For Better Health

Foundational Community Supports

Supportive Housing

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Introducing yourself and your program

HELLO
my name is

- **Kimberly Castle** – Supportive Housing Program Manager (West)
- **Amanda Polley** – Supportive Housing Program Manager (East)

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- Social determinants of health are the economic and social conditions that affect health outcomes and are the underlying, contributing factors of health inequities. Examples include housing, educational attainment, employment and the environment.

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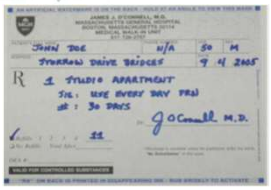
Supportive housing is the best medicine



Access to safe, quality, affordable housing - and the supports necessary to maintain that housing - constitutes one of the most basic and powerful social determinants of health.

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Outcomes

- "Results from the claims analysis showed significantly lower overall health care expenditures for the people after they moved into supportive housing. Expenditure changes were driven primarily by reductions in emergency and inpatient care. Survey data suggest that the savings were not at the expense of quality."
- Wright, B. J., Vartanian, K. B., Li, H. F., Royal, N., & Matson, J. K. (2016). Formerly homeless people had lower overall health care expenditures after moving into supportive housing. Health Affairs, 35(1), 20-27.

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Building on opportunities: housing & employment

- Legislative direction to improve client outcomes (employment and housing) and use **Evidence-based, Research-based, and Promising Practices:**
  - **SB 5732 (2013)**
  - **HB 1519** (2013)

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Evidence-based PSH model

- DBHR is legislatively mandated to implement EBPs
- Using EBPs increases likelihood of success based on research
- Continuous quality improvement approach through a learning collaborative approach
  - A 'recipe' or fidelity tool is used to measure and identify areas of improvement within the 7 dimensions of the PSH model

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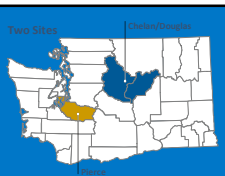
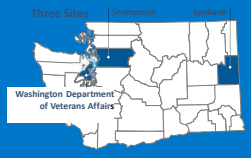
The PORCH Program

- **Located in two sites**: Pierce and Chelan Douglas counties
- **Target population:** Individuals with a serious mental illness or co-occurring substance use and mental health disorder who are homeless, unstably housed or transitioning from institutions





The BRIDGES Program

- **Located in three sites**: Kitsap, Snohomish and Spokane counties
- **Target population:** Individuals with a substance use or co-occurring substance use and mental health disorder who are homeless or unstably housed

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Dimensions of Permanent Supportive Housing

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Principles of Permanent Supportive Housing

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Choice of Housing

- **Tenants have choice of type of housing**
  - Clean and sober housing, apartment, house
- **Real choice in housing unit**
  - Are they shown multiple units to choose from?
- **Tenant can wait without losing their place in line**
  - Is there a waiting list? If I want to wait for another place to be available, do I lose my position on the waitlist?
- **Choice of living arrangements**
  - Does the tenant decide who they live with?

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Decent, Safe & Affordable

HQS (Housing Quality Standards), a person has a right to live in a home that is safe and in good condition.

What percent of their income must tenants pay for rent?

- Tenant pays a reasonable amount of income toward rent and utilities. (HUD/TBRA/Subsidized standard of 30% of adjusted income for housing expenses.)

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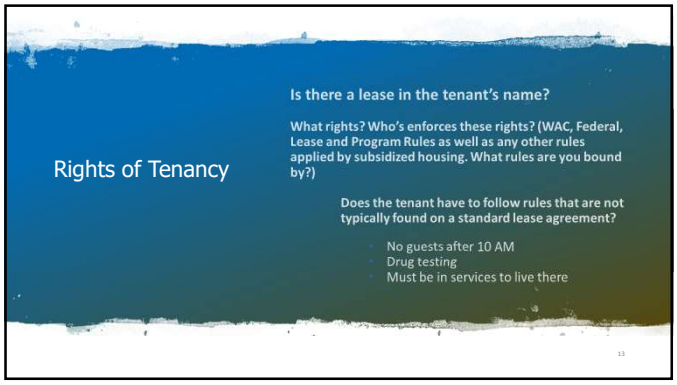
Rights of Tenancy
Is there a lease in the tenant's name?
What rights? Who's enforces these rights? (WAC, Federal, Lease and Program Rules as well as any other rules applied by subsidized housing. What rules are you bound by?)
Does the tenant have to follow rules that are not typically found on a standard lease agreement?
No guests after 10 AM
Drug testing
Must be in services to live there
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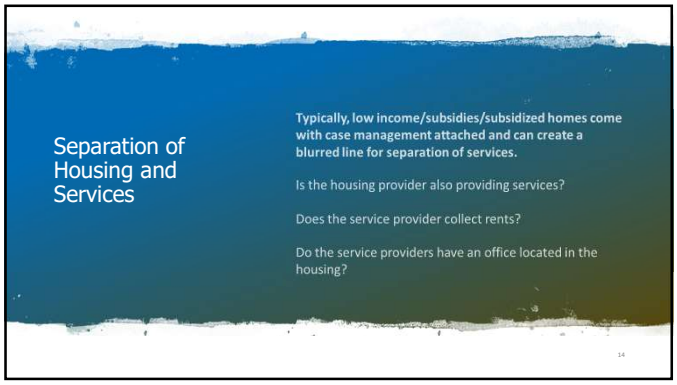
Separation of Housing and Services
Typically, low income/subsidies/subsidized homes come with case management attached and can create a blurred line for separation of services.
Is the housing provider also providing services?
Does the service provider collect rents?
Do the service providers have an office located in the housing?
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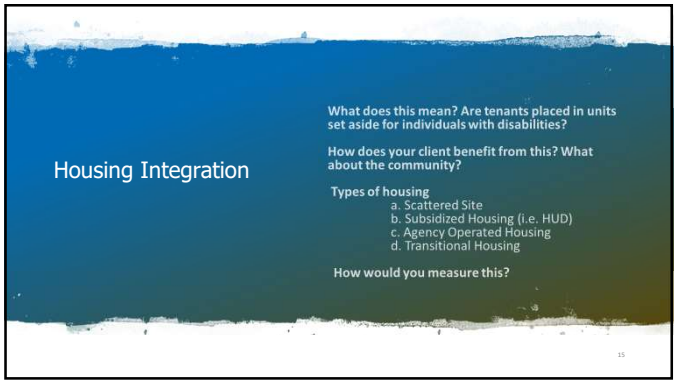
Housing Integration
What does this mean? Are tenants placed in units set aside for individuals with disabilities?
How does your client benefit from this? What about the community?
Types of housing
a. Scattered Site
b. Subsidized Housing (i.e. HUD)
c. Agency Operated Housing
d. Transitional Housing
How would you measure this?
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Access to Housing

What does access to housing mean to you and your participant?

- Is there a "readiness" criteria?
- Are people with barriers to housing prioritized?
- Who can enter the unit without the tenant there?

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Flexible, Voluntary Services

Flexible: Is there a menu of options for types of services to choose from?

What about ocation, duration, frequency, availability, etc…

Can a person change the frequency and intensity of services?

Voluntary Services: Varies with participant needs, not mandatory.

Can a person choose no services?

Are services person centered?

What's typical caseload size for service providers?

Are all services provided by a team?

Are services available 24/7?

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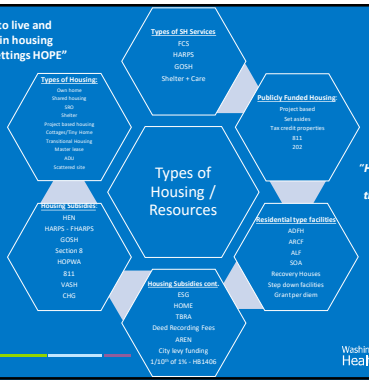
"Finding out where you want to live and asking people for their choice in housing gives people in institutional settings HOPE"
Wanda Johns
HARPS Program Manager



"Hope is often found in the everyday things, especially in housing."
Amanda Polley
FCS SH Trainer

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The Housing First Model

- No Preconditions
- No Barriers to Entry
- Honors Choice

Yields:
- Higher Housing Retention Rates
- Lower Returns to Homelessness
- Significantly reduction in use of crisis services & institutions

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Participant Advocacy: Why do we do this?

- Lowers Stigma
- Gives our client a voice (which honors choice)
- Promotes growth
- Builds Community Relationships
- Builds trust and natural problem solving skills
- Creates an environment for new opportunities (i.e. housing, recovery, job opportunities, homeless services, resources, etc.)

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Meeting people where they're at

- Allows for a safe space.
- Freedom to express themselves.
- Builds a trusting relationship.
- Shows respect!
- Acceptance!

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Homeless Outreach
What does this mean to you?

Street outreach involves moving outside of the walls of your agency in order to engage people experiencing homelessness who may be disconnected from mainstream services and supports.

Activity time:

- What does Homeless Outreach look like for you?
  (please type your answer in the chat box)

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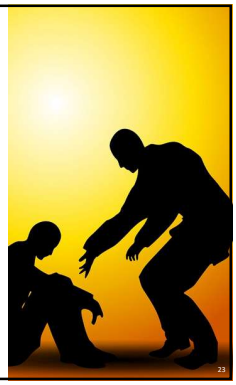
Homeless Outreach in Washington State

How many agencies in your area have a Homeless Outreach team?

(Please type your answer in the chat)



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DBHR Housing/Homeless Programs available in Washington State

HARPS
Wanda Johns wanda.johns@hca.wa.gov

Forensic HARPS
Nicole Mims nicole.mims@hca.wa.gov

PATH/ Peer Pathfinder
Lisa Bennett-Perry lisa.bennett-perry@hca.wa.gov

Forensic PATH
Craig Jacobson craig.jacobson@hca.wa.gov

Foundational Community Supports
Amanda Polley amanda.polley@hca.wa.gov
Kimberly Castle kimberly.castle@hca.wa.gov

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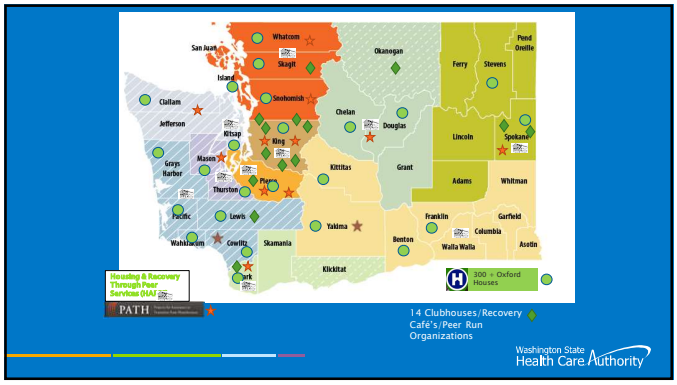

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Coordinated Entry

- What the heck is Coordinated Entry?
- Where does this fit in to the Whole Person approach?
- Who would I refer to CE?
- How does CE help with housing my participant?
- At what point should someone be referred?

(How many of these questions can you answer with confidence?)

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Foundational Community Supports (FCS)

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Foundational Community Supports (FCS)

What it is

- Targeted Medicaid benefits that help eligible clients with complex health needs obtain and maintain housing and employment stability.
  - Supportive Housing services
  - Supported Employment services

What it isn't

- Ongoing payments for housing, rent, or room & board costs
- Wages or wage enhancements for clients
- Entitlement

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Who is eligible to receive FCS benefits?

FCS benefits are reserved for people with the **greatest need**.
To qualify, you must:

1. Qualify for Medicaid
2. Meet the requirements for complex needs
   - You have a **medical necessity** related to mental health, substance use disorder (SUD), activities of daily living, or complex physical health need(s) that prevents you from functioning successfully or living independently.
   - You meet specific **risk factors** that prevent you from finding or keeping a job or a safe home.
3. Be at least 18 years of age (Supportive Housing) or 16 years of age (Supported Employment)

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FCS Reimbursement Rates

Foundational Community Supports (FCS) reimbursement rates
Effective July 1,2020 – 12/31/2021

Supported Employment Benefit

- 1 unit = **15 minutes** of service
- Limit of **120 units** (30 hours) of service per **6 month** authorization period
- Reimbursement rate of **$27/unit** of service
- Services may be **reauthorized** if a participant continues to need services
- "**Exception to Rule**" authorization process is available for additional service units within a 6 month period for participants who have exceptional service needs

Supportive Housing Benefit

- Per diem rate
- Limit of **30 days** of service per **6 month** authorization period
- Reimbursement rate of **$112/day**
- Services may be **reauthorized** if a participant continues to need services
- "**Exception to Rule**" authorization process is available for additional service units within a 6 month period for participants who have exceptional service needs

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What benefits are available through FCS?

Supportive housing helps you find a home or stay in your home

- Housing assessments and planning to find the home that's right for you
- Outreach to landlords to identify available housing in your community
- Connection with community resources to get you all of the help you need, when you need it
- Assistance with housing applications so you are accepted the first time
- Education, training and coaching to resolve disputes, advocate for your needs and keep you in your home

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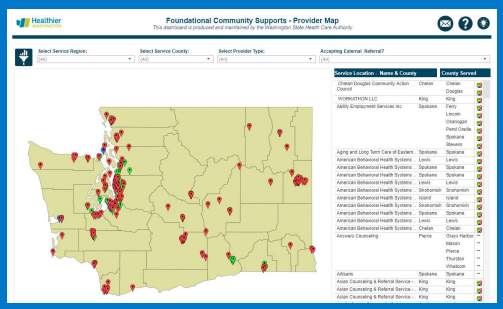

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You've got questions?

We've got answers!

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What are the individual's needs?

- HOPE
- HOUSING
- LIFE SKILLS
- MED MANAGEMENT
- ADL'S

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Assessments

- Provide & help honor participant choice
- Offers an opportunity for self-advocacy
- Empowers!
- Opens up lines of communication
- Builds trust
- Can take time!

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Pre-Tenancy Supports

- **Conducting Assessments**
- **Coordination of Care**
- **Development of Community Supports**
- **Treatment Planning** (Establishing short term & longterm goals)
- **Advocacy**
- **Landlord Liaison**
- **Financial Skill Building**
- **Benefits Support**

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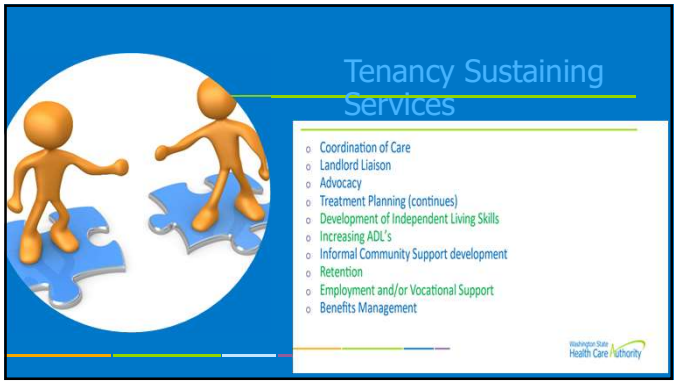
Tenancy Sustaining Services
Coordination of Care
Landlord Liaison
Advocacy
Treatment Planning (continues)
Development of Independent Living Skills
Increasing ADL's
Informal Community Support development
Retention
Employment and/or Vocational Support
Benefits Management
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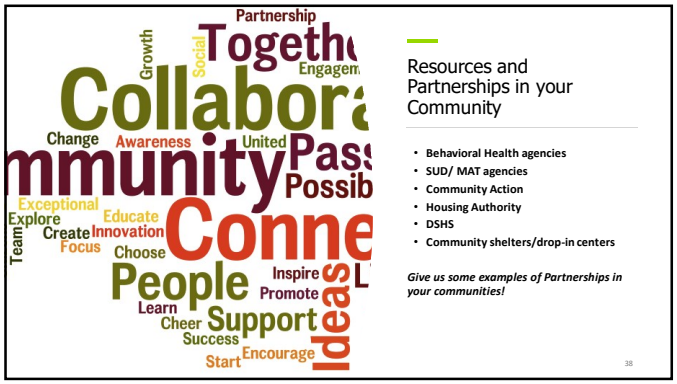
Partnership
Growth
Social
Engagem
Collabora
Change
Awareness
United
mmunity
Possib
Exceptional
Explore
Educate
Team
Create
Innovation
Focus
Choose
People
Inspire
Promote
Learn
Cheer
Success
Support
Start
Encourage
Ideas
Resources and Partnerships in your Community
Behavioral Health agencies
SUD/ MAT agencies
Community Action
Housing Authority
DSHS
Community shelters/drop-in centers
Give us some examples of Partnerships in your communities!
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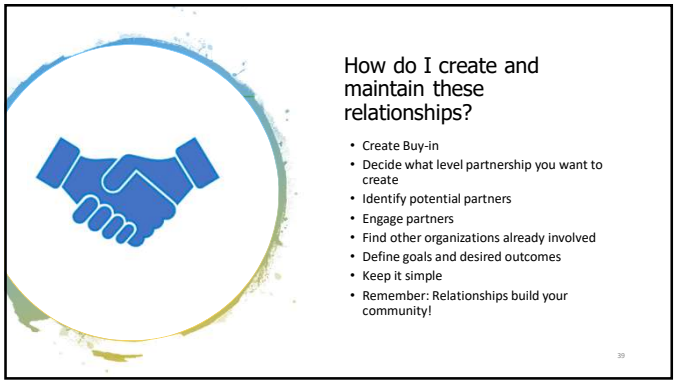
How do I create and maintain these relationships?
Create Buy-in
Decide what level partnership you want to create
Identify potential partners
Engage partners
Find other organizations already involved
Define goals and desired outcomes
Keep it simple
Remember: Relationships build your community!
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Warm Handoffs

What: A **warm handoff** is a handoff conducted in person between two members of the health care team in front of the patient and family or caregiver.

Why: To create trust and buy in with a new provider and help assure positive future outcomes (i.e. improved attendance, eases the way with continuing services, etc.)

When: As soon as possible in order to avoid a gap in services.

Who: Any individual who you serve (warm handoffs are just a good practice!)

Let us give you a couple examples…

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Internal Coordination

- Regular check-ins (i.e. weekly meetings, one on one or team based, etc.)
- Assessments and/or Referral forms
- Treatment/Care Plans (Define Goals and Outcomes)
- Make your presence known! (People in your agency may not even know what you do on behalf of their participants!)
- Educate Colleagues (i.e. All Staff Presentations, newsletters, etc)
- Leadership buy in!

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External Coordination

- Leadership buy in!
- Regular check-ins (i.e. phone calls, in person meetings, real time conversations)
- Assessments and/or Referral forms
- MOU's, Releases & Disclosures
- Define goals and desire outcomes
- Make your presence known! (Meet people where they are at! That includes your partners!)
- Educate/Market (Make no assumptions that providers and/or community members understand your role.)

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Let's hear from you!

- Example of positive Coordination
- Example of negative Coordination

Share in the chat box an example of an internal coordination.

-or-

Share an example of an external coordination.

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What's Next?

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Future training opportunities

DBHR IS COMMITTED TO PROVIDING TRAINING ACROSS THE STATE.

FCS NEWSLETTER

FCS EVENT CALENDAR

FCS TRAINER CONTACT INFORMATION

CHECK-OUT THE FCS EVENT CALENDAR BIT.LY/FCS-CALENDAR FOR UPCOMING EVENTS NEAR YOU!

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Resources

- SAMHSA EBP toolkit
- Pathways to Housing - http://pathwaystohousing.wa.gov
- Pathways to Employment – http://pathwaystoemployment.wa.gov
- CAP - Community Action Council
- HUD – US. Dept. of Housing & Urban Development
- WA State Housing and Employment Wiki
- PSH Tool Kit- Building your Program
- IPS Works

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