically homeless people with high levels of vulnerability and/or frequent use of emergency or inpatient hospital care, ambulance, etc.

  - Some communities are prioritizing the most vulnerable and chronically homeless people for all or most housing resources, using systems of Coordinated Entry (described below).

Is there a Coordinated Entry system for housing programs?

- Are local housing and service providers and leaders in the Continuum of Care working to

design and implement a system of Coordinated Entry for housing and homeless assistance?

- What assessment tools or other criteria are being used to identify and prioritize the most vulnerable homeless people for housing?

- Is there a coordinated outreach approach that is working to assess and engage the most vulnerable homeless people and link them to housing assistance? Where can a homeless person get assessed and connected to the Coordinated Entry system?

- Are providers of health care and behavioral health services connected to this Coordinated Entry system, so they can help homeless consumers get assessed and linked to housing assistance?

- Is the Coordinated Entry system being used to match available supportive housing opportunities (vacancies) to homeless people who have been prioritized based on vulnerability and/or health service utilization?

- Are housing navigators available to help people with getting identification documents, completing applications, qualifying for housing assistance, and finding a housing unit? Do housing navigators stick with the individual until they are housed, and continue to provide assistance, regardless of whether they are in a shelter or sleeping on the streets, or moving from one place to another?

- Are alternative, interim housing arrangements available if permanent supportive housing is not immediately available?

- Are there different systems of Coordinated Entry for single adults, families with children, and/or transition aged youth?

Who to contact for planning and strengthening connections between Medicaid providers or health plans and supportive housing / homeless assistance system?

- Who leads the local, regional, or state Continuum of Care?

- Who leads the implementation of a coordinated entry system?

- Is there a local, regional, or state plan to end homelessness? Who leads implementation of this plan?

SAMPLE :
HELPING HOMELESS MEDICAL HEALTH PLAN MEMBERS IN SANTA CLARA COUNTY, CA

BIG PICTURE

Santa Clara County has more than 3,000 units of permanent supportive housing (see below), as well as emergency shelter and transitional housing programs for homeless families and adults without children.

Destination: Home http://destinationhomescc.org is a public-private partnership that works to coordinate the implementation of strategies to reduce chronic homelessness and to align resources and systems to intervene with families and individuals who are experiencing or at risk of homelessness in Santa Clara County. Partners include Santa Clara County, the City of San Jose, Santa Clara Valley Medical Center, The Health Trust, and other public and private organizations. Santa Clara County's Office of Supportive Housing coordinates county investments in and collaborations with housing and homeless assistance programs http://www.sccgov.org/sites/oah/Pages/Office -of-Affordable-Housing.aspx.

In 2011, a partnership of public and private organizations launched the Housing 1000 campaign, with the goal of housing 1,000 chronically homeless people in Santa Clara County. The Housing 1000 Care Coordination Project provided intensive case management services to engage and identify the most vulnerable homeless people and connect them to permanent housing. For more information see:

http://www.housing1000sv.org/index.php/care-coordination-project/

The Housing 1000 campaign ended in December 2014, but the work of housing chronically homeless people is continuing through the Care Coordination Project.

2015 Point in Time count of homeless people: 6,556

- 4,627 (71%) were living in unsheltered locations (sleeping outdoors in streets, cars, camping, etc.)

Permanent Supportive Housing

Permanent supportive housing (PSH) in Santa Clara County includes a mix of site-based housing (apartment buildings) and scattered site programs. Most of the PSH in Santa Clara County is for persons experiencing chronic homelessness,

and most vacancies are filled through the Care Coordination Project (described above). A large number of PSH units in Santa Clara County are designated for homeless veterans or persons with serious mental illness. Some PSH is also available to homeless people with other types of disabilities.

There has been a significant increase in the availability of PSH in Santa Clara County in recent years, supported in part by commitments of county funding and housing assistance provided by the county's public housing authority to augment the resources available through federal homeless assistance programs. Much of the PSH in Santa Clara County is in scattered site programs that use tenant-based rent subsidies (housing vouchers). There is a lot of competition for available rental housing units in the area, and this sometimes makes it difficult for people to find an apartment even when they have a voucher to help pay for rent.

The Continuum of Care and PSH providers are committed to using a Housing First approach; this is a change for some programs.

Who is likely to have priority for permanent supportive housing?

- Chronically homeless people who are highly vulnerable
- Veterans

As funding is allocated for new PSH units in the county, projects that will serve people who are experiencing chronic homelessness are prioritized.

Coordinated Entry for housing and homeless assistance programs

Now: Since 2011, access to most PSH has been prioritized based on vulnerability and the length of time a person has been experiencing homelessness. Initially the Vulnerability Index has been used as a screening tool to identify the most vulnerable homeless people; by the end of the year (2015) the VI-SPDAT will be used for this purpose.[1] Training to support the increased use of the VI-SPDAT is planned for 2015.

A more comprehensive coordinated entry system is currently under development. The Santa Clara County Continuum of Care has established a coordinated assessment working group that is meeting regularly. (For a calendar of Continuum of Care meetings see http://www.sccgov.org/sites/oah/coc/Pages/home.aspx)

The system will have multiple points of entry to housing assistance, including outreach teams, shelters, and the Valley Homeless Healthcare Program, and all of these entry points will use a consistent and coordinated approach to assessment. The goal is that all PSH vacancies, including both new units and units that become vacant in existing PSH projects, will be filled from a list of homeless people prioritized based on level of vulnerability.

Innovative programs for homeless "frequent users" in Santa Clara County

New Directions, an intensive case management program for people with frequent and avoidable visits to hospital emergency departments, was launched in 2002. The program, which was initially sponsored by the Hospital Council of Northern and Central California and supported with grant funding, focused on identifying and improving care for people with complex medical and psychosocial needs, who were frequently homeless. In 2013 *New Directions*, which continues to serve some of the highest cost and highest need patients in the hospital system, became a program of Peninsula Healthcare Connection. For more information see http://peninsulahcc.org/casemanagement.html

More recently Santa Clara County has launched a new program that will target services to more than 100 chronically homeless people who are among the highest users of emergency and inpatient care and other county services. A predictive modeling tool will be used to identify those homeless individuals who are likely to be the most costly consumers of public services. Implementation began in mid-2015. As part of the program, 112 units of permanent supportive housing are available for participants. Abode Services is responsible for managing housing placements and providing supportive services using a modified Assertive Community Treatment (ACT) model that includes nurse-case managers and peer counselors. Santa Clara County is committed to providing funding through an innovative Pay for Success Initiative. http://www.sccgov.org/sites/opa/nr/Pages/Abode-Services.aspx

For more information:
https://www.sccgov.org/sites/oah/Pages/Office-of-Affordable-Housing.aspx

Endnotes

[1]   For more information about the Vulnerability Index see http://usich.gov/usich_resources/solutions/explore/vulnerability_index and for information about the VI-SPDAT see http://www.orgcode.com/product/vi-spdat/