



City of Austin

Permanent Supportive Housing Strategy

September 30th, 2010

City of Austin
Neighborhood Housing & Community Development
Health and Human Services

Prepared by:
Corporation for Supportive Housing



Executive Summary

On March 25th, 2010, the Austin City Council passed a resolution¹ directing the City Manager to give priority to the funding of permanent supportive housing, and to develop a comprehensive strategy for the construction and operation of 350 permanent supportive housing units over the next four years. The council directed the City Manager's Office to present the plan to Council by October 1st, 2010, and to develop the strategy in coordination with governmental and private-sector stakeholders. The present report is intended to respond to the City Council's direction.

The City of Austin's program definition of permanent supportive housing (PSH) is:

Affordable housing linked to a range of support services that enable tenants, especially the homeless, to live independently and participate in community life. PSH can be offered in diverse housing settings, but usually consisting of apartment units that are

- *Targeted to households earning under 30% of Area Median Income with multiple barriers to housing stability;*
- *Deeply affordable. Rents are subsidized so that the tenant ideally pays no more than 30% of household income towards rent, even where tenants have extremely limited or no income;*
- *Lease-based. Tenancy is based on a legally-enforceable lease or similar form of occupancy agreement, and there are not limits on a person's length of tenancy as long as they abide by the conditions of the lease or agreement;*
- *Supported by the availability of a flexible array of comprehensive services, but participation is typically voluntary. The tenant has access to a flexible array of comprehensive services, including, but not limited to, case management, medical, mental health, substance use treatment, employment, life skills, and tenant advocacy, but a lease will not be terminated solely because a tenant chooses not to participate; and*
- *Managed through a working partnership that includes ongoing communication between service providers, property owners/managers, and subsidy programs.*

City of Austin-funded PSH will serve individuals or families headed by individuals that are:

1. Chronically homeless as established in the HEARTH Act²,
2. Households that would otherwise meet the HUD definition as above, but have been in an institution for over 90 days, including a jail, prison, substance abuse facility, mental health treatment facility, hospital or other similar facility,
3. Unaccompanied youth or families with children defined as homeless under other federal statutes that demonstrate housing instability and have other barriers that will likely lead to continued instability, as detailed in the plan.
4. Youth aging-out of state systems, whether homeless or at-risk of homelessness.

Among those served, priority will be given to

- At least 225 households identified as frequent users of public systems, and
- At least 75 households identified using a method linked to 'vulnerability,' as described in the plan.

Additionally, the City has a goal of serving the following subpopulations, which may be represented in either of the above priority screening methods (note that categories will overlap and will not total to 350):

- At least 270 single adults
- At least 30 families
- At least 10 unaccompanied youth
- 300 Individuals with severe and persistent mental illness, including 150 with co-occurring disorders
- 20 "youth aging out" of foster care and/or juvenile justice systems (10 single adults/10 families)
- 70 veterans
- 50 single women

¹ See Appendices for full resolution.

² *Homeless Emergency Assistance and Rapid Transition to Housing Act*, enacted on May 20, 2009.

Under the financing model proposed, a \$9M City of Austin investment through FY2014 would leverage an additional \$34M in federal, state, and local funds over the four years. Once all units are in service, ongoing operations and maintenance of the units are projected to total \$7.3M per year, with approximately \$775,000 annually coming from City funding, primarily for services.

In order to achieve the objectives related to the PSH strategy, capital funding will be implemented through a new programmatic structure, with a total of at least \$6M anticipated to be funded via Neighborhood Housing Community Development over the next four years, including \$1,775,000 in FY2011. Elements of the program design may include the set-aside of specific funding for PSH units, with deeper per-unit subsidies than otherwise available (since PSH units cannot typically carry hard debt), the creation of scoring preferences or set asides to support the achievement of subpopulation targets, and direct or indirect linkage of capital funding to operating and service funding sources.

Health and Human Services will utilize \$100,000 in the FY2011 budget to support PSH efforts, and will incorporate the PSH goals into its planning for FY2012-2015 social service contracts. The plan contemplates a City investment of \$625,000 per year in services at full occupancy in 2014.

Providers will be asked to track shared outcome measures, with a focus on housing stability, and an independent evaluation of cost avoidance among PSH tenants will be conducted.

Systems Redesign

The City is engaging in the present PSH strategy as part of an intentional effort to redesign the delivery of homeless services to explicitly achieve the goal of markedly reducing long-term homelessness in Austin. As such, the plan includes a number of ancillary activities that will serve to improve or mature the system overall, particularly as it relates to the ability to effectively create and operate permanent supportive housing. Throughout its efforts, the City will seek to repurpose, where appropriate, existing resources to support PSH production.

The City of Austin will take a leadership role in convening partners to achieve the PSH goal, including, but not limited to, Travis County, Central Health, local Public Housing Authorities, Veterans Affairs, Austin/Travis County Integral Care, local hospitals, and various State of Texas agencies. To that end, the City will invite potential partners to participate in a PSH leadership group, for the purposes of identifying and coordinating necessary funding, as well as monitoring the pipeline of PSH units.

The City will engage with ECHO and other community partners to assess the role that Austin Resource Center for the Homeless can play in this arena, and will collaborate with community partners to develop frequent user and vulnerability screening tools that may be used to prioritize tenants. To support its community partners as they enhance their existing expertise in PSH, the plan contemplates funding capacity building for both developers and service providers.

In addition, the City will investigate the creation of a dedicated tax or fee for homeless services, while working with the philanthropic community to identify potential vehicles for private contributions. Special attention will be paid to leveraging Medicaid under the current funding structure as well as under upcoming healthcare reform, and the City will support efforts that increase PSH funding at the State and Federal levels.

Introduction

During its annual point-in-time count in 2010, ECHO (Ending Community Homelessness Coalition) reported a total of over 2,000 homeless individuals counted on a single night. Of those persons, 965 were chronically homeless, meaning that they were single, disabled individuals that had been homeless for over a year, or had experienced homelessness at least four times over the previous three years. Austin's Homeless Management Information System (HMIS) shows evidence of over 5,800 persons accessing homeless services annually; most observers consider the HMIS total to be substantially lower than the number of people actually experiencing homelessness over the course of a year.

The Comprehensive Housing Market Study, commissioned by the City of Austin in 2009, identified very low-income renters as one of the most underserved populations in the market overall. The report found that there is a tremendous need for rental housing affordable to those earning 0-30% of the area's median family income—just one in 6 renters earning less than \$20,000 can find affordable housing in Austin. This translates to a gap of almost 40,000 rental units for this population.

Based on this evidence and on longstanding concern about the impacts of homelessness in the City, members of the Austin City Council and other stakeholders explored a number of models for addressing homelessness, through research and visits with homeless providers, community leaders, and elected officials locally and in other jurisdictions such as Miami, Phoenix, Dallas, and San Antonio. Through these explorations, community leaders began to focus on permanent supportive housing as one of the key approaches to addressing the issue of long-term homelessness.

As a parallel to these efforts, in 2009 ECHO, the Mayor's Mental Health Task Force Monitoring Committee (MMHTFMC), and the Austin/Travis County Re-entry Roundtable engaged Corporation for Supportive Housing to assess Austin's needs for permanent supportive housing for individuals and families, and to produce a permanent supportive housing programmatic and financial model.

In February 2010, the Corporation for Supportive Housing released the Permanent Supportive Housing Program and Financial Model. This report assessed Austin's needs for permanent housing for individuals and families, identifying an overall need of 1,889 permanent supportive housing units, and recommending the creation of 350 new PSH units within four years.

Based on this report and on other City research on potential policy approaches, the Austin City Council passed a March 25, 2010 resolution directing the City Manager to give priority to the funding of permanent supportive housing, and to develop a comprehensive strategy for the construction and operation of 350 permanent supportive housing units over the next four years. The council directed the City Manager's Office to present the plan to Council by October 1st, 2010, and to develop the strategy in coordination with governmental and private-sector stakeholders. The full resolution is included in the Appendices.

Community Stakeholder Process

In mid-2010, the City of Austin engaged the services of Corporation for Supportive Housing to support the development of the PSH strategy, including support of the PSH public input process called for in the Council resolution. CSH, in cooperation with the City, held a series of five public input sessions in August and September of 2010, inviting the public at large, with specific outreach to service providers, affordable housing developers, advocacy groups, neighborhood associations, and prospective tenants. The meetings were attended by approximately 85 community members.

Dates and locations of the public input sessions were as follows:

Public Input: PSH Guiding Principles	August 17th: 10am -12pm	Street Jones Building
Public Input: PSH Guiding Principles	August 23rd: 1:30 – 3:30pm	Trinity Center
Public Input: PSH Guiding Principles	August 23rd: 5:30-7:30	Street Jones Building
Public Input Report Back Session	September 8th: 5:30 – 7:30	Street Jones Building
Stakeholder Session on Policy & Process	September 9th: 9am – 11am	Austin City Hall

The City used an informal consensus-building model to gather public input into the plan. At the first three public input meetings participants reviewed and provided feedback on a draft version of the *Austin Permanent Supportive Housing Strategy Guiding Principles*, a final edited version of which is included in the Appendices. Attendees were given the opportunity to indicate their level of comfort with each principle as stated, and to recommend specific changes to the principles. At the September 8th "Report Back Session," the results of public input session and online voting on the survey were summarized, and further discussion was held. The last stakeholder session, targeted to developers and providers, was organized to elicit specific feedback around a variety of specific program design and implementation elements.

CSH and the City also considered feedback garnered through an online permanent supportive housing survey, through written comment received via the HUD Action Plan process, and through email and telephonic communication received via a dedicated address and phone number.

In addition to these avenues, which were all open to the public, members of the City Council and staff also carried out specific outreach to potential governmental and community partners, including Travis County, the Housing Authority of the City of Austin, Veterans' Affairs, Central Health, Austin/Travis County Integral Care, and local hospitals, among others.

Finally, this report draws heavily on the *Austin/Travis County ECHO Housing Report – Services for Permanent Supportive Housing*, released August 31st, 2010 (the "ECHO PSH Services Report"), which was developed through the collective research, experience, and feedback of 34 service providers that participated in the nine meetings which comprised the PSH services working group process. See the Appendices for the full report.

Background on PSH: National Cost Studies

Supportive housing can help people with psychiatric disabilities, people with histories of addiction, formerly homeless people, frail seniors, families, young people aging out of foster care, individuals leaving correctional facilities, and people living with HIV/AIDS to live independently with dignity in the community. Tenants of supportive housing often face two or more of these categories of challenges. For these populations, permanent supportive housing is a highly effective intervention. Research indicates that

- More than 80% of residents stay housed for at least one year³
- Incarceration rates are reduced by 50%⁴
- Emergency room visits decrease by 50%⁵
- Emergency detoxification services decrease by 85%⁶, and
- There is a 50% increase in earned income.

Although permanent supportive housing is a resource-intensive intervention, **the high public costs of homelessness mean that it costs essentially the same amount of money to house someone in stable, supportive housing as it does to leave that person homeless and stuck in the revolving door of high-cost crisis care and emergency housing.** Cost studies demonstrate that we can either waste money prolonging people's homelessness or spend those dollars on a long-term solution that produces positive results for people and their communities.

One of the most comprehensive cases for supportive housing is made by a study from the University of Pennsylvania's Center for Mental Health Policy and Services Research⁷. Researchers tracked the costs associated with nearly 5,000 mentally ill people in New York City for two years while they were homeless and for two years after they were housed. Among their conclusions: supportive and transitional housing created an average annual savings of \$16,282 per unit by reducing the use of public services. This reduction in costs nearly covered the cost of developing, operating, and providing services in supportive housing.

Results from the *Chicago Housing for Health Partnership* (CHHP) show that offering housing and case management to homeless adults with chronic illnesses creates stability and dramatically reduces hospital days and emergency room visits. CHHP is an integrated system of housing and supports for individuals with chronic medical illnesses who are homeless upon discharge from hospitalization. An 18-month randomized control trial compared hospitalizations, hospital days, and emergency department visits among housed participants and a comparison group of chronically ill homeless persons who continued to receive "usual

³ *Supportive Housing and Its Impact on the Public Health Crisis of Homelessness*, Corporation for Supportive Housing, May 2000.

⁴ *Making a Difference: Interim Status Report of the McKinney Research Demonstration Program for Homeless Mentally Ill Adults*, 1994.

⁵ *The Effectiveness of Permanent Supportive Housing in Maine: A Review of Costs Associated with the Second Year of Permanent Supportive Housing for Formerly Homeless Adults With Disabilities*. Melody Mondello, Thomas McLaughlin, and Jon Bradley, October 2009.

⁶ *Analysis of the Anishinabe Wakaigun*, September 1996-March 1998. See also *Denver Housing First Collaborative: Cost Benefit Analysis and Program Outcomes Report*. Jennifer Perlman and John Parvensky, Colorado Coalition for the Homeless, December 2006.

⁷ "The Impact of Permanent Supportive Housing for Homeless Persons With Severe Mental Illness on the Utilization of the Public Health, Corrections, and Emergency Shelter Systems: The New York/New York Initiative." Dennis Culhane, Stephan Metaux, and Trevor B. Hadley, Center for Mental Health Policy and Services Research, University of Pennsylvania, *Housing Policy Debate*, 2002.

care” – a piecemeal system of emergency shelters, family, and recovery programs. Results were recently reported in the *Journal of the American Medical Association*.⁸ At 18 months, 66% of the intervention group reported stable housing compared to only 13% of the “usual care” group. Controlling for a range of individual and service variables, housed participants had 29% fewer hospitalizations, 29% fewer hospital days, and 24% fewer ED visits than their “usual care” counterparts. As the authors note, for every 100 chronically ill homeless persons offered the intervention, this translates annually into 49 fewer hospitalizations, 270 fewer hospital days, and 116 fewer emergency department visits. For the one-third of study participants living with HIV/AIDS, housed participants also experienced significantly better health outcomes than those who continued in “usual care.”⁹ Still to come are a comparison of nursing home days used by the two groups and a full cost-benefit analysis that takes into account the cost of the intervention. However, preliminary results indicate a 50% reduction in nursing home days among housed participants, and that the reductions in avoidable health care utilization translated into annual **savings of at least \$900,000 for the 200 housed participants after taking into account the cost of the supportive housing.**¹⁰

In Seattle, the Downtown Emergency Service Center’s (DESC) 1811 Eastlake project is a Housing First program with on-site services targeting homeless men and women with chronic alcohol addiction who are frequent users of crisis and emergency healthcare services. Nearly half of the residents have a co-occurring mental illness and almost all have other chronic and disabling health conditions. Sobriety is not required as a condition of tenancy and residents are encouraged, but not required, to participate in chemical dependency and mental health treatment. An evaluation conducted by the Addictive Behaviors Research Center of the University of Washington reported outcomes of the 1811 Eastlake project on public use and costs for 95 housed participants compared with 39 wait-list control participants enrolled between November 2005 and March 2007.

Findings reported in the April issue of the *Journal of the American Medical Association* show that 1811 Eastlake saved taxpayers more than \$4 million dollars over the first year of operation: median costs in the year prior to being housed of \$4,066 per person per month in publicly funded services (such as jail, detoxification center use, hospital-based medical services, alcohol and drug programs, and emergency medical services), dropped to \$958 after 12 months in housing. **During the first six months, even after considering the cost of administering housing for the 95 residents in this Housing First program, the study reported an average cost-savings of 53%—nearly \$2,500 per month per person—in health and social services, compared to the costs of the wait-list control group of 39 homeless people.** Moreover, alcohol use by Housing First participants dropped by about one-third, with use decreasing over time while housed.¹¹

Further evidence shows that supportive housing provides public benefits beyond these savings. An analysis of the Connecticut Supportive Housing Demonstration Program found that supportive housing improved

⁸ “Effect of A Housing and Case Management Program on Emergency Department Visits and Hospital Visits Among the Chronically Ill Homeless Adults: A Randomized Trial,” L.S. Sadowski, R.A. Kee, T.A. VanderWeele, and D. Buchanan, *Journal of the American Medical Association*, May 2009.

⁹ “The Health Impact of Supportive Housing for HIV-Positive Homeless Patients: A Randomized Controlled Trial. R. Kee, L.S. Sadowski, and D. Garcia, *American Journal of Public Health*, 2009.

¹⁰ *Wall Street Journal*, March 6, 2008.

¹¹ “Health Care and Public Service Use and Cost Before and After Provision of Housing for Chronically Homeless Persons With Severe Alcohol Problems,” Mary E. Larimer, PhD; Daniel K. Malone, MPH; Michelle D. Garner, MSW, PhD; David C. Atkins, PhD; Bonnie Burlingham, MPH; Heather S. Lonczak, PhD; Kenneth Tanzer, BA; Joshua Ginzler, PhD; Seema L. Clifasefi, PhD; William G. Hobson, MA; G. Alan Marlatt, PhD, *Journal of the American Medical Association*, 2009.

neighborhood safety and beautification, increasing or stabilizing property values in most communities.¹² A 2008 study by New York University tracked changes in property values in areas surrounding over 100 new permanent supportive developments over a multi-year period, and found no evidence of negative impact on values; in fact, tracts surrounding PSH developments appreciated more quickly than otherwise-similar counterparts.¹³

Indicators of Potential Cost Avoidance in Austin/Travis County

While it is impossible to project precisely the reductions in public system utilization that are likely to occur as a result of implementing the City's PSH strategy, a number of indicators illustrate substantial potential for avoiding unnecessary cost to public services.

In the **Travis County Jail**, there were 814 inmates in 2008 that were homeless and screened for mental illness. The costs of incarcerating this population locally are substantial. Based on the average cost for a jail bed per day and the booking cost for each arrest (excluding costs for mental health assessment, counseling, and medication services), the Austin/Travis County Reentry Roundtable estimates the costs associated with this population at over \$3 million for 2008.

Of the group of 814 inmates, forty-five individuals (5%) accounted for 611, or 25% of all arrests (2,587) for this population. If the per-arrest cost for these 45 inmates is equal to that of the larger population, their costs of incarceration would be approximately \$750,000 for the year. A number of PSH cost-benefit studies demonstrate an average 50% decrease in arrest/days of incarceration. **Thus if only the 45 most frequent homeless and mentally-ill users of the Travis County Jail were provided permanent supportive housing, these individuals' utilization of the Travis County Jail could be reasonably expected to decrease by \$375,000 per year.**

The **Downtown Austin Community Court (DACC)** has identified 245 frequent offenders (offenders with 25 or more cases) that produced 52% of all docketed cases in 2009; DAAC estimates court and jail costs for these individuals averaging \$4,850 per person in 2009. Of the 245 frequent offenders, 30% have had cases for the life of the court (over 10 years). **Targeting only the 100 most frequent DACC users should produce *court and field booking* cost avoidance of at least \$140,000 annually, assuming a 50% reduction in use.** Note that these reductions do not include jail bed days, referenced above.

City of Austin Emergency Medical Services (EMS) carried out a review of emergency calls by identifiable transient citizens, identifying 76 individuals that produced a total of 863 EMS trips in 2009, at a cost of \$594,296. **Targeting these heavy users of EMS for PSH would likely result in at least \$297,000 in cost avoidance per year, since EMS use is commonly seen to decrease by 50%.**

National data generally indicates that individuals' use of emergency rooms and primary care hospitals decrease between 29% and 62% once living in PSH.. In Los Angeles, for example, primary health care utilization was reduced, on average, by over \$12,000 per PSH resident. **Central Health indicates that among homeless individuals enrolled in the Medical Assistance Program (MAP), the 112 most**

¹² *Connecticut Supportive Housing Demonstration Program: Final Program Evaluation Report*. Arthur Andersen LLP; University of Pennsylvania Health System Department of Psychiatry, Center for Mental Health Policy and Services Research; Kay Sherwood, and TWR Consulting. May 2002.

¹³ *The Impact of Supportive Housing on Surrounding Neighborhoods: Evidence from New York City*. Furman Center for Real Estate and Urban Policy, New York University. November 2008.

frequent users of emergency room (ER) services incurred a total of \$3.4 million in ER charges over the course of a single year, and that among the 112, the 49 most frequent users of hospital inpatient services incurred \$5.3 million in inpatient charges. At an average of \$77,000 in MAP charges per frequent user, there is clearly substantial potential for cost avoidance when targeting these individuals for PSH tenancy.

Decreases in psychiatric inpatient treatment are some of the most dramatic: **in a recent Los Angeles cost study, PSH tenants decreased their costs of inpatient psychiatric care by 80%, and in Chicago, costs decreased by over 95%.** While state hospital costs are generally funded by the State, these reductions in use are of particular relevance to the local community, since Travis County regularly exceeds its allotted capacity at the Austin State Hospital (ASH), risking required repayment to the State, and since community safety net providers are burdened when ASH is full and mental health crisis patients are diverted to local emergency departments. In addition to these reductions in use at the inpatient level, PSH tenants will likely demonstrate decreased utilization of local mental health crisis resources that are delivered via ATCIC and others.

The Austin Resource Center for the Homeless has identified 101 individuals that were in the shelter over 200 days in 2008; other local shelters likely house similar populations. Not only will shelter costs for housed individuals be virtually eliminated, but capacity would be freed at the shelters for more appropriate emergency interventions to other individuals.

INITIATIVE POPULATION & DEFINITIONS

For the purposes of this initiative, **permanent supportive housing** is defined as a rental dwelling unit that is characterized as follows:

Affordable housing linked to a range of support services that enable tenants, especially the homeless, to live independently and participate in community life. PSH can be offered in diverse housing settings, but usually consists of apartment units that are

- *Targeted to households earning under 30% of Area Median Income with multiple barriers to housing stability;*
- *Deeply affordable. Rents are subsidized so that the tenant ideally pays no more than 30% of household income towards rent, even where tenants have extremely limited or no income;*
- *Lease-based. Tenancy is based on a legally-enforceable lease or similar form of occupancy agreement, and there are not limits on a person's length of tenancy as long as they abide by the conditions of the lease or agreement;*
- *Supported by the availability of a flexible array of comprehensive services, but participation is typically voluntary. The tenant has access to a flexible array of comprehensive services, including, but not limited to, case management, medical, mental health, substance use treatment, employment, life skills, and tenant advocacy, but a lease will not be terminated solely because a tenant chooses not to participate; and*
- *Managed through a working partnership that includes ongoing communication between service providers, property owners/managers, and subsidy programs.*

The City of Austin acknowledges that permanent supportive housing is a powerful strategy that can be effective for a broad range of low-income, high service need populations. However, given the relative resource intensity of permanent supportive housing, the scarcity of financing, and the higher cost avoidance for higher need individuals, the City will take a strategic approach to targeting population served under this initiative. In recognition of the high human and public fiscal costs of long-term homelessness, the City will direct its resources to the following prospective tenants for the next four years:

Individuals or families headed by individuals that are:

1. Chronically homeless as established in the HEARTH Act¹⁴,
2. Households that would otherwise meet the HUD definition of chronically homeless as above, but have been in an institution for over 90 days, including a jail, prison, substance abuse facility, mental health treatment facility, hospital or other similar facility,
3. Unaccompanied youth or families with children defined as homeless under other federal statutes who:
 - a. have experienced a long term period without living independently in permanent housing;
 - b. have experienced persistent instability as measured by frequent moves over such period; and
 - c. can be expected to continue in such status for an extended period of time because of chronic disabilities, chronic physical health or mental health conditions, substance addiction, histories of domestic violence or childhood abuse, the presence of a child or youth with a disability, or multiple barriers to employment.¹⁵
4. A single adult or household led by a youth 'aging out' of state custody of the foster care or juvenile justice system, where the head of household is homeless or at-risk of homelessness.

To support populations not included in the PSH initiative, the City will continue to invest in other programs along the housing continuum to address comprehensive community housing needs, including affordable home ownership, home repair, and affordable rental projects for low and moderate income residents, as directed in the Council resolution on permanent supportive housing.

¹⁴ *Homeless Emergency Assistance and Rapid Transition to Housing Act, enacted on May 20, 2009.*

¹⁵ This category is also consistent with the HEARTH Act.

SUBPOPULATION TARGETS

The City will work with providers and funding partners to target the following demographic goals within the population to be served, subject to regular review and direction from City Council. Note that there is substantial overlap among the categories, such that not all targets will total to the 350 unit overall goal.

Targets by Tenant Selection Method (Total 350)

- At least 225 households identified as frequent users of public systems (“See subsequent section, *Screening for High-Need Tenants*”)
- At least 75 households identified using a method linked to ‘vulnerability’ (See the Vulnerability Index and the Vulnerability Assessment Tool, both described in subsequent section, *Screening for High-Need Tenants*.)
- An additional 50 units for eligible tenants identified under either screening method, or that meet other targeted populations

Targets by Household Composition (Total 350)

- At least 270 single adults
 - At least 30 families
 - At least 10 unaccompanied youth
 - 40 units open to any household size
- (Note that the budgets are modeled on 320 single individuals and 30 families)*

Additional Population Targets (Does Not Total to 350)

- At least 300 Individuals with Severe & Persistent Mental Illness
- At least 150 Individuals with Co-occurring Disorder
- At least 20 “Youth Aging Out” of foster care and/or juvenile justice systems (10 single adults/10 families)
- At least 70 Veterans
- At least 50 Single women

The City, in collaboration with its funding partners, will adjust annual scoring preferences or funding set-asides based on progress toward subpopulation targets. The City will implement the following strategies to enhance the initiative’s reach to priority subpopulations:

- Capital dollars will be prioritized, and deeper subsidy will be available to, developers that explicitly set aside units for permanent supportive housing as defined under this plan, agree to cooperate with qualified referral sources, and establish a written affirmative marketing plan targeting populations described above.
- In order to receive additional points and/or qualify for deeper subsidy, developers must provide written policies demonstrating practices intended to lower barriers to housing the target populations. These policies should address screening around criminal history, credit, and rental history.
- Where permissible under the Fair Housing Act, the City, in collaboration with its funding partners, will seek to create capital, operating, and/or service set-asides for specific target populations.

Because permanent supportive housing is a resource intensive intervention, the City of Austin will seek to ensure that public and private resources are targeted to maximize positive outcomes. As previously indicated, substantial research shows that targeting homeless households that are the most frequent users of other public systems results in marked savings to those systems, making PSH a cost-neutral or cost-saving approach, even in the first year after placement in housing.

Corporation for Supportive Housing and others have advanced frequent user, or “FUSE” (Frequent Users of Services and Emergency Systems) Initiatives in multiple communities across the United States. While tools vary from program to program, typical screening processes screen for high utilization of emergency rooms, emergency medical service, jails, prisons, shelters, psychiatric hospitals, and primary care hospitals, among others. The criteria used for screening depends largely on the data that is readily available at the local level. As referenced previously, Austin and Travis County entities have done substantial preliminary data analysis that can be leveraged for an effective frequent user effort.

In addition to the FUSE approach, which focuses on public system cost avoidance, some communities are focusing efforts on ‘vulnerability’ tools that are aimed at housing homeless persons that are found in a particular geographic area, that are deemed to be most at risk of early morbidity, or that are identified as being at high risk of victimization when unsheltered. Used in this context, the term ‘vulnerability’ is not intended to define an individual person as vulnerable, but rather as an indicator of the level of an individual’s susceptibility to harmful factors in the environment.

The “Vulnerability Index™,” pioneered by Common Ground, screens for the following attributes:

- 1) more than three hospitalizations or emergency room visits in a year
- 2) more than three emergency room visits in the previous three months
- 3) aged 60 or older
- 4) cirrhosis of the liver
- 5) end-stage renal disease
- 6) history of frostbite, trench foot, or hypothermia
- 7) HIV+/AIDS
- 8) tri-morbidity: co-occurring psychiatric, substance abuse, and chronic medical condition

Some communities have modified the Vulnerability Index to suit local conditions and priorities. For example, history of frostbite would perhaps be less relevant in warm climates like Austin, but the community might wish to particularly prioritize older individuals. Community volunteers have begun to organize a registry week for the Vulnerability Index, tentatively scheduled for December 6th, 2010. Note that neither the FUSE approach or the Vulnerability Index specifically target (and may select against) young people or women, both of whom may be particularly susceptible to criminal victimization while homeless regardless of medical risk factors or costly use of public systems.

In this vein, a second tool linked to vulnerability, The Vulnerability Assessment Tool (VAT), developed by Seattle’s Downtown Emergency Service Center (DESC) aims to objectively assess the relative vulnerability of the homeless men and women. The tool is comprised of a set of scales, each rating the individual’s level of functioning, health, and other specific characteristics relevant to their personal safety. The tool was first put to use in the DESC main shelter program nearly a decade ago as a way to determine who among the many would receive one of the limited beds available each night. By identifying a vulnerability rating for each client,

staff members assigned beds to those individuals who were most at risk of being victimized or injured, of harming themselves, of coming to harm simply because they could not take care of their basic needs, or of being unable to make progress without substantial support. Following the VAT's success in the shelter program, the Vulnerability Assessment Tool was implemented in the DESC supportive housing program to better allocate limited housing resources to those clients with the greatest need. In March of 2010, the University of Washington concluded a research evaluation of DESC's Vulnerability Assessment Tool and concluded that it held strong properties of both reliability and validity. FrontSteps has recently begun implementing the use of the VAT at the Austin Resource Center for the Homeless; a copy is included in the Appendices.

The frequent user and vulnerability approaches have much in common. They are both intended to help communities prioritize prospective tenants for permanent supportive housing, with a focus on high-need individuals, many of whom would likely be targeted under *either* approach. However, initial evidence indicates that there is only about a 50% overlap in individuals identified by frequent user strategies and the Vulnerability Index. This is likely because the Vulnerability Index would presumably tend to identify medically fragile individuals that are *not intensively engaging public systems*. There may be compelling public policy reasons for taking this approach, but it will be less likely to produce short-term avoidance of costs to other public systems.

Over the next four years, the City will focus its efforts primarily on frequent user populations in order to demonstrate reductions in tenants' costly use of local public systems; this strategy is intended to lay the groundwork for continued expansion of the supply of permanent supportive housing in the future. As noted, of the 350 units projected, 225 will be targeted to a frequent user population. However, the City will also specifically target 75 of the initial 350 units to individuals identified by a vulnerability screening. The City will work with ECHO and other community partners to devise preliminary frequent user screening criteria, as well as, ideally, a single vulnerability-oriented tool. Refer to sample frequent user screening criteria in the Appendices.

DEVELOPMENT APPROACHES

The City's Neighborhood Housing Community Development Department expects to be a major contributor to capital funding of PSH. In order to achieve the objectives related to the PSH strategy, capital funding will be implemented through a new program. Elements of the program design may include:

- The set-aside of specific funding for PSH units, with deeper per-unit subsidies than otherwise available, since PSH units cannot typically carry hard debt.
- The creation of scoring preferences or set asides to support the achievement of subpopulation targets, with potential Requests for Proposals around specific goals
- Direct or indirect linkage of capital funding to operating and service funding sources.
- Ongoing staff tracking and monitoring of unit counts toward 350-unit goal

Unit Mix and Progress Toward Goal

In addition to setting targets for the population to be served, the City will establish goals as to the nature and quality of units to be established. Units financed under the initiative will meet the standards of other affordable units receiving assistance via the City of Austin, including compliance with S.M.A.R.T. Housing guidelines. The City envisions 250 units built, acquired, or rehabbed through the program, and 100 units leased (with no long-term use restriction on the unit itself, although the landlord may intend long-term use),

Last years' HUD Continuum of Care bonus project was awarded to Front Steps/ATCIC to carry out a housing first model for 25 units. Also, NHCD General Obligation bonds were utilized to provide capital subsidy to Green Doors' Sweeney Circle; layering of these resources, along with additional rental subsidies, could well produce 40 units of PSH that align with the City of Austin's proposed definitions for Permanent Supportive Housing and Target Populations. Other projects are in planning or predevelopment stages. NHCD and HHSD will jointly track progress toward the goal.

Diverse Settings

While buildings may be of any size, the City will ensure that a variety of projects are developed, and that efforts are made to maximize tenant choice, ensuring that at least some of the units are:

- in projects that are mixed tenancy (including both PSH and non-PSH tenants, as well as disabled and non-disabled tenants),
- integrated within other affordable housing developments, with long-term set-asides for the PSH population (25% or less of project, minimum PSH 5 units)
- in site-specific deals with a substantial concentration of PSH units for community building and effective service delivery (25%-100% of project, minimum 18 PSH units), and
- in projects that are small in size (50 total units or less)

Development and Financing Strategies

A variety of capital financing strategies will be considered by Neighborhood Housing and Community Development and its partners to achieve the mix of housing indicated above. These include

- Leasing existing units in private market, whether from market-rate landlords or nonprofit landlords
- Subsidizing site-specific New Construction or Acquisition/Rehabilitation, combining capital subsidy with additional operating subsidy identified via other community sources.

- Encouraging modest set-asides for PSH in new affordable housing projects requesting City support, including those financed by General Obligation Bonds, low income housing tax credits, or other financing sources.
- Financing debt relief on existing affordable units to allow for their operation as PSH units, securing additional operating subsidy where necessary.
- Incorporating PSH into affordable housing preservation efforts by encouraging set-aside of PSH units in deals with existing project-based subsidy contracts that are seeking City of Austin or other assistance to restructure their projects.
- Working to build a strong partnership with local housing authorities, which can provide critical tenant- and project-based subsidies (Housing Choice Vouchers and Veterans Affairs Supportive Housing vouchers), set aside public housing as PSH units, and/or may develop and manage PSH outside of their public housing portfolio.

Building Standards

The City will work with its partners to ensure that housing units created or financed under the initiative are high quality, meet tenant special needs, and serve as assets to the neighborhoods in which they are sited. To this end, the City may require that

- Studio apartments dedicated to individual tenants should be at least 300 square feet in size. Family units should be at least 600 square feet.
- PSH developments should include service and community space and amenities sufficient to meet the service and recreational needs of residents, which may include, but are not limited to, the following: common meeting spaces, communal kitchens, communal lounges, computer rooms, and gardens.
- City-funded buildings will have appropriate security measures in place, which may include secured entry and exit, and/or 24-hour on-site staff. The City will seek to identify additional sources of funding to offset the cost of these security measures where necessary.
- All units will, at a minimum, meet Housing Quality Standards, and the City and its partners will endeavor to provide incentives for built environments of the highest quality.

Siting Policies and Strategies

The City recognizes that siting and collaborative design of permanent supportive housing are of essential interest to tenants, providers, and prospective neighbors. The City will promote effective siting as follows:

- NHCD will review its various scoring criteria to ensure that current standards and incentives are appropriate for permanent supportive housing. PSH units should be located near ample transportation, with access to grocery stores and other retail, off-site health services and other necessities.
- Developers will be encouraged to proactively engage prospective tenants and neighborhood stakeholders in project planning. The City will endeavor to identify funds that can be utilized for costs related to a PSH Neighborhood Liaison Council for each approved project over a threshold size to be determined by the City. These funds may be used for meeting costs, to tour existing PSH facilities in other cities, or other city-approved costs.
- This report reflects the opinion of the City that, under current land use regulations, no specific zoning or permitting is needed for the siting of PSH.
- The City will utilize GIS to identify areas suited to PSH development, and consider the integration of such information into future scoring criteria related to siting.

SERVICE APPROACH

The City of Austin, through the Health and Human Services Department, will seek to promote high-quality, PSH services based on approaches that have demonstrated results for the target population. Financing quality services for tenants will require substantial investment of new or redirected funding, and the effective leveraging of Medicaid dollars will be essential to the initiative's success. Given systemic changes on the horizon, particularly related to national health care reform slated to take effect in 2014, community partners will need to be creative and flexible enough to respond to a rapidly changing landscape. Critical partners in this arena will include Austin Travis County Integral Care (ATCIC), Central Health, and Travis County, among others.

The initial financial model presumes that ATCIC will continue to provide mental health services to a modest caseload of currently homeless individuals at Service Packages 3 and 4 which correspond to case management and ACT Teams, as defined by the Department of State Health Services. Also, CSH recommends leveraging Texas Department of Criminal Justice funding of mental health services via ATCIC's ANEW program by targeting homeless individuals in that program for permanent supportive housing. In order to effectively maximize federal funds available for Medicaid funding of mental health care services (including case management services), a substantial portion of new local, non-City service funding will need to be captured as Medicaid match for mental health services. HHSD, ATCIC, Travis County and Central Health, with participation of the psychiatric stakeholders group convened by Central Health, should explore alternatives for structuring this match.

As part of this process, local partners should consider alternative delivery models that build on the strengths of existing partners, including:

- Building on the E-MERGE integrated primary/behavioral health delivery system for PSH residents.
- Considering whether community-based case management agencies could subcontract to ATCIC for services, and/or serve as subcontractors under ATCIC.
- Exploring any advantages of accessing the Medicaid reimbursement structure for Federally Qualified Health Centers
- Contemplating how tenants that do not qualify for ATCIC services can be supported when mental health needs arise, and how that service will be delivered.

CSH proposes a modest funding set-aside to engage in the development of a locally-relevant policy paper on the issues above, taken in the context of impending health care reform that will likely extend insurance coverage to much of the subject population.

In keeping with the recommendations of the recent ECHO PSH Services Report, for any new City of Austin service funding, priority will be given to providers that demonstrate the availability of case management staff at ratios of 1:12 or less for individuals, and 1:10 for families, at least for the first year of occupancy. Alternately, providers may propose the use of ACT teams or other evidence-based practice for intensive service delivery. Scoring preference will be given to providers that can demonstrate frequent, voluntary client contact.

With the possible exception of housing focused on families and youth, new PSH service funding will be directed to providers willing and able to implement a voluntary services approach. The City acknowledges that service engagement may be mandatory for some tenants as ordered by courts or other systems; the voluntary nature of services is understood to extend primarily to the right of tenancy and access to housing

subsidy. In other words, a tenant that is *otherwise lease-compliant* should not lose their housing only because they are not engaging in services.

Scoring and funding preference will be given to service providers that

- Agree to carry out specific outreach to and can effectively provide services tailored for the target populations
- Demonstrate effective outreach to and services for individuals w/behavioral health, substance abuse, and co-occurring disorders
- Demonstrate willingness and capacity to implement a Housing First approach
- Demonstrate willingness and capacity to implement a Harm Reduction approach
- Demonstrate an established partnership with housing provider that will accept PSH tenants with substantial barriers to housing, as evidenced by a memorandum of understanding with the housing provider. The memorandum of understanding should be accompanied by written operating policies that support the partnership, including information on how the property owner will lower barriers for prospective tenants related to criminal history, credit rating, and rental histories or the lack thereof.
- Evidence a partnership with housing provider that will provide a well-designed, well-built, well-managed, and safe physical environment for tenants
- Effectively leverage potential Medicaid resources

City of Austin HHSD may also, from time to time, dedicate service dollars to a project pre-construction, allowing the initial contract year funding to be utilized for construction-related purposes.

SYSTEMS DEVELOPMENT AND RE-DESIGN

Coordinated Screening and Referral

The use of system-wide screening tools and priority tenant lists implies a greater degree of coordination than has existed to date in Austin/Travis County. The City recognizes that, in partnership with ECHO, stakeholders may need to discuss methods for centralized maintenance of priority tenant lists, as well as methods for referring target tenants to the most appropriate housing. These coordinated efforts may be linked to efforts around facilitating tenant access to mainstream benefits for which they are eligible, including possible funding of a SOAR Initiative and/or expansion of the “Medicaider” tool utilized by members of the Integrated Care Collaborative.

The City of Austin, as owner of the Austin Resource Center for the Homeless, will work through HHSD and ECHO to determine the appropriate structure and resources needed to achieve effective system-wide screening and referral, including tools to expand or complement the current capacity of the Homeless Management and Information System (HMIS).

In addition to funding permanent supportive housing and technical resources, the City of Austin recognizes that substantial coordination will be necessary between funders and providers. The City will seek to contribute to effective coordination among entities. To this end, the City of Austin will assess resources to identify dedicated staff time to ensure the completion of several core deliverables, including coordination of the PSH leadership group, ensuring PSH provider capacity building, conducting community education, and tracking legislative issues.

PSH Leadership Group

The City will convene or participate in a PSH leadership group that will be created to a) identify and secure specific funding streams, and to b) regularly review and strategize around potential projects in the Austin/Travis County area. The group can be diverse, but must include members with substantial development expertise and influence at the funding level. At a minimum, members should include representation from ECHO/Continuum of Care, City of Austin Neighborhood Housing and Community Development/Austin Housing Finance Corporation, City of Austin Health and Human Services, Housing Authority of the City of Austin, Travis County Housing Authority, Veterans’ Affairs, Central Health, Austin/Travis County Integral Care, and Travis County Criminal Justice Planning and Health and Human Services. Additional partners may be identified. The City of Austin will provide staff support to establish the PSH leadership group by December 31st, 2010.

In 2011, the PSH leadership group will develop begin to share information and seek to streamline funding processes. An additional charge of the group will be to explicitly explore joint funding efforts (e.g. joint Requests for Proposals) that link would PSH capital, operating, and services funding; similar efforts have been carried out in communities including Fort Worth, Seattle, and Los Angeles. The PSH leadership group will report on these efforts to the City and other funding partners no later than May 30th, 2011.

New Funding Mechanisms

The City will seek to identify a dedicated revenue stream via a food and beverage tax or fee, or a portion of the hotel/motel tax. In addition to the expansion and coordination of public funding, the City and/or ECHO should explore a community-wide strategy for raising private funds for PSH. In Fort Worth, the United Way

carries out a special campaign around homelessness, as well as coordinating the joint Request for Proposal process for other funding sources, including City and Continuum of Care funds. The ECHO PSH Services Report recommended the establishment of a community endowment for homeless services, which could be coordinated via the Austin Community Foundation. Existing and new relationships with the faith-based community may be leveraged to identify gap operating and service funding at modest levels per unit, and congregations can also serve as a key resource for furnishing units.

Provider Capacity Building

In order to effectively mature the Permanent Supportive Housing delivery system, developers, service providers, and property managers will need ongoing training and professional development around how to effectively serve the target population.

In addition to direct provider training, the City of Austin will endeavor to ensure that its policies and actions are in compliance with relevant Fair Housing regulations, which may impact tenant selection strategies, zoning and variance considerations, and other program elements. This law is extremely complex, and CSH recommends that City staff, Council, and related commission members receive training on Fair Housing and its specific relationship to permanent supportive housing efforts.

Community Education

Community outreach and education, as well as effective developer/neighborhood relations, are critical to any successful PSH effort. The City will work with ECHO and other stakeholders to plan a public information campaign around PSH, focusing on educating neighborhood and civic groups about PSH independent of the siting of any specific project. In addition, the City will explicitly work to collaborate with the faith-based community as a key community education strategy. Training around building community support for specific PSH projects will be included in the provider capacity building effort, as above.

EVALUATION

Common Program Outcome Measures

Consistent with, and building on, the recommendations of the ECHO Services report, the City will focus its service provider program evaluation primarily on the following output and outcome measures:

1. Housing stability: percent of tenants remaining in housing at pre-determined periods, or exiting to safe and permanent housing situations
2. Increase in rates of employment
3. Increase in income stability (employment or benefits)
4. Family stability and/or reunification, where relevant
5. Levels of social support and connection: Participants report a sense of social support and reduced isolation. Participants report a sense of feeling hopeful and cared for and progress toward personal goals.
6. Turnover rate
7. Eviction Rate

Independent Evaluation

The City will identify funding for an independent evaluator to assess the effectiveness and cost-benefit comparison of the program overall, to be presented to City Council and other funding partners no later than June 30th, 2014. While specific evaluation design will be determined at a later date, the City will seek to evaluate, at a minimum, the following outcomes, generally assessing individual outcomes at least 12 months previous to and 12 months after placement in housing:

1. Increased number of operational PSH housing units
2. Changes in number of chronically homeless individuals.
3. Reduction in number of days spent incarcerated, and in associated costs
4. Reduction in emergency room visits, and in associated costs.
5. Reduction in EMS transfers, and in associated costs.
6. Reduction in 911 calls, and in associated costs.
7. Reduction in psychiatric hospitalization, and in associated costs.
8. Reduction in primary care hospitalization, and in associated costs.
9. Reduction in court cases, and in associated costs.
10. Reduction in detoxification services, and in associated costs.
11. Impact on utilization of Medicaid, and in associated costs.
12. Impact on health indicators

Overall, the evaluation should determine the extent to which local investment of funds has resulted in avoidance of costs associated with individuals' utilization of specific public systems and public systems as a whole.

In addition to the data-driven analysis described above, the City will ensure ongoing user input by instituting qualitative evaluation with both tenants and providers. The City will develop partnerships with academic and other partners to achieve this goal.

TOTAL INITIATIVE TIMELINE AND COSTS

The projected timeline would bring the 350 units online by the end of 2014, with a mix of 250 new construction or rehab units, and 100 units leased in the private market. Total initiative costs through the end of 2014 are approximately \$43.2 million. The City-controlled portion of that total cost is estimated at around \$9 million, with only \$6.3 million projected to come from local dollars (including \$3.8 million related to General Obligation proceeds)

Overview of Unit Production Plans by Unit Type, Unit Size, and Year															
	Total Units	Unit Production by Year Placed In Service												Total by Unit Size	
		Thru October 2010		2010		2011		2012		2013		2014			
		0/1 BR	2/3 BR	0/1 BR	2/3 BR	0/1 BR	2/3 BR	0/1 BR	2/3 BR	0/1 BR	2/3 BR	0/1 BR	2/3 BR	0/1 BR	2/3 BR
New Construction/Rehab	250			0	0	35	15	63	0	72	15	50	0	220	30
Leased Units	100			0	0	50	0	25	0	25	0	0	0	100	0
TOTAL UNITS:	350	0	0	0	0	85	15	88	0	97	15	50	0	320	30

SUMMARY OF CAPITAL, OPERATING, AND SERVICE COSTS BY YEAR

Summary of Financing Expenditures Required for the Production of the Units (By Year)						
	Total Costs	Financing Expenditures by Year				
		2010	2011	2012	2013	2014
Capital Financing Expenditures:	\$21,568,173	\$100,000	\$1,775,675	\$5,851,553	\$8,914,030	\$4,926,915
Operating (Rental Subsidy) Financing Expenditures:	\$9,387,252		\$1,389,111	\$2,027,142	\$2,779,100	\$3,191,900
Services Financing Expenditures:	\$11,068,400	\$0	\$1,130,000	\$2,268,400	\$3,540,000	\$4,130,000
Ancillary Costs	\$1,162,500	\$140,000	\$300,000	\$267,500	\$247,500	\$207,500
TOTAL FINANCING EXPENDITURES:	\$43,186,325	\$240,000	\$4,594,786	\$10,414,595	\$15,480,630	\$12,456,315

Detail of City of Austin Expenditures (By Year)						
	Total Costs Thru 2014	Financing Expenditures by Year				
		2010	2011	2012	2013	2014
New Source: Front Desk Coverage	\$588,560		\$147,140	\$147,140	\$147,140	\$147,140
City of Austin HTF, HOME, CDBG	\$2,100,000			\$700,000	\$700,000	\$700,000
City of Austin: GO Bonds 2011 Action Plan Designated	\$1,775,000		\$1,775,000			
Austin: GO Bonds: Add'l 2011 and Future	\$2,000,000			\$450,000	\$950,000	\$600,000
New City of Austin Service funding	\$1,500,000	\$0	\$100,000	\$350,000	\$500,000	\$500,000
City of Austin/TDHCA HHSP	\$375,000	\$0	\$0	\$125,000	\$125,000	\$125,000
City of Austin for Ancillary Costs (HHS/NHCD primarily)	\$667,500	\$40,000	\$160,000	\$160,000	\$160,000	\$147,500
City of Austin CHDO Capacity Building	\$50,000	\$0	\$20,000	\$20,000	\$10,000	\$0
	\$9,056,060	\$40,000	\$2,202,140	\$2,002,140	\$2,592,140	\$2,219,640
TOTAL CITY OF AUSTIN COSTS (including federal)						
	\$9,056,060					
Total Local Funds	\$6,531,060					
Local Dollars as % of Total Budget	15.2%					
All City of Austin funds as % Total Budget	21%					

Detail of Austin Expenditure by Department	
Neighborhood Housing and Community Development	\$5,925,000
Health and Human Services Department	\$1,875,000
TBD	\$1,256,060
TOTAL	\$9,056,060

DETAIL OF CAPITAL FUNDING BY SOURCE AND YEAR

The City of Austin would contribute approximately \$5.9M of the estimated total \$21.6M remaining in capital costs. Of that amount, \$3.8M would come from General Obligation bonds, with \$2.1M coming from federal formula funding. Neighborhood Housing and Community Development has already programmed \$1,775,000 for FY2011 via its HUD Action Plan.

Detail of Projected Capital Financing Expenditures (By Year)						
	Total Costs	Financing Expenditures by Year				
		2010	2011	2012	2013	2014
Capital Financing Expenditures:	\$21,568,173	\$100,000	\$1,775,675	\$5,851,553	\$8,914,030	\$4,926,915
<u>Projected Sources</u>						
9% Low Income Housing Tax Credits:	\$4,620,000	\$0	\$0		\$3,465,000	\$1,155,000
State Housing Trust Fund:	\$200,000			\$100,000	\$100,000	
Federal Home Loan Bank Affordable Housing Program:	\$2,200,000			\$733,333	\$733,333	\$733,333
City of Austin: HOME, CDBG	\$2,100,000			\$700,000	\$700,000	\$700,000
Neighborhood Stabilization Program	\$3,000,000			\$3,000,000		
Austin: GO Bonds FY2011	\$1,775,000		\$1,775,000			
Austin: GO Bonds: Add'l 2011 and Future	\$2,000,000			\$450,000	\$950,000	\$600,000
Other Local Funds	\$1,500,000			\$500,000	\$1,000,000	
HUD 811	\$3,060,000				\$1,530,000	\$1,530,000
Philanthropic	\$1,113,173	\$100,000	\$675	\$368,220	\$435,697	\$208,582
TOTAL FINANCING EXPENDITURES:	\$21,568,173	\$100,000	\$1,775,675	\$5,851,553	\$8,914,030	\$4,926,915

DETAIL OF OPERATING FUNDING BY SOURCE AND YEAR

All direct rental subsidies are expected to come from federal sources. The \$147,140 shown in the budget corresponds to potential gap operating that could be utilized to help cover the costs of 24 hour front desk coverage.

Detail of Projected Operating Financing Expenditures (By Year)						
	Total Costs at Full Occupancy	Financing Expenditures by Year				
		2010	2011	2012	2013	2014
Operating (Rental Subsidy) Financing Expenditures:	\$3,191,900		\$1,389,111	\$2,027,142	\$2,779,100	\$3,191,900
<u>Projected Sources</u>						
HUD Continuum of Care	\$701,760		\$206,400	\$371,520	\$536,640	\$701,760
Housing Choice Vouchers	\$1,426,584		\$602,131	\$740,674	\$1,178,904	\$1,426,584
Family Unification Program	\$82,560		\$82,560	\$82,560	\$82,560	\$82,560
Set-Asides in Preservation Deals (Existing Housing Assistance Payment rental subsidy contracts)	\$165,120		\$165,120	\$165,120	\$165,120	\$165,120
HUD 811	\$297,216			\$148,608	\$297,216	\$297,216
Veterans' Affairs Supportive Housing Program subsidies	\$371,520		\$185,760	\$371,520	\$371,520	\$371,520
New Source: Front Desk Coverage/Security	\$147,140		\$147,140	\$147,140	\$147,140	\$147,140
TOTAL FINANCING EXPENDITURES:	\$3,191,900	\$0	\$1,389,111	\$2,027,142	\$2,779,100	\$3,191,900

DETAIL OF SERVICE COSTS AND SOURCES BY YEAR

By the end of 2014, the City is projected to contribute \$625,000 annually of the \$4.13M projected annual service cost; Of this amount, the bulk would come from the General Fund, and the remaining \$125,000 consists of a pass-through of the State-funded Homeless Housing and Services Program monies. The Health and Human Services Department's budget was increased by \$100,000 for FY2011 to support the City's efforts around homelessness, and HHS anticipates releasing a NOFA for service funds soon after the submission of this report.

Detail of Projected Service Expenditures (By Year)						
	Total Costs at Full Occupancy	Financing Expenditures by Year				
		2010	2011	2012	2013	2014
Services Financing Expenditures:	\$4,130,000		\$1,180,000	\$2,218,400	\$3,540,000	\$4,130,000
<u>Projected Sources</u>						
Austin/Travis County Integral Care In-Kind: Current State Funds + Medicaid	\$308,000	\$0	\$205,300	\$308,000	\$308,000	\$308,000
Austin/Travis County Integral Care In-Kind: ANEW Caseload	\$180,000	\$0	\$150,000	\$180,000	\$180,000	\$180,000
Medicaid leveraged by new local match ATCIC	\$1,000,000	\$0	\$144,700	\$325,000	\$700,000	\$1,000,000
Veterans Affairs Supportive Housing	\$180,000	\$0	\$180,000	\$180,000	\$180,000	\$180,000
New City of Austin funding	\$500,000	\$0	\$100,000	\$400,000	\$500,000	\$500,000
New Local Funding	\$1,000,000	\$0	\$150,000	\$400,000	\$800,000	\$1,000,000
City of Austin/TDHCA HHSP	\$126,000	\$0	\$0	\$126,000	\$126,000	\$126,000
New Federal and State Sources: VA CBS; SAMHSA; DoJ; 2nd Chance	\$500,000	\$0	\$200,000	\$225,000	\$500,000	\$500,000
Philanthropy	\$336,000	\$0	\$50,000	\$74,400	\$246,000	\$336,000
TOTAL FINANCING EXPENDITURES:	\$4,130,000	\$0	\$1,180,000	\$2,218,400	\$3,540,000	\$4,130,000

DETAIL OF ANCILLARY INITIATIVE COSTS AND SOURCES

In addition to the core capital, operating, and services costs associated with creating and operating the 350 PSH units, the City has identified \$662,500 in costs through 2014 that would support the Initiative. Of these costs, the City of Austin is projected to cover \$317,500, including \$50,000 of HUD HOME dollars.

PSH Strategy Ancillary Costs						
	Year					
	TOTAL	2010	2011	2012	2013	2014
Ancillary Services/Systems Improvements	\$105,000	\$5,000	\$25,000	\$25,000	\$25,000	\$25,000
Cost /Benefit Evaluation	\$150,000	\$5,000	\$20,000	\$50,000	\$50,000	25,000
White Paper on Medicaid and Health Care Reform Related to PSH	\$25,000		\$25,000			
Developer, Service Provider, Property Manager Training	\$110,000	\$10,000	\$25,000	\$25,000	\$25,000	\$25,000
Community Outreach/Education	\$52,500	\$5,000	\$25,000	\$7,500	\$7,500	\$7,500
Neighborhood Liaison Fund	\$50,000		\$20,000	\$20,000	\$10,000	
PSH Staffing CoA	\$400,000	\$0	\$100,000	\$100,000	\$100,000	\$100,000
Providers/Funders Technical Assistance/Consulting	\$170,000	\$15,000	\$60,000	\$40,000	\$30,000	\$25,000
	\$1,062,500	\$40,000	\$300,000	\$267,500	\$247,500	\$207,500

Detail of Projected Ancillary Sources (By Year)						
	Total Costs at Full Occupancy	Financing Expenditures by Year				
		2010	2011	2012	2013	2014
Ancillary Costs	\$1,062,500	\$40,000	\$300,000	\$267,500	\$247,500	\$207,500
<u>Projected Sources</u>						
City of Austin (HHS/NHCD primarily)	\$667,500	\$40,000	\$160,000	\$160,000	\$160,000	\$147,500
City of Austin Community Housing Development Organization Capacity Building	\$50,000		\$20,000	\$20,000	\$10,000	
Other Local Jurisdictions	\$150,000		\$0	\$50,000	\$50,000	\$50,000
Philanthropy	\$195,000		\$70,000	\$50,000	\$40,000	\$35,000
TOTAL FINANCING EXPENDITURES:	\$1,062,500	\$40,000	\$250,000	\$280,000	\$260,000	\$232,500

APPENDICES

1. About Corporation for Supportive Housing
2. Austin City Council Resolution #20100325-053
3. Permanent Supportive Housing Strategy Guiding Principles
4. Vulnerability Assessment Tool (VAT)
5. Sample Frequent User Screen
6. Austin/Travis County ECHO Housing Report – Services for Permanent Supportive Housing

*APPENDIX 1:
ABOUT CORPORATION FOR SUPPORTIVE HOUSING*



About the Corporation for Supportive Housing

The Corporation for Supportive Housing (CSH) is a national non-profit organization and Community Development Financial Institution that helps communities create permanent housing with services to prevent and end homelessness. Founded in 1991, CSH advances its mission by providing advocacy, expertise, leadership, and financial resources to make it easier to create and operate supportive housing. CSH seeks to help create an expanded supply of supportive housing for people, including single adults, families with children, and young adults, who have extremely low-incomes, who have disabling conditions, and/or face other significant challenges that place them at on-going risk of homelessness. For information regarding CSH's current office locations, please see www.csh.org/contactus. For more information about CSH's consulting and training services, please see www.csh.org/CSHConsultingGroup or contact the CSH Consulting Group at consulting@csh.org. For information about CSH's Texas activities, contact Dianna Lewis dianna.lewis@csh.org.

Inquiries

Readers interested in learning more about supportive housing are encouraged to also visit CSH's website at www.csh.org for additional on-line resources and materials.

*APPENDIX 2:
AUSTIN CITY COUNCIL RESOLUTION #20100325-053*

RESOLUTION NO. 20100325-053

WHEREAS, the City of Austin receives funding from several sources to finance affordable housing projects including general obligation bonds, community development block grants, and other federal and state grants; and

WHEREAS, the 2009 Austin Housing Market Study determined that those earning below \$20,000 in annual income are most at risk of homelessness and showed the greatest need for rental housing among residents with incomes at or below 30 percent of the median family income (MFI); and

WHEREAS, in January, 2010, the Corporation for Supportive Housing analyzed the need for permanent supportive housing and made a recommendation to the Austin/Travis County Reentry Roundtable, Ending Community Homelessness Coalition, and the Mayor's Mental Health Task Force Monitoring Committee that 350 permanent supportive housing units be constructed over the next four years; **NOW, THEREFORE**,

BE IT RESOLVED BY THE CITY COUNCIL OF THE CITY OF AUSTIN:

The city manager is directed to give priority to funding for permanent supportive housing that targets the most vulnerable populations, those residents with annual incomes at or below 30 percent MFI, but continue to fund affordable home ownership, home repair, and rental projects.

BE IT FURTHER RESOLVED:

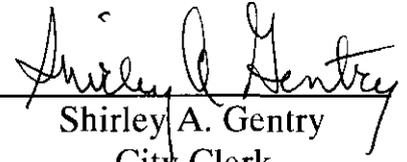
The city manager is directed to work with the Director of Neighborhood Housing and Community Development, the Director of Health and Human Services, and community stakeholders to develop a comprehensive strategy, based on information gathered on best practices in

other cities, that will include both the construction and operation of 350 permanent supportive housing units over the next four years. Community stakeholders should include both governmental and private-sector entities.

The city manager shall present the comprehensive strategy for the permanent supportive housing units to Council before October 1, 2010 and report annually on the status.

ADOPTED: March 25, 2010

ATTEST:


Shirley A. Gentry
City Clerk

**APPENDIX 3:
AUSTIN PERMANENT SUPPORTIVE HOUSING STRATEGY
GUIDING PRINCIPLES**

1. The City's PSH Strategy shall utilize the following definition of Permanent Supportive Housing:

Affordable housing linked to a range of support services that enable tenants, especially the homeless, to live independently and participate in community life. PSH can be offered in diverse housing settings, but usually consists of apartment units that are:

- *Targeted to households earning under 30% of Area Median Income with multiple barriers to housing stability*
 - *Deeply affordable. Rents are subsidized so that the tenant ideally pays no more than 30% of household income towards rent, even where tenants have extremely limited or no income;*
 - *Lease-based. Tenancy is based on a legally-enforceable lease or similar form of occupancy agreement, and there are not limits on a person's length of tenancy as long as they abide by the conditions of the lease or agreement;*
 - *Supported by the availability of a flexible array of comprehensive services, but participation is typically voluntary. The tenant has access to a flexible array of comprehensive services, including, but not limited to, case management, medical, mental health, substance use treatment, employment, life skills, and tenant advocacy, but a lease will not be terminated solely because a tenant chooses not to participate; and*
 - *Managed through a working partnership that includes ongoing communication between service providers, property owners/managers, and subsidy programs.*
2. Housing units produced under the City's PSH Strategy should be compliant with the City of Austin's S.M.A.R.T. Housing Program (Safe, Mixed-Income, Accessible, Reasonably-Priced, Transit-Oriented, & Green Building Standards).
 3. The City's PSH Strategy should use evidence-based models and data-driven solutions as a guide, considering applicability to local conditions, as well as other program models with demonstrated results Evidence-based practices for PSH include Housing First, Harm Reduction, and the use of ACT (Assertive Community Treatment) teams.
 4. The strategy shall address the method or methods to be used to prioritize prospective tenants, including but not limited to models based on serving individuals most costly to public systems while homeless ("frequent users" of public systems), the level of medical vulnerability of the prospective tenant, and the prospective tenant's susceptibility to victimization if homeless.

5. The City's PSH Strategy should support an array of approaches across the housing continuum, including new construction, acquisition/rehab, and scattered-site leasing strategies, to create a comprehensive approach to ending long-term homelessness.
6. The City's PSH Strategy should promote partnerships across public, private, and nonprofit entities to ensure a coordinated, collaborative strategy supported by sufficient and diverse sources of funding
7. The City's PSH Strategy should provide a scalable model that focuses on achieving early successes and expanding the model for future results.
8. The City's PSH Strategy should offer cost-effective solutions that result in the reduction of costs to public systems and leverages existing public and private resources and investments. Potential cost-benefit should be considered in the scoring of potential projects.
9. The City's PSH Strategy should allow for the geographic dispersion of housing units across the city, in areas with amenities suitable to the target population. The strategy should not seek to concentrate PSH units in a single neighborhood.
10. The City's PSH Strategy should promote housing choice and fair housing principles by promoting residential integration through mixed-population and/or mixed-income arrangements.
11. The City's PSH Strategy should seek to reduce barriers to housing for homeless individuals with criminal records.

*APPENDIX 4:
VULNERABILITY ASSESSMENT TOOL (VAT)*



VULNERABILITY ASSESSMENT TOOL

Client Name _____ Staff Name _____

Survival Skills

Vulnerability, safety, dependency on others, ability to maneuver independently in safe manner, judgment

No evidence of vulnerability	Evidence of mild vulnerability	Evidence of moderate vulnerability	Evidence of high vulnerability	Evidence of severe vulnerability
Strong survival skills; capable of networking and self advocacy; knows where to go and how to get there; needs no prompting regarding safe behavior	Has some survival skills; is occasionally taken advantage of (e.g. friends only present on payday); needs some assistance in recognizing unsafe behaviors and willing to talk about them.	Is frequently in dangerous situations; dependent on detrimental social network; communicates some fears about people or situations; reports being taken advantage of (e.g. gave \$ to someone for an errand and person never returned or short changed)	Is a loner and lacks "street smarts"; possessions often stolen, may be "befriended" by predators; lacks social protection; presents w/ fearful, childlike or helpless demeanor; has marked difficulty understanding unsafe behaviors	Easily draws predators; vulnerable to exploitation; has been victimized regularly (e.g. physical assault, robbed); prefers street to shelter; no insight regarding dangerous behavior (e.g. solicitation of sex/drugs) clear disregard for personal safety (e.g. walks into traffic)
0	1	2	3	4

Comments or observations about survival skills: _____

Basic Needs

Ability to obtain / maintain food, clothing, hygiene, etc.

No Trouble Meeting Needs	Mild Difficulty Meeting Needs	Moderate Difficulty Meeting Needs	High Difficulty Meeting Needs	Severe Difficulty Meeting Needs
Generally able to use services to get food, clothing, takes care of hygiene, etc.	Some trouble staying on top of basic needs, but usually can do for self. e.g. hygiene/clothing are usually clear/good	Occasional attention to hygiene; has some openness to discussing issues; generally poor hygiene, but able to meet needs with assistance, e.g. prompting, I&R	Doesn't wash regularly, uninterested in I&R or help, but will access services in emergent situations; low insight re: needs	Unable to access food on own; very poor hygiene/clothing, e.g. clothes very soiled, body very dirty; goes thru garbage & eats rotten food; resistant to offers of help on things; no insight
0	1	2	3	4

Comments or observations about basic needs: _____

Physical / Medical

Physical limitations or medical conditions that impact person's ability to function

No impairment	Temporary impairment	Significant medical or physical issue, or Chronic medical condition that is being managed	Chronic medical condition that is not well-managed or physical impairment	Totally neglectful of physical health, extremely impaired by condition
	Cast x 4 weeks, recovering from surgery	Sight or hearing-impaired; Cerebral Palsy; smaller or larger stature/size making person vulnerable; seizure disorder	e.g. symptomatic & disabling physical illness	e.g. open wound, appears sickly, refusal to get treatment, missing limb
0	1	2	3	4

Comments or observations about physical/medical health: _____

For more information about this tool, or about DESC programs, please contact our Director of Administrative Services at 206-515-1514.

Organization / Orientation*Thinking, Developmental Disability, memory, awareness, cognitive abilities—how these present and affect functioning*

No impairment	Mild impairment	Moderate impairment	High impairment	Severe impairment
Good attention span; adequate self care; able to keep track of appointments	Occasional difficulty in staying organized; may require minimal prompting re: appointments; possible evidence of mild developmental disability; dementia or other organic brain disorder; some mild memory problems	Appearance is sometimes disorganized; has a significant amount of belongings making mobility challenging; occasional confusion w/ regard to orientation; moderate memory or dev. disability problems	Disorganized or disoriented; poor awareness of surroundings; memory impaired making simple follow-through difficult	Highly confused; disorientation in reference to time, place or person; evidence of serious developmental disability; dementia or other organic brain disorder; too many belongings to manage; memory fully or almost or absent / impaired
0	1	2	3	4

Comments or observations about organization / orientation: _____

Mental Health*Issues related to mental health status, MH services, spectrum of MH symptoms & how these impair functioning*

No MH issues	Mild MH issues	Moderate MH issues	High MH issues	Severe MH needs
	Reports feeling down about situation; circumstances	Reports having MH issues, but does not talk about them or reports having service connection already in place, may be taking prescribed medications	Tenuous service engagement, possibly not taking medications that are needed for MH, not interested in services due to mental illness / low insight	No connection to services (but needed clearly), extreme symptoms that impair functioning (e.g. talking to self, distracted, severe delusions/paranoia, fearful/phobic, extreme depressed or manic mood), no insight re: Mental illness
0	1	2	3	4

Comments or observations about mental health: _____

Substance Use*Issues related to substance use, services, spectrum of substance use & how use impairs functioning*

No or Non-Problematic Substance Use	Mild Substance Use	Moderate Substance Use	High Substance Use	Severe Substance Use
No substance use or strictly social – having no negative impact on level of functioning.	Sporadic use of substances not obviously affecting level of functioning, is aware of Sub Use, still able to meet basic needs most of the time	Sub Use affecting ability to follow through on basic needs, has some support available for substance use issues but may not be actively involved, some trouble making progress in goals, e.g. could be a binge user	Sub Use obviously impacting ability to gain/maintain functioning in many areas, e.g. clear difficulty following through with appointments, self-care, interactions with others, basic needs (food, hygiene), not interested in support for substance use issues but this may be due to low insight or other reasons, e.g. mental illness	Obvious deterioration in functioning, e.g. MH, due to Sub Use, severe symptoms of both Sub Use & Mental Illness, low or no insight into Sub Use issues, clear cognitive damage due to substances, no engagement with substance use support services (and clearly needed)
0	1	2	3	4

Comments or observations about substance use OR observed/suspected signs of using drugs/alcohol: _____

Communication*Ability to communicate with others, when asked questions, initiating conversations*

No communication barrier	Mild communication barrier	Moderate communication barrier	High level communication barrier	Severe communication barrier
Has strong and organized abilities; no language barriers; able to communicate clearly with staff about needs	Has occasional trouble communicating needs; language barrier may be an issue; occasionally reacts inappropriately when stressed	Some disorganized thoughts; poor attention span; withdrawn but will interact with staff/service providers when approached; pressured speech; very limited English	Physical impairment making communication very difficult (e.g. hearing impaired & unable to use ASL); unwilling/unable to communicate w/ staff (e.g. shy; poor or no eye contact); doesn't speak English at all	Significant difficulty communicating with others (e.g. mute, fragmented speech) draws attention to self (e.g. angry talk to self/others) refuses to talk to staff when approached; may leave to avoid talking to provider
0	1	2	3	4

Comments or observations about communication: _____

Social Behavior:*Ability to tolerate people & conversations; ability to advocate for self; cooperation, etc.*

Predatory behaviors, and / or no problem; advocating for self	Mildly problematic social behaviors	Moderately problematic social behaviors	Highly problematic social behaviors	Severely problematic social behaviors
Has a hx of predatory behavior: is observed to be targeting vulnerable clients to "befriend"; uses intimidation to get needs met (e.g. threatening and menacing to staff/clients); more than adequately advocates for own needs, if not overly so	Mostly "gets along" in general; if staff need to approach person, s/he can tolerate input & respond with minimal problems; may need repeated approaches about same issue even though it seems s/he "gets it"	Has some difficulty coping with stress; sometimes has angry outbursts when in contact with staff/others; some non-cooperation problems at times	Often has difficulty engaging positively with others; withdrawn and isolated; has minimal insight regarding behavior and consequences; has few social contacts; negative behavior often interferes with others in surrounding; often yells, screams or talks to self	Responds in angry, profane, obscene or menacing verbal ways; may come across as intimidating and off-putting to providers; may provoke verbal and physical attacks from other clients; has significantly impaired ability to deal with stress; has no apparent social network
0	1	2	3	4

Comments or observations about social behaviors: _____

Homelessness*Length of Time Homeless*

Newly homeless	Moderate hx of homelessness	Chronically homeless
Has been homeless less than 1 month; new to the area (e.g. moved here looking for work or only here for the season)	Has been homeless for 1-12 months; few prospects for housing at present	Has been homeless for 1 year + or has had at least 4 episodes of homelessness within the last 3 years; may have no options for housing due to history, ability to participate in process, etc.
0	1	2

Comments or observations about homelessness: _____

**APPENDIX 5:
SAMPLE SCREENING CRITERIA FOR FREQUENT USER APPROACH**

Target users that are frequent users of multiple systems or extremely frequent users of single systems; e.g. in top 5% of a single system, or 10-20% of users of **two or more** systems: substantial crossover anticipated, with

City-funded Systems

- Shelters: ARCH
- Downtown Austin Community Court
- Emergency Medical Services (Transports/Calls)

County-funded Systems

- Travis County Jail frequent users
- Project Recovery
- Mental Health Docket
- Veterans Docket (may be captured in jail data)

Health-Care District Systems

- Emergency Room Visits
- Primary Care Hospitalization Days
- Psychiatric Hospitalization Days (as indicator risk to Psych ER)

For reference, systems that primarily impact state budget

State-borne costs:

- Families with open DFPS Case related to housing instability, History of Out of Home Placement
- Nursing home use
- Psychiatric hospitalization

*APPENDIX 6:
AUSTIN/TRAVIS COUNTY ECHO HOUSING REPORT
SERVICES FOR PERMANENT SUPPORTIVE HOUSING*



**Ending Community Homelessness Coalition (ECHO) Housing Committee
Austin/Travis County, Texas**

Permanent Supportive Housing Services Work Group

August 31, 2010

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**Ending Community Homelessness Coalition (ECHO) Housing Committee
Permanent Supportive Housing Services Work Group
EXECUTIVE SUMMARY
August 31, 2010**

In May of 2010, the City of Austin Health & Human Services Department (HHSD) asked ECHO to identify The types/components of support services, based on best practices, for the 350 units of Permanent Supportive Housing (PSH) identified in a Council resolution that are needed for chronically homeless:

- Individuals
- Youth
- Families

In addition, ECHO was asked to explore the following: the costs of these services, the impact of these services, outcomes to measure success, and possible revenue sources for these services. To create the final report, ECHO researched evidence-based and best practices, conducted nine community input sessions, and conducted a survey of local PSH providers.

Definition of Permanent Supportive Housing: For the purposes of this study, ECHO used the Corporation for Supportive Housing (CSH) definition that identifies the following as the critical components of PSH:

- Tenant pays no more than 30% for housing
- Tenant has a lease
- No limit on tenancy if lease is met
- Flexible/comprehensive array of services
- Proactively engage clients but participation not condition of tenancy
- Effective, coordinated, integrated services

Population to be Served

The Corporation for Supportive Housing identified a high risk target population that has proven to benefit from PSH, as well as a priority population within the target population.

Target Population:

- Homeless or at-risk of being homeless
- Extremely low-income – no higher than 30% of Area Median Income
- Chronic health conditions that are at least episodically disabling, AND
- Not able to obtain or retain appropriate stable housing without easy, facilitated access to services focused on providing necessary supports to the tenant household

Within the target population, there is a very vulnerable and costly population that has been identified as a priority population.

Priority Population:

- Experiencing long-term homelessness

- Chronic health conditions that are at least episodically disabling AND
- Meet definition for chronically homeless often cycling between homelessness and hospitals, jails, prisons, or other emergency systems

Key Findings

Based on the evidence-based practices, community input, and a local PSH survey, following are some of the key findings:

Overall

- There are currently 540 permanent supportive housing units in Travis County but studies show that there is a need for an additional 1,800 such units
- Initially, it is helpful to be able to provide services within the home
- Because of the intensity of need with a chronically homeless population, professionals serving them often “burn-out” or leave. Generally, it takes a more sophisticated and experienced professional to serve these clients and assist them in accessing the services that are needed. Best practices indicate that professionals should have a balanced caseload so that not all their clients have such intense demands.
- The establishment of a professional, strong relationship with a client combined with the ability to use motivational interviewing is critical to success

Case Management

- Case management is a core component of success
- Low case management ratios are critical
- Case management services should focus on housing stabilization
- Services have to be highly individualized

Income Stability

- Studies show higher incomes after 5 years for individuals who earn a high school diploma or equivalent and one year of college credit courses with a credential or certificate, compared to individuals who complete less than one year of college.
- Supported employment is an evidence-based approach for homeless individuals who suffer from substance abuse disorders, severe mental illness, and have a history of involvement with the criminal justice system
- A combination of SOAR training for initial application and the use of legal support for appeals can vastly increase success in clients accessing public benefits

Behavioral Health

- There is an overall lack of behavioral health services available in the community. This includes psychiatric support, substance abuse treatment, and counseling support.
- Peer support models are emerging as an effective practice with chronically homeless individuals in reducing isolation and increasing social skills
- When an individual is suffering from both substance abuse and mental illness, both disorders have to be addressed
- A harm reduction approach is effective with chronically homeless individuals
- Trauma issues have to be addressed as chronically homeless individuals on the streets have often experienced trauma and are vulnerable to victimization

Physical Health

- There is a lack of community respite beds
- There is high physician turnover for physicians serving the homeless and low access to medical care

- Lack of access to nutritious foods and nutritional education
- Lack of access to dental healthcare

Desired Outcomes

Based on community input, the following were identified as the outcomes that should be measured by PSH operators:

- **Housing Stability:** ability to obtain and remain in safe and stable housing and, if exiting, documentation that they are exiting to a safe and permanent housing situation.
- **Involvement with the criminal justice system:** reduction in the number of days spent in jail (for comparison with previous 12 months)
- **Involvement with emergency rooms and emergency psychiatric service providers:** reduction in number of ER visits (for comparison with previous 12 months) and reduction in number of psychiatric hospitalizations (for comparison with previous 12 months). Increased connection to medical care.
- **Income stability:** increase in income, ability to obtain and maintain employment and/or connection and maintenance to mainstream resources such as SSDI
- **Social support and connection:** Participants report a sense of social support and reduced isolation. Participants report a sense of feeling hopeful and cared for and progress toward personal goals
- **Stability for children:** children remain with parents, if appropriate. Children and adolescents attend and remain in school.

Costs

Supportive Service Costs

According to CSH, the costs for supportive housing services vary in projects that have been established, but are generally in the range of \$7,000 to \$13,000 per unit. These costs assume that operating expenses (including maintenance, security, and property management services) are adequately funded and agencies have sufficient cash flow to fund supportive services.

According to a survey, local PSH providers are generally on the low-end of the CSH range, and they report that they are generally under-resourced and thus unable to provide the full-range of services that their clients need.

Recommendations for Services for PSH

Based on the research and community input the following recommendations were identified:

Overall

- Create an integrated approach that incorporates as much client choice as possible.
- Co-locate services whenever possible either using the housing site or an easily accessible site and, whenever possible, provide services in the home and then connect client with services in the community
- Use a team approach to providing services, i.e, the ACT model which incorporates many professionals working together
- Explore utilization of a common intake and vulnerability/cost assessment tool

- Train case managers and health professionals in SOAR to increase the number of successful applications for public benefits
- Train case managers and other professionals in motivational interviewing to increase effectiveness of strategies
- Identify strategies to maximize Medicaid

Case Management

- Use low client to case manager ratios: between 1:8 and 1:10 for families & 1:10-1:12 for individuals. This may be increased to 1:15 -20 once individuals are stabilized
- Initially focus case management on housing stabilization & creating strong relationship between the case manager and the client
- Provide more intense services at beginning (if client wants services)
- Use the harm reduction model with chronically homeless individuals – but be aware of lease challenges & have caution with this approach when children involved
- Train case managers in the SOAR approach for enrolling clients in public benefits
- Explore creation of a PSH case manager certification

Income Stability

- Dedicate staff to employment/training activities
- Provide incentives for positive behavior, such as time on the job
- Provide training for jobs that will provide a living wage
- Create community service opportunities for clients to gain experience
- Create asset building opportunities
- Provide financial management information
- Provide child care

Behavioral Health (Mental Health and Substance Abuse)

- Ensure that dual diagnosis services , including psychiatric support, are available and that substance abuse services can be accessed for at least 90 days
- Identify mental health resources for individuals whose diagnosis do not qualify for Austin Travis County Integral Care (ATCIC)
- Use a cognitive approach, especially with those who are criminal justice involved
- Use peer support and address isolation
- Provide children-centered programming to address their unique trauma
- Ensure housing is not lost if person enters in-patient treatment

Physical Health

- Explore using a centralized intake
- Promote the use of the Medicaider model
- Create stronger partnership with MAP intake workers
- Train physicians and healthcare workers in motivational interviewing
- Provide basic health information to PSH residents and teach them how to manage physical health conditions
- Collect physical health demand and cost data
- Increase the number of respite beds

Additional Recommendations

- Educate landlords and employers regarding how to address clients with behavioral health issues
- Reach out to employers to increase employment opportunities
- Increase connections between Workforce Solutions and PSH operators

Background

Who is ECHO?

The Ending Community Homelessness Coalition (ECHO) is a collaboration of homeless service providers, interested organizations and individuals. ECHO is charged with providing dynamic proactive leadership that engages policy makers and the community in ending homelessness. In order to accomplish this, ECHO engages in a variety of activities including:

- Coordinating the annual Housing & Urban Development (HUD) Continuum of Care application;
- Conducting the annual homeless count;
- Providing outreach through the annual Homeless Resource Fair;
- Serving as the homeless planning entity for the community; and
- Advocating for homeless issues

Why is ECHO involved in identifying services for Permanent Supportive Housing?

ECHO is charged with planning for and ensuring that there is a continuum of services for the homeless and in completing the annual HUD Continuum of Care application. In May of 2010, the City of Austin asked ECHO to identify the types of services that should be incorporated into a Permanent Supportive Housing (PSH) approach.

The Housing Inventory chart completed annually by ECHO for the HUD Continuum of Care process demonstrates an overall lack of Permanent Supportive Housing in Travis County with a specific lack of PSH available for the chronically homeless. In addition, the PSH units that are developed often are not available to people with criminal histories.

Austin City Council Resolution

In early 2009, like many other communities, ECHO initiated an effort to update the *10 Year Plan to End Chronic Homelessness* to include current data and resources, with the goal of creating a living document that would help guide their ongoing efforts to end homelessness in Austin/Travis County. This goal was achieved in the subsequent *Plan to End Community Homelessness*. In 2009, the Corporation for Supportive Housing was retained by ECHO, the Mayor's Mental Health Task Force Monitoring Committee, and the Austin/Travis County Reentry Roundtable to provide analysis on PSH that would help strengthen the next iteration of the 10-year plan. Based on the CSH report recommendations, the Austin City Council passed the following resolution to result in the construction of 350 new units of permanent supportive housing.

RESOLUTION NO. 20100325-05

WHEREAS, the City of Austin receives funding from several sources to finance affordable housing projects including general obligation bonds, community development block grants, and other federal and state grants; and ' WHEREAS, the 2009 Austin Housing Market Study determined that those earning below \$20,000 in annual income are most at risk of homelessness and showed the greatest need for rental housing among residents with incomes at or below 30 percent of the median family income (MFI); and

WHEREAS, in January, 2010, the Corporation for Supportive Housing analyzed the need for permanent supportive housing and made a recommendation to the Austin/Travis County Reentry Roundtable, Ending Community Homelessness Coalition, and the Mayor's Mental Health Task Force Monitoring Committee that 350 permanent supportive housing units be constructed over the next four years;

NOW, THEREFORE, BE IT RESOLVED BY THE CITY COUNCIL OF THE CITY OF AUSTIN:

The city manager is directed to give priority to funding for permanent supportive housing that targets the most vulnerable populations, those residents with annual incomes at or below 30 percent MFI, but continue to fund affordable home ownership, home repair, and rental projects.

BE IT FURTHER RESOLVED:

The city manager is directed to work with the Director of Neighborhood Housing and Community Development, the Director of Health and Human Services, and community stakeholders to develop a comprehensive strategy, based on information gathered on best practices in other cities, that will include both the construction and operation of 350 permanent supportive housing units over the next four years. Community stakeholders should include both governmental and private-sector entities.

The city manager shall present the comprehensive strategy for the permanent supportive housing units to Council before October 1, 2010 and report annually on the status.

Adopted: March 25, 2010

Charge to the ECHO Housing Committee Services Work Group

The City of Austin Health & Human Services Department (HHSD) asked ECHO to identify the following by August 31st, 2010:

2. The types/components of support services, based on best practices, that are needed for chronically homeless:
 - Individuals
 - Youth
 - Families
3. The costs of these services
4. The impact of these services
5. Outcomes to measure success
6. Possible revenue sources for these services

In addition, the committee was charged with supporting the City's comprehensive strategy and planning process for the 350 units of permanent supportive housing by:

- reviewing the recommendations from:
 - Corporation for Supportive Housing's *Permanent Supportive Housing Program and Financial Model for Austin/Travis County, Texas*
http://www.ci.austin.tx.us/housing/downloads/csh_austin_travis_model_rpt.pdf ,
 - the Austin/Travis County CSH Texas Re-entry Initiative Report http://atc-reentryroundtable.org/issue_areas/ATCCSHTXReentryExecutiveSummary.pdf
 - and the ECHO White Paper
<http://www.caction.org/homeless/documents/SolutionsHomelessChronicAlcoholicsAustin.pdf>
- working through HHSD and ECHO to request that the City of Austin's Neighborhood Housing & Community Development's process for funding the units includes strong community engagement with clear timelines

Current demand: While the annual housing inventory and the CSH report demonstrate the need for over 1,800 additional units of permanent supportive housing, local participants in the process identified some of the impacts of the demand. During the community input process, it was discovered that local providers are experiencing high demand for their PSH units. For example, Mary Lee Foundation receives approximately 10 inquiries a week from people who are homeless and seeking their housing services, Austin Travis County Integral Care (ATCIC) reports receiving 5-10 calls per day from people seeking supportive housing, and Saint Louise House receives 50 requests per week for PSH units for single women and families.

Methodology: The following methodologies were used to create the report.

Definitions: In order to create a common understanding of terms being used the following HUD definitions for homeless and chronically homeless individuals:

***Homeless:** an individual living outside or in a building not meant for human habitation or which they have no legal right to occupy, in an emergency shelter, or in a temporary housing program which may include a transitional and supportive housing program if habitation time limits exist.*

***Chronically Homeless:** An unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more, or has had at least four episodes of homelessness in the past three years*

***Evidence Based Practices** – Approaches that are supported by systematic, empirical research using statistical analysis to demonstrate effectiveness.*

***Best Practice** - A superior method or innovative practice that contributes to the improved performance of an organization, usually recognized as "best" by other peer organizations. It implies accumulating and applying knowledge about what is working and not working in different situations and contexts, including lessons learned and the continuing process of learning, feedback, reflection and analysis (what works, how and why).*

Research of evidence-based practices: Research was conducted on best and evidence-based practices for case management, income stability, behavioral health, and physical health services and the results were summarized and presented at the community input sessions. While communities are engaging in successful innovative models, this type of rigorous research has simply not been conducted in some areas to demonstrate effectiveness. The results of the research are included in this report.

Community Input

From June 11th to August 24th, 2010, ECHO held 9 meetings in order to facilitate discussions around the services that should be included as part of permanent supportive housing. In addition, The City procured the Corporation for Supportive Housing as a consultant to assist in developing the City's PSH Strategy. Three community stakeholder meetings will be held to solicit public input on the strategy and those results will be reported separately.

<u>ECHO PSH Services Committee Sessions & Meeting Dates</u>
<ul style="list-style-type: none"> • Initial Meeting - June 11, 2010 • Case Management - June 29, 2010 • Behavioral Health - July, 2010 • Income Stability - July, 2010 • Project Review - July 16, 2010 • Physical Health - July 20, 2010 • Youth and Families - July 28, 2010 • Survey Review - August 9, 2010 • Final Report Review - August 24, 2010

The following 34 agencies were represented in the services focused meetings:

- | | |
|---|---|
| AIDS Services of Austin | Goodwill Industries of Central Texas |
| Austin Recovery | Green Doors |
| Austin Travis County Emergency Medical Services | LifeWorks |
| Austin Travis County Integral Care | Mary Lee Community |
| Austin/Travis County Reentry Roundtable | National Alliance on Mental Illness Austin |
| Caritas of Austin | SafePlace |
| Central Health | Salvation Army |
| City of Austin HHSD | Seton |
| City of Austin NHCD | St. David’s Community Health Foundation |
| Community Action Network | St. Louise House |
| Corporation for Supportive Housing | Texas Rio Grande Legal Aid |
| Crime Prevention Institute | Travis County Adult Probation |
| Downtown Austin Community Court | Travis County Criminal Justice Planning |
| Ending Community Homelessness Coalition | Travis County District Attorney’s Office |
| Foundation Communities | Travis County Health & Human Services & Veterans Services |
| Foundation for the Homeless | Travis County Sherriff’s Office |
| Front Steps | Trinity Center |

Overview of Permanent Supportive Housing (PSH)

Core Components

Permanent supportive housing is permanent, affordable housing linked to a range of support services that enable tenants to live independently and participate in community life. It is a cost effective and successful alternative to more expensive and less efficacious emergency services or institutional settings.

Supportive housing units are intended to meet the needs of people with special needs who are homeless or would be at-risk of homelessness – or cycling through institutions - were it not for the integration of affordable housing and supportive services. CSH has also defined the following dimensions of quality for supportive housing. Detailed information can be found at:

Usual Core Components of Permanent Supportive Housing:

- Tenant pays no more than 30% for housing
- Tenant has a lease
- No limit on tenancy if lease is met
- Flexible/comprehensive array of services
- Proactively engage clients but participation not condition of tenancy
- Effective, coordinated, integrated services

Source: Corporation for Supportive Housing

<http://documents.csh.org/documents/Quality/SevenDimensionsQualityIndicatorsWEBFINAL.pdf>



Source: Corporation for Supportive Housing

Population to be Served

The Corporation for Supportive Housing identified a high risk target population that has proven to benefit from permanent supportive housing, as well as a priority population within the target population.

Target Population:

- Homeless or at-risk of being homeless;
- Extremely low-income – no higher than 30% of Area Median Income (AMI)
- Chronic health conditions that are at least episodically disabling; and
- Not able to obtain or retain appropriate stable housing without easy, facilitated access to services focused on providing necessary supports to the tenant household

Within the target population, there is a very vulnerable and costly population that has been identified as a priority population.

Priority Population:

- Experiencing long-term homelessness

- Chronic health conditions that are at least episodically disabling AND
- Meet definition for chronically homeless often cycling between homelessness and hospitals, jails, prisons, or other emergency systems

Current State of Local Permanent Supportive Housing

In 2008, ECHO re-focused its priorities in the continuum of care process to prioritize permanent supportive housing. Since that time, the community has prioritized PSH projects in the annual continuum of care application process and ECHO has advocated for additional units through local funding sources as well.

PSH beds designated for the homeless in Austin/Travis County:

Each year Austin /Travis County participates in the HUD required annual homeless count and reports the number of beds that are available that night. The count is generally completed during the last week of January. In 2010, it was conducted on February 4th. In the 2010 count, there were 2,087 homeless persons identified. The numbers in the following charts reflect the number of beds available on the night of the count. The permanent housing chart does not include all the units that were funded through the local Homeless Prevention & Rapid Re-housing Program (HPRP) funding as those units were not on-line at the time of the inventory.

Austin/Travis County CoC PSH Beds 2008 - 2010				
Permanent Supportive Housing	2008	2009	2010	Change In 24 months
Individual beds	305	392	471 (plus an additional 25 beds in development)	+166
Family beds	87	73	69	- 18
TOTAL	392	465	540	+ 148

Source: Austin/Travis County Continuum of Care

Beds for the Chronically Homeless in Austin/Travis County		
Year	Number of Chronically Homeless Persons	Number of Permanent Housing beds for the Chronically Homeless
2005	258	20
2006	258	20
2007	443	40
2008	919	45
2009	555	57
2010	982*	125

**While it appears that the number of chronically homeless increased, it is more likely a function of better trained survey administrators who asked the questions to determine chronically homeless status during the annual count.*

Need for an Integrated and Individual Approach

PSH is designed for individuals and families who have faced multiple challenges such as mental illness, substance abuse disorders, lack of job skills, insufficient income, untreated physical health challenges, untreated trauma, and a history of involvement with the criminal justice system, and are unable to find and maintain housing on their own. “People experiencing chronic homelessness have often been described as markedly mistrustful and suspicious of service providers, and highly value their autonomy” (e.g., Francis and Goldfinger, 1986)ⁱ. Because of the challenges in trusting the system and complexity of the needs, each individual needs to undergo an individual assessment that assesses vulnerability, cost to current services, and service needs and then be provided options for housing and services that are part of an integrated system that allows them as much choice about housing and service options as possible.

Evaluation Components

Based on the feedback of the process participants and best practices, it is recommended that the following data and evaluation components are measured as part of any PSH project that is developed;

- **Housing Stability:** Increase in the availability of permanent supportive housing units, the ability to obtain and remain in safe and stable housing and, if exiting, document whether they are exiting to a safe and permanent housing situation;
- **Involvement with the criminal justice system:** reduction in number of days spent in jail (for comparison, with previous 12 months);
- **Involvement with the emergency rooms and psychiatric services:** reduction in number of Emergency Room visits (for comparison with previous 12 months) and reduction in the number of psychiatric hospitalizations (for comparison with previous 12 months). Increased connection to primary medical care;
- **Income stability:** increase in income, ability to obtain and maintain employment and/or obtain and maintain mainstream resources such as Social Security Disability Income;
- **Social support and connection:** participants report a sense of social support and reduced isolation. Clients report a sense of feeling hopeful and cared for and progress toward personal goals; and
- **Stability for children:** children remain with parents, if appropriate. Children and adolescents attend and remain in school.

Case management

Evidence-based Practice Research

Case management is a broad, loosely defined term utilized across a variety of human services settings. In the last several decades, it has become the foundation of efforts to serve individuals experiencing homelessness. Models vary widely depending on the needs of the clients. Not coincidentally, there are significant gaps in research assessing the effectiveness of case management. There is very little information about the cost-effectiveness of providing homeless case management services.ⁱⁱ

However, in the context of PSH, there are promising practices that have demonstrated positive outcomes for the priority/target population identified in this report. When housing stability is the primary focus of a case management service, research has demonstrated decreased utilization of hospitals, jails, emergency shelters, and other public services, as well as improved quality of life. The complexity of needs that confront this population suggests case management is a linchpin that is a strong determinant of success in PSH.

In simple terms, a case manager provides the following services:

- outreach
- assessment
- planning
- service linkage
- monitoring
- advocacy
- follow-up

The role of a case manager is to provide a single point of accountability to promote residential stability and independent living.ⁱⁱⁱ A case manager may also provide some direct services, including support and counseling, medication monitoring, and assistance with daily living skills. Another component of the case manager's role is linking clients to resources and advocating for them to receive benefits for which they qualify.

Because participation in support services is not a condition of tenancy in PSH, efforts to proactively engage the tenant are important. As noted, the target/priority population is often service resistant and mistrustful of service providers. Case managers should possess a skill set conducive to meeting the tenant on their own terms and allow for as much client choice as possible. Evidence-based practices emphasize the need for trusting relationships between case managers and clients as well as the need for the case manager to be integrated into a team approach. Additionally, research suggests that case management will always fall short if intervention techniques are not specific and realistic. Service delivery for the target/priority population should focus on:

- assertive, community-based outreach,
- developing a nurturing, trusting and caring relationship,
- respecting client autonomy,
- prioritizing self-determined needs, and
- providing active assistance in obtaining resources.^{iv}

A study of homeless individuals who suffer from serious mental illness demonstrates that a strong therapeutic alliance is associated with fewer days in homelessness.^v Generally, a therapeutic alliance is characterized by two factors:

1. the quality of the interpersonal relationship between case manager and client, and,
2. the degree to which the client is engaged in treatment services.

Social service organizations that provide or work with PSH programs should ensure that case managers have a set of core competencies including:

- knowledge of homelessness and the ability to engage and develop trusting relationships with a population that is often service resistant
- specialization in various disciplines such as mental health, substance abuse and employment
- HIV/AIDS education and prevention
- psychosocial assessments
- suicide assessment and prevention
- crisis intervention
- comprehensive knowledge of local services and resources
- case management approaches and methods
- individualized service planning
- burnout prevention.^{vi}

Permanent Supportive Housing programs should clearly define organizational practices. This serves in part to empower case managers and allows them operate in a flexible environment in order to meet the complex needs of tenants. Empowerment and flexibility can increase the likelihood of success when working with service resistant clients.^{vii}

Organizational Practices for Case management	
Training	Provide initial and ongoing educational opportunities
Intervention	Should be focused, specific and realistic
Quality Assurance	Include treatment specification and implementation evaluations
Outcome Evaluations	Internally assess needs and progress of clients served
Data	Utilize to implement quality improvements
Service	Promote attitudes and practices that result in service adaptation and innovations
Partnerships	Engage state and local governments, and other sources to support ongoing funding of case management services

Local Case management Practices

What Works: Based on the expertise of the input session participants the following were identified as case management practices that work locally for chronically homeless clients in permanent supportive housing:

- Using a team or partnership approach that incorporates strong communication between partners;
- Having resourceful, well-trained case managers who are skillful at negotiating the complex systems that clients have to navigate;
- Using a client-centered approach that provides options of services to the client;
- Using a strength-based approach and motivational interviewing;
- Linking clients to psychiatrists and medication;
- Linking clients to substance abuse treatment;
- Using policies and practices that create low barriers to housing;
- Using a harm reduction strategy;

- Using the Homeless Management Information System to share, with permission, client information;
- Connecting participants with mainstream services;
- Maximizing the use of Medicaid to pay for services; and
- Having a mix of clients at a site and creating a sense of community.

On-going Challenges

Local service providers identified the following challenges for effective case management:

- Lack of documentation, including birth certificates, social security cards, etc.;
- Lack of housing options for people with criminal backgrounds;
- Funding streams often create a service focused rather than a client focused approach;
- Prior legal issues such as unpaid parking tickets, unpaid child support, et. al. often require legal representation;
- Conflicts can occur between the roles of property manager and case manager when an organization both manages the property and provides case management; and
- Lack of client income drives the need for deep rental subsidies. The majority of local PSH residents have incomes that are 10-15% of median area income.

Case management Ratios:

Both evidence-based and local practices indicate that for a chronically homeless population higher intensity case management services are often needed at the beginning of the engagement and therefore lower case management ratios are more effective. Additionally, if clients are being served at scattered sites and on-site case-management is not available, then ratios will need to be lower as case managers will require time for travel.

Evidence-based practice

Case manager to client ratios, duration and intensity are important factors to consider when developing a PSH program. Many successful PSH programs place a strong emphasis on high-intensity case management and frequent contact upon entry. In general, ratios should range from 1:10 to 1:20. Lower case loads are recommended for the priority population.

Local Practice:

Survey of local PSH providers identified that local practices for case management ratios are in alignment with national recommendations. In order to reduce the levels of burn-out that are often associated with a high caseload of highly vulnerable clients, organizations often split case-manager caseloads into thirds based on intensity with only one-third focused on higher needs clients.

National/Local Case Management Ratios:

- **Families:** a ratio of one case manager to every 8-10 families
- **Initial engagement chronically homeless individuals:** One case manager to every 10-12 individuals
- **Once clients have been engaged and are stable:** Local providers indicated that ratios may be increased to closer to one to every 15-20 individuals

Case Management Opportunities to Explore:

- Use a common vulnerability assessment tool that includes an assessment of housing.
- Consider local certification of case managers to ensure a common level of training in these complex issues.
- Partner with the court and corrections systems to screen people into permanent supportive housing opportunities.
- Create stronger connections between the criminal justice and service providing systems while maintaining a separation between housing status and criminal justice requirements.
- Explore ways to provide clients more options for their housing and services. This includes more flexible funding sources.
- Consider not placing time limits on case management support.

Income Stability

Income stability is critically important to maintaining and stabilizing the chronically homeless in housing. Based on the individuals' capacities, this may take the form of regular employment, training and education, and/or enrollment in public benefits.

Evidence-based Practice Research

Employment

The need for stable employment at a decent wage is one important factor in moving people from the streets into stable housing. Studies show higher incomes after 5 years for individuals who earn a high school diploma or equivalent, and have one year of college credit courses with a credential or certificate, compared to individuals who complete less than one year of college.^{viii} When homeless individuals were asked about their most immediate needs, a majority cited unemployment and the inability to find and retain affordable housing.^{ix} The target/priority populations often face significant psychological and social barriers to obtaining and maintaining employment including the following:

- Fear of losing public benefits
- Limited or no family support
- Hidden barrier to employment (e.g. criminal conviction)
- Past or current substance abuse issues
- Problems relating/weak communication skills
- Fear of asking for or applying for jobs^x

Supported employment (SE) is a specific approach designed to assist people with disabilities to maximize their level of participation in the workforce. Depending on individuals needs, it provides for different levels of professional support to place people in the competitive labor market. The federal government defines SE as:

Competitive work in integrated work settings in which individuals are working toward competitive employment, consistent with the strengths, resources, priorities, concerns, capabilities, interests and informed choice of the individuals, for individuals with the most significant disabilities for whom competitive employment has not traditionally occurred.^{xi}

As the definition implies, supported employment aligns with the key components of success in PSH, maximizing client choice and integration of services. It can be applied across a broad range of clients and settings.^{xii} Supported employment has been identified as an evidence-based practice for homeless individuals who suffer from substance abuse disorders with a history of involvement in the criminal justice system.^{xiii} There is also substantial research that demonstrates SE results in positive vocational outcomes for people with serious mental illness (SMI).^{xiv} Some evidence suggests that optimal employment outcomes occur when clients with SMI are also receiving adequate case management services. Annual costs for SE are \$2000 to \$4000 per participant. This is on par with the cost of traditional vocational programs^{xv}

Qualities for Long-Term Success in Supported Employment	
Accessibility	Assuring proximity to potential participants
Inclusiveness	Serving any tenant who asks for assistance, rather than designing services based on certain criteria, such as individuals considered to be job-ready
Flexibility	Developing a variety of tools for people with different skill sets (education, soft-skills, on and off-site training, a range of full and part-time work)
Standing Offer of Work	A variety of options, including internships, on-site jobs and outside employment to increase options for participants in training programs
Coordinated and Integrated Approach	Creating a dialogue between case managers, vocational counselors, employers, job coaches and employers
Emphasize High-Quality, Long Term-Employment	Work with clients before, during and after with the goal of finding and keeping high-quality jobs
Linking to Private and Public Sector	Helps to build new job opportunities, leverage resources and indentifies new approaches to serving participants

Customized employment is a preferred practice for U.S. Department of Labor (DOL) funded programs.^{xvi} It is a specific approach to supported employment that incorporates principles and interventions designed for individuals with complex needs and barriers to employment. The process involves determining the strengths, needs and desires of the client, as well as the specific needs of the employer. The result is employment with responsibilities that are customized and negotiated.

Individual Placement and Support (IPS) is an evidence-based model for people with severe mental illness.^{xvii} IPS is successful in part because it adopts an integrated approach where the employment specialist is an essential part of the case management team. Employment services that are brokered out to a separate agency have been shown to be a counterproductive approach.^{xviii} The employment specialist assists throughout the process, including engagement, assessment, job search, job placement and job training. Individual Placement and Support is

different from traditional employment models in that it emphasizes rapid placement in community-based competitive employment.

Peer Support is an emerging evidence-based practice that is utilized in supported employment programs, in particular for individuals with SMI. It is a consumer-driven approach whereby mental health consumers provide social and emotional support to each other. In an employment setting, peer support can offer social and emotional support to another mental health consumer to aid in recovery and improve employment outcomes. An example of a peer support arrangement is having a mental health consumer working on a treatment team to assist in recovery of another consumer. Peer support may be either voluntary work or a paid position.

In Texas, Peer Support is eligible for Medicaid reimbursement if services are provided by a Certified Peer Specialist. A certification program is offered, with support from the Texas Department of State Health Services. (Daniels, A. et al, 2010)

Public Benefits

The ability to access public benefits such as Social Security Income (SSI) and Social Security Disability Income (SSDI) provides income stability for some clients who are unable to work because of significant disabilities. SSI/SSDI may also automatically qualify a client for other public benefits, including Medicaid and Food Stamps (now called SNAP in Texas). Only an estimated 11% of the overall homeless population receives SSI/SSDI.^{xi} Consistent income is a critical factor in housing stability. The defining characteristics of the target/priority population suggest that there is a gap in services to assist individuals in obtaining benefits.

The experience of homelessness creates barriers to accessing these public benefits. Many individuals who are homeless lack even basic documentation, such as an identification card. Furthermore, the extensive medical information necessary for applications requires gathering documentation from a variety of sources. Those who are able to apply are often denied because Disability Determination Services (DDS) is not able to reach the applicant to request more information.^{xx}

SSI/SSDI Outreach, Access and Recovery (SOAR) is a best practice training model with a high rate of approval for applications. In 1993, the City of Baltimore initiated an SSI outreach project for homeless people with severe mental illness using the SOAR model. Since its inception, the program has achieved a 95% approval rate on initial applications. It has been named a Best Practice by the National Alliance to End Homelessness (NAEH) and an Exemplary Practice by the Federal Substance Abuse and Mental Health Services Administration (SAMHSA).^{xxi} A detailed description of the SOAR model can be found in Appendix A.

Bill Payer Programs

Bill payer services are often volunteer-based programs that promote independent living for people who are unable handle their own finances. The AARP Money Management Program is a frequently used model, and is offered through state and local governments and non-profit agencies.^{xxii} The model is easily adaptable to a PSH setting to assist clients with limited incomes to afford their housing and other basic needs. Bill payer programs include two distinct components:

1. bill payer service
2. representative payee service

The bill payer program offers assistance such as organizing and paying bills and checking account reconciliation. The client remains in control of their own finances. The representative payee program is used when the client is determined to be unable to handle their own finances. The representative payee manages the client's funds on their behalf.

Youth and Families

Unaccompanied youth, who are aging out of foster care, and families merit special mention when considering strategies to promote income stability. The most significant barrier to educational success for homeless youth is struggling to meet basic needs and to manage the daily emotional and physical stress of homelessness. Studies, anecdotal evidence (including the experience of educators), and interviews with homeless youth indicate that most want to go to school and think their education is important. However, up to 75% of homeless youth do not finish high school.^{xxiii} Strategies for homeless youth should focus on providing a continuum of services to promote connection with the educational system.

Families coming out of homelessness often struggle to balance the myriad of personal and institutional responsibilities. A majority of these households are headed by a single parent. Responsibilities can include requirements related to probation/criminal justice involvement, child and family protective services, substance abuse recovery and relapse prevention, as well other requirements related to maintaining a safe and stable living environment for children. One simple, but effective strategy is to gather all parties around the table to develop a schedule that allows the client to meet all of their obligations. This can reduce stress and allow the client to focus on achieving employment.

Local Practices

What Works:

- Peer support models whereby individuals participate either with a formerly homeless peer or in a group of peers where they learn both concrete skills in searching for employment as well as soft skills, and they can receive support;
- Dedicated staff focused on employment, benefits enrollment, and training issues and can be part of a team working with the individual;
- Internships and community services opportunities where individuals can learn, practice their skills, gain experience, and receive feedback;
- Financial management training and asset building programs which provide individuals with the opportunity to better manage the financial resources they do gain and then to build their assets. Based on provider experience, it generally it takes about 12 months of housing stability before a person begins to focus on asset development;
- Incentives for maintaining employment: The provision of bus passes, gift cards, etc when meeting employment or job training goals has proven effective in assisting in maintaining employment;
- SOAR training for case managers: Case managers who have trained in SOAR have consistently higher positive response rate that result in clients receiving public benefits on their initial application;
- Texas Rio Grande Legal Aid: Legal assistance has proven effective with clients whose applications have been denied for public benefits. Legal assistance providers are engaged at the

point of the first denial. And work on the appeal. The effectiveness increases when there is clear communication between the case manager and the legal assistance provider;

- City of Austin Youth Development Employment Program: Provides low-income youth (16-23 yrs. of age) with opportunities to gain experience and earn some money. This may be a model that has components to explore for homeless individuals;
- Downtown Austin Community Court: Community Court provides landscaping and graffiti abatement workforce experience through its community service restitution program. This has proved useful in assisting some participants with finding employment;
- Skillpoint Alliance: Offers construction and electronic gateway programs which may be resources for the chronically homeless;
- The City of Austin and Travis County have instituted the 'Ban the Box' initiative which removes the question about criminal history from the initial employment application; and
- In Travis County, there are a number of organizations with staff who are certified as "Offender Workforce Development Specialists" by the National Institute of Corrections and provide training in our community to certify other persons as Offender Employment Specialists.

On-going Challenges:

- **Underemployment and lack of jobs that pay a living wage.** Many of the homeless individuals who do obtain employment are either underemployed or the low income makes it difficult to find and maintain housing
- **Lack of access to job training programs and education** that lead to a living wage.
- **Lack of job training and employment opportunities for people with criminal histories:** While Project Rio, Travis County, and Goodwill Industries provide training for people with criminal histories and have successfully reached out to employers to encourage them to hire people with criminal histories, both programs are under-resourced
- **Lack of documentation.** Individuals lack and/or have lost documentation such as birth certificates or other types of documentation that will allow them to work and/or qualify for benefits.
- **Lack of child care:** Parents are faced with not only an overall lack of affordable childcare options, but the availability of childcare if working on nights or weekends is especially limited.
- **Unwillingness to take certain jobs that are available.** Some individuals refuse to work at jobs that are available either because of the type of work or the wages that are being paid
- **Lack of transportation supports.** Navigating public transportation between housing, day care, school and work can be challenging and public transportation is not an option for those working late at night, before 5 am or on Sunday. Those who lease or purchase cars often find they cannot afford to maintain, park, or insure the vehicle and new problems ensue that affect income and housing stability. In addition, Capital Metro is considering cut-backs on medical and mobility impaired transportation services that would likely impact the PSH population.
- **Lack of paid work leave to attend to sick family members.** Very low income parents and adult children of parents with disabilities are unlikely to hold jobs which will give them paid leave or any leave to attend to sick or disabled family members. This makes them more vulnerable to job loss.

Income Stability Opportunities:

- **Create community service/volunteer opportunities:** Identify opportunities whereby individuals experiencing chronic homelessness can participate in community service or volunteer activities

- **Educate individuals and case managers on the employment opportunities in which individuals can participate without losing their benefits.** There appears to be a fear and lack of information about how much income someone receiving benefits can receive without losing their housing and benefits.
- **Expand outreach to employers:** Provide employers with information and connection to the services that are offered to individuals who are in permanent supportive housing
- **Expand connections with Workforce Solutions:** ECHO to work with Workforce Solutions to identify potential training and employment opportunities for chronically homeless individuals as well as to identify potential resources to fund these opportunities. May want to explore providing workforce information at the permanent supportive housing sites.
- **Increase case manager training in the SOAR approach:** Since it has proven to be an effective method for increasing the initial approval for public benefits, it was recommended that case managers are trained in the SOAR method.
- **Increase the collaboration between case managers and Legal assistance providers.** Increased communication between legal providers and case managers should result in increased success at obtaining benefits at the time of the first appeal.
- **Focus on asset building.** Once chronically homeless individuals and families are stabilized, offer financial management and asset building opportunities such as individual development accounts.

BEHAVIORAL HEALTH

Evidence-based Practice Research

The U.S. Department of Health and Human Services' Substance Abuse and Mental Health Service Administration (SAMHSA) indicates that nearly 40% of the homeless experience some type of mental illness, with 20-25% suffering from serious mental illness.

Behavioral Health is continuum of services for people who are at risk of or suffering from mental illness, addiction or other behavioral health disorders.^{xxiv} The priority/target populations suffer from high rates of behavioral health disorders. Untreated severe and persistent mental illness (SMI) and substance abuse disorders (SA) are precipitating factors leading to homelessness, and often serve to perpetuate it. Establishing the prevalence of behavioral health disorders and associated utilization of public services in the homeless population presents difficulties. However data from multiple sources indicate the following:

- Some studies report an 80% prevalence rate of substance abuse disorders
- Up to 50% have co-occurring mental health and substance abuse disorders
- 52% of hospital admissions are for mental health and substance abuse disorders (compared to 23% for low-income non-homeless)^{xxv}

In Austin this would suggest that, using the model's conservative estimate of total individuals experiencing homelessness, between 1175 (20%) and 1469 (25%) experience severe and persistent mental illness (SPMI). The *2010 CSH Financial Model for Austin/Travis County* suggests that among the chronically homeless, these numbers increase dramatically, with around 35% of the chronically homeless estimated to be living with severe and persistent mental illness. In the case of Austin, this would correspond to around 322 individuals in the chronically homeless population. Because of the high incidence of substance abuse among the chronically homeless,

co-occurring mental health and substance use disorder will be extremely prevalent among this population.

The priority/target population faces significant barriers to accessing services, from both an individual and institutional perspective. Rosenheck and colleagues surveyed homeless individuals entering into an Access to Community Care and Effective Services Supports (ACCESS) program, an initiative of the Centers for Mental Health Services. ACCESS was a demonstration project designed to identify effective approaches for systems integration for homeless individuals with serious mental illness (SMI). Four common barriers to accessing services were identified by the individuals surveyed:

- Not knowing where to go for services
- Inability to afford services
- Experiencing confusion, hassle or waiting for services
- Previously being denied services^{xxvi}

The following mental health and substance abuse interventions have proven to be effective and should be considered as part of the permanent supportive housing services approach.

Assertive Community Treatment (ACT) is a service-delivery model that provides comprehensive, multidisciplinary, community-based treatment to people with SMI. While it may be viewed as a population-specific case management model, it differs from traditional case management practices in that it uses a team approach to provide direct treatment and other support services. Among other characteristics, ACT calls for continuous assertive engagement, high intensity, individualized services, low caseloads, 24 hour staff availability and shared accountability among team members.^{xxvii} A detailed description of the ACT model can be found in Appendix B.

ACT is a widely researched, evidenced-based practice and has been successfully adapted to serve individuals experiencing homelessness with severe mental illness. While ACT is not the only effective intervention for serving this population, it is highly defined, clear and specific in program principles, functions and operations.^{xxviii} Fidelity to the model is associated with improved client outcomes.^{xxix} It should be noted that implementing and operating an ACT program is resource intensive and can be costly. Communities and PSH providers should consider these and other factors when designing a service model plan for transitioning homeless individuals with SMI into PSH.

Cognitive-Behavioral Therapy (CBT) is an evidence-based practice that is effective for individuals with criminal justice involvement. Numerous studies have demonstrated that CBT is the most effective intervention for reducing future criminal behavior and recidivism. It can be applied in both institutions and community setting, and with a broad range of offenders, including juveniles, adults, and violent offenders.^{xxx} Other mental health treatment approaches are highlighted below.

Mental Health Treatment Models and Approaches	
Assertive Community Treatment	Focuses continuous assertive engagement, high intensity, individualized services, low caseloads, 24 hour staff availability and shared accountability among team members.
Intensive Case Management	Similar to ACT in focus on assertive and persistent outreach, reduced caseloads, and active assistance in accessing needed resources. Frequent services contact is critical ingredient to improving treatment outcomes and achieving stable housing
Illness Management and Recovery	Core component is illness self-management training, including recognizing symptoms and signs of relapse, managing and reducing stress and understanding the side effects of medications.
Critical Time Intervention	Focuses on providing emotional and practical support during transition from shelter to housing and on developing and strengthening long-term ties to other services and supports
Strengths Model	Focuses on environment and individual client, use of paraprofessional staff, emphasis on client strengths instead of weaknesses and places priority on client directed interventions
Motivational Interviewing	A counseling intervention designed to tap into the intrinsic motivation of an individual in order to resolve ambivalence. Designed to elicit responses and engagement, thereby facilitating a client-driven treatment and recovery plan. Can be used with distinct populations, including families, veterans, and individuals with co-occurring disorders, and re-entry populations.
Psychosocial Intervention	A primary component of family intervention. Helps to establish a collaborative relationship between the treatment team and the family and helps family members to understand the nature and complexity of SMI. The objective of this approach is to decrease stress and tension, and promote social support and empathy. In PSH, this may help to promote family unification and housing stability.
Cognitive-Behavioral Therapy	Models and approaches focus on rational self-counseling skills by teaching clients how to think differently. Based on the idea that thoughts cause our emotions and behaviors, not external events. Proven especially effective with individuals involved in the criminal justice system.

Peer support was highlighted as an approach to SE in the income stability section of this report. It is also an established component in the system of mental health care. Numerous government reports on mental health, dating back to the Carter Administration have emphasized that a part of mental healthcare system transformation should promote the idea of consumer-driven recovery approaches. Peer support align with this concept, and is an approach that is well-suited for PSH, in particular place-based and population specific projects.

Homeless individuals with substance abuse (SA) disorders are a highly visible population and account for high costs within the healthcare and criminal justice systems. Long-term SA is also associated with acute and chronic medical conditions.^{xxxvi} Alcohol is the most common substance of choice. Typical interventions such as shelters, abstinence-based housing and treatment programs fail to work for chronically homeless individuals with long histories of substance abuse.^{xxxvii} Additionally, individuals with a primary diagnosis of substance abuse may not be eligible for SSI/SSDI and other public benefits.^{xxxviii}

Housing First is a “low demand” approach to PSH based on the premise of consumer choice, psychiatric rehabilitation and harm reduction.^{xxxix} Additionally HF is identified as an evidence-based practice by U.S. Department of Health and Human Services for people with severe mental illness and co-occurring SA disorders. While it is not the only approach to PSH, research has demonstrated that HF reduces utilization of public services for substance abusers, including jail, hospitals, emergency medical services, treatment and detoxification. Cost reductions continue the longer individuals remain in housing. Additionally, tenants decrease substance use over time.^{xxxv}, ^{xxxvi}

According to the new 10 year Federal Strategic Plan to End Homelessness, Housing First is the solution for the chronically homeless. (United States Interagency Council on Homelessness, 2010)

In Seattle, a Housing First program known as 1811 Eastlake has been effective for chronically homeless alcoholics, many of whom suffer from chronic medical and psychiatric issues. Tenants are allowed to consume alcohol; however there is an option to move to a sober floor. Participation in treatment is voluntary, but on-site case managers work to engage clients in moving toward behavior change. Program participants reduced median number of drinks by 32% over a 12 month period, from 16 to 11 per day.^{xxxvii}

Harm reduction is one public health approach designed to reduce the harmful effects of drug use and other high risk behaviors. It removes requirements of sobriety and participation in services to remain in housing. It augments the housing first approach in that it meets the individual where they are at and recognizes that while abstinence is the final goal, it is not the only objective. Additionally, harm reduction is multidisciplinary, involving healthcare providers, police, drug treatment professionals, and others who work with drug users. It is important to note that harm reduction principles and practices are not universally defined, so PSH programs that are considering implementing Housing First and harm reduction should structure programs based on community needs.^{xxxviii} Harm reduction effectiveness has been identified as a best practice with chronically homeless individuals. Harm reduction approaches have to take into consideration the impact on the other individuals in the household, especially if children are present. In addition, a harm reduction approach often conflicts with stated policies in certain housing settings and may result in a resident facing a lease violation.

Integrated dual disorders treatment (IDD) is an emerging evidence-based practice for individuals with co-occurring SMI and SA. IDD provides treatment through one integrated program designed to address both disorders. As noted above, prevalence of both SMI and SA is high in homeless populations. The experience of homelessness can greatly exacerbate these conditions and, unlike the non-homeless population, lead to higher incidence of chronic medical conditions and higher mortality rates as well.^{xxxix} Individuals with dual diagnosis also tend to drop out of traditional treatment programs that address only one condition. IDD has

demonstrated higher rates of recovery, as well as positive outcomes in the areas of housing, hospitalizations, arrests, functional status and quality of life.^{xi}

Veterans represent 11% of the general population, but 26% of the homeless population.^{xii} Isolation is a distinct issue for homeless veterans who suffer from behavioral health disorders, such as Post Traumatic Stress Disorder (PTSD), depression, and substance abuse. Veteran specific PSH communities can relieve isolation and promote recovery. One example of a successful veteran specific PSH project is Swords to Plowshares in San Francisco. The program provides on-site services, such as ACT, motivational interviewing and harm reduction. It is also located near a veteran's healthcare facility. This demonstrates that low-barrier, project-based PSH for veterans is an effective model when coupled with assertive on-site services.^{xiii}

Local Practices

What Works in Behavioral Health with the priority population:

- **Low demand access:** Focus of support is on building a relationship and housing stabilization. Using a check-in approach, and building trust using other tangible services, identifying the right organization and service mix to serve the client; considering the terms used for counselors, ie Lifeworks refers to them as Life Coaches
- **Peer support:** creation of small housing communities to build support, e.g., the fourplex approach used by LifeWorks; use of the SHAC for people with mental illness, Alcoholics Anonymous and other support groups.
- **Team approach:** ATCIC currently employs the ACT model for behavioral health services. Other providers are interested in creating a similar team approach.
- **Project Recovery** is a 90-day substance abuse treatment program for homeless chronic inebriates who are engaged in the county court or community court systems and includes 90 days of aftercare but lacks access to permanent housing.
- **Veteran's Administration co-location at ARCH:** The recent co-location of VA services at the ARCH appears to have had a positive impact in increasing the access of veterans to services and housing.
- **Cognitive therapy with the criminal justice population in particular.** Experience has shown that combining cognitive therapies with other approaches has proven successful with people involved with the criminal justice system

On-going Challenges:

- **Lack of available behavioral health resources:** Psychiatric and inpatient psychiatric beds are in limited supply and difficult to access. The Salvation Army was unable to continue to fund the mental health and substance abuse counselor who worked with the women and children in housing. Lack of availability of treatment that meets the best practice of 90 days of substance abuse treatment. Lack of resources for people with non ATCIC priority populations, i.e., anxiety, post traumatic stress
- **Texas is 49th in available mental health resources**
- **Medication management** – many individuals who are homeless face challenges with consistent use of their medication, access to psychiatrists and doctors who can provide medications, monitoring of medications, and clients choice about taking medication
- **Lack of services for children and parenting classes:** PSH services are often focused on the adults and the children's emotional and social needs are not met. Providers also experience a need for increased access to parenting and early childhood intervention services

- **High level of trauma:** Providers serving all types of chronically homeless persons report that they have experienced a high level of trauma ranging from domestic violence, sexual and physical abuse, and violence on the streets. The need for counselors who can provide trauma informed care is high.
- **Head trauma can often look like mental illness:** This results in people being treated with mental health services which often are not appropriate.

Behavioral Health Opportunities:

- Train landlords and other people and professionals engaged with the chronically homeless in Mental Health First Aid. This program is currently offered by ATCIC.
- Build on the current ACT teams and ensure that any team approach includes
- Increase the integration of behavioral health and physical health services
- Identify how to increase substance abuse services, including exploring ambulatory detox conducted in the home, and other harm reduction strategies
- Educate funding sources so that a person who enters inpatient treatment does not lose their housing
- Educate property managers about the opportunities for support services with permanently housed individuals as well as provide them with tools for addressing people who exhibit behaviors related to their behavioral health issues.

PHYSICAL HEALTH

The priority/target population suffers disproportionately from chronic, long-term, and complex medical conditions. For single individuals, provision of health care is the highest cost associated with homelessness.^{xliii} Homelessness can have devastating effects on physical health.

- About one-third to one-half of the 750,000 homeless individuals in the U.S. have chronic diseases, and more than half lack health insurance. In Texas, most homeless single adults do not qualify for Medicaid as they may in other states. Homeless individuals have a life expectancy of between ages 42 and 52, according to the National Health Care for the Homeless Council.
- Rates of serious illness and injury are 3 to 6 times higher
- Mortality rates are 3 or more times higher
- Average age of death is 30 years less than housed people
- 30-70% of homeless individuals’ deaths are related to alcohol
- Individuals with SMI have a 30% increased risk of physical health conditions/disease
- Among the homeless, the cigarette smoking rate is 70% or more; these rates are 3 times higher than national average. Two of the three leading causes of death among homeless persons, heart disease and cancer are tobacco related (City of Austin HHSD)
- Homeless individuals are more vulnerable to victimization

Common Medical Conditions Among Homeless Populations^{xliv}	
Tuberculosis	Transience and congregate living increase risk of contracting. Shelters are major sites of transmission
HIV/AIDS	Prevalence is 3-9 times higher than housed individuals
Hepatitis	High rates reported among adults and use, particular when accompanied with injection drug use and unprotected sex.
Skin Conditions	Dermatological and parasitic skin conditions are commonly reported in emergency rooms
Chronic Pain	Commonly self-reported
Other Medical Conditions	Prevalence of common medical conditions including cardiovascular disease, asthma, chronic kidney and liver disease is higher

There are a multitude of barriers to providing healthcare to homeless people.

- The health care delivery system is not responsive to individuals who do not have housing
- Clinics and healthcare facilities are often not located close by and transportation is often lacking
- Clinic appointments are difficult to negotiate
- Standard treatment plans require resources that are not available to people experiencing homelessness
- High turnover rate among doctors serving this population
- Lack of medical respite care, which provides critical support and recovery services after a homeless individual is released from the hospital
- Prior negative experiences cause homeless individuals to avoid mainstream systems of care.
- Survival needs take precedence^{xlv}

The following services should be made available for those who have experienced long-term homelessness and are in transition or in PSH:

Health Care in Permanent Supportive Housing^{xlvi}	
Urgent Care	Immediate outpatient care to treat acute and chronic illness or injury
Preventative Care	Screening for mental illness, substance abuse, cognitive impairment, TB, HIV/AIDS, STD's, baseline labs, blood lead levels (children), vision, dental and hearing screenings, mammograms and other cancer screening, immunizations and health education
Primary Care	Treatment and management of chronic disease, health promotion, and primary care case management. Should be integrated with behavioral health whenever possible
Pain Management	Acute pain among homeless people is commonly associated with trauma, unattended tooth decay, advanced gum disease, and abscesses from wound infections

Health Behavior Education	Explanation of health problem, discussion of condition/disease self-management, risks and risk reduction
Motivational Enhancement	Client-centered directive clinical strategies used to help resolve ambivalence and move towards behavioral change.

PSH providers should take into account several factors when considering healthcare service delivery options. These include program scale, resources, severity of tenant’s health problems, and proximity to an off-site clinic. Considering the complex healthcare needs of the target/priority population, it is generally advisable for PSH programs to begin with home/onsite care and move to clinic-based care when tenants are ready.

Healthcare Service Delivery Options		
	On-Site	Off-Site
Advantages	easily accessible, no waiting period, follow-up and services coordination is easier, easier to engage vulnerable, hard to serve with complex health and mental health problems, clinicians are able to see home environment and understand barriers to treatment	more independence, opportunity to learn how to navigate the social services system, and more confidentiality, and more comprehensive and efficient services
Disadvantages	less comprehensive than community-base health centers, productivity can be limited especially if the PSH setting is small, provision of psychiatric services may be challenging, unless the roles of services providers and property management are not clearly distinguished	some tenants too ill, on-site may work better in Housing First model, evidence that families do better with on-site services

Federally Qualified Health Centers (FQHC’s) are community-based health systems that provide healthcare to low-income individuals and families. In Austin/Travis County the Community Health Care System operates 18 health care facilities and is funded primary through Central Health, formerly Travis County Health Care District, and the Federal Bureau of Primary Health Care. FQHC’s have increasingly become involved in PSH, and bring several advantages to the table for serving tenants in PSH. FQHC’s receive funding for a wide array of health and wrap-around services. Practitioners understand the complex healthcare needs of underserved populations. Additionally, FQHC’s may qualify Medicaid enhanced reimbursement for services such as case management, behavioral health and other wrap around services.^{xlvii}

Local Practices

Providers noted that there are four health areas that seem to be very prevalent in the local homeless population: wound care, diabetes, epilepsy, and the need to address dental issues.

What Works:

- **Providing basic health care information.** In both formal and informal settings, an approach that teaches very basic care for health conditions and outlines what to expect to occur based on the condition has proven effective
- **Integration of physical and behavioral health** services at some CommUnity Care sites has created strong connections and a more integrated approach.
- **Providing health care at the Austin Resource Center for the Homeless** through an onsite health clinic, provided by the National Healthcare for the Homeless grant.

On-going Challenges:

- **Lack of respite beds.** Currently the Austin/Travis County community has four respite beds for the homeless leaving health care systems, although this will increase to six with expanded funding from Central Health. These beds are located in a nursing home and due to the nursing home rules, they are not accessible to people with certain criminal histories.
- **Lack of step-down services for people leaving incarceration or the state hospital.** Individuals who have become stable on medications in the jail and hospital settings often leave with little access to continuing medication, counseling, or housing support, and therefore often return to homelessness.
- **Ethical prescription of medications for polydrug users.** Physicians often face an ethical dilemma about prescribing medications for physical ailments when they know that the individual is using multiple drugs and could either have a negative drug interaction, sell the prescribed drug, or not have access to storing it safely.
- **Lack of primary care physicians and psychiatrists.** While this shortage is a national issue, physicians often get “burned out” serving high needs clients who often are not able to or refuse to follow healthy protocols
- HIV providers are reporting **an increased number of people with HIV/AIDS being released from State corrections.**
- **Lack of access to nutritious foods and education about nutrition and health.** Providers report that homeless individuals and families don’t have the opportunity to access nutritious foods. While local organizations that provide food do all that they can to provide a nutritious meal, they are heavily dependent on local donations for the food that they distribute. One provider reported that the most requested food item is milk.
- **Dental issues** commonly lead to other health issues. The lack of dental care was identified as one of the key contributors to other health issues.

Physical Health Opportunities:

- Collect demand and cost data of homeless individuals and families use of physical health services, emergency room services, and EMS. This can be done in collaboration with the City of Austin EMS and the ICC.
- Explore the possibilities for a centralized approach for the homeless to access healthcare so that there can be consistency in their care and follow up. Note: This could be done in partnership with the Indigent Care Collaboration.
- Explore enhanced use of the Medicaid model for eligibility identification
- Create a stronger partnership between MAP intake workers and case managers to ensure on-going services as a person moves from homelessness into housing
- Maximize Medicaid. HUD has indicated that it will be funding pilot programs that have permanent supportive housing units and that maximize Medicaid funding, probably in 2011. Recommend that ECHO host a follow up conversation to identify how the community can maximize Medicaid.

- Create connections and maximize use of faith community physical health programs. Many congregations have physical health programs and there may be opportunities to connect those programs with permanent supportive housing units.
- Train physicians and healthcare professionals in motivational interviewing techniques
- Create a stronger connection and referral system between the EMS, CommUnityCare, criminal justice, Austin State Hospital, and permanent supportive housing providers
- Conduct a local epidemiological study of the homeless to assess their health needs and identify successful protocols
- Ensure that all PSH residents have easy access to health supports. This can be accomplished through a clinic or nurses/medical staff on-site and/or through ease of transportation to the nearest clinic. It was noted that often when someone first enters PSH, it may be most useful to have the services onsite and/or in-home
- Address diet and nutrition needs

Medicaid plays a significant role in financing services and supports for many individuals needing PSH. However, because of the complexity of the Medicaid program, supportive housing providers and local and state government agencies are not always able to access these resources systematically. Currently, some individuals needing permanent supportive housing may not be eligible for Medicaid. In general Medicaid covers pregnant women, women with children and adults who are disabled. Eligibility for the latter group of individuals is closely tied to their eligibility for the federal Supplemental Security Income (SSI) Program due to their disability. <http://www.tacinc.org/downloads/Medicaid-Final-July10.pdf>

Which Services Does Medicaid Cover?

Service coverage for health, mental health, substance abuse and supportive services varies significantly across state Medicaid programs. However, each state Medicaid program must cover “Mandatory Services” identified in the federal statute. These service categories include:

- Inpatient hospital services
- Outpatient hospital services
- Prenatal care
- Vaccines for children
- Physician services
- Nursing facility services for persons aged 21 or older
- Family planning services and supplies
- Rural health clinic services
- Home health care for persons eligible for skilled-nursing services
- Laboratory and x-ray services
- Pediatric and family nurse practitioner services
- Nurse-midwife services
- Federally qualified health-center (FQHC) services, and ambulatory services of an FQHC that would be available in other settings
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for children under age 21

Considerations for Special Populations

Families:

- Families are often more complex as they often have multiple system involvement and therefore need a lower client to case manager ratio. The more and younger the children are the increase in complexity and need for additional services.
- PSH often uses a definition that states that an adult in the family has to have a disability in order to qualify. Local providers state that often a child in the family has a disability which requires constant adult support but leaves the family ineligible for permanent supportive housing
- Providers who are working with families are challenged to locate permanent quality childcare for the children that are served. Often the jobs that parents are able to access require flexible hours at night and/or on the weekend which makes locating child care even more challenging.
- Adults in the family also often need access to on-going training and education and need child care in order to allow them to attend.
- Providers have had difficulty accessing Temporary Assistance for Needy Families (TANF). Providers report that there seems to be inconsistent responses to questions regarding accessing and maintaining TANF benefits and recommend that a local liaison is established between the local TANF office and homeless providers
- Providers report the need for access to on-going parenting classes
- A harm reduction approach can conflict with the needs and safety of children and will need to be explored further
- Evidence-based practices for victims of domestic violence indicate the need to empower clients through providing choices rather than mandating services

Youth:

- Youth aging out of foster care are among the most chronically homeless as, according to LifeWorks, many of those leaving foster care have experienced over 30 placements
- Lifeworks has identified a high level of trauma, especially sexual trauma, amongst their homeless youth population as well as a high need for parenting classes and support.

Veterans:

- Veterans are provided case management through the Department of Veterans Affairs (VA). Traditionally, there has not been a strong connection between the VA and local service providers. PSH provides an opportunity to strengthen this connection.
- Veterans experience a high level of Post Traumatic Stress Disorder
- Providers report that many chronically homeless veterans don't receive VA benefits due to discharge status

Criminal Justice:

- People exiting the criminal justice system often leave the criminal justice system with limited resources or income, and face additional barriers to employment and housing

Costs and Potential Funding Sources

Community Costs of Homelessness

Recent reports have shown the costs to the community of not providing permanent supportive housing. The CSH Texas Re-entry report identified that in 2008 of the 814 individuals who were released from a the Travis County Jail and had a disability (including mental illness, chemical dependency, physical, or intellectual or developmental disability); and was homeless at release the cost of incarceration alone exceeded \$3 million. This total excludes any additional costs for the provision of mental health assessments, medication or psychiatric support.

In 2008, Travis County Jail costs for homeless individuals with a disability exceeded \$3 million.

In 2009, EMS costs for the transient population exceeded \$2.3 million

In addition, the City of Austin Emergency Management Services (EMS) has documented the costs of providing EMS services to the “transient” population. This population is defined as those that describe themselves as homeless and are not found to have an address during the billing process and those who list their address as the ARCH or Salvation Army. In 2009, EMS provided 3,177 trips for transients at a cost of \$2.3 million. In 2009, the average cost per EMS call for "transients" was \$732.87 and approximately 85% of the EMS calls to ARCH and Salvation Army resulted in a transport to a hospital for additional services.

Most public expenditures attributed to homelessness are related to healthcare, including costs incurred by hospitals, ER's, clinics, mental health facilities, and public health systems. Studies show a 70% reduction in healthcare costs once individuals are in PSH..^{xlviii}

Supportive Services Costs

The 2010 CSH Financial Model for Austin/Travis County noted that the success of individuals living in permanent supportive housing requires an adequate level of funding for services in supportive housing to meet the array of needs of people who have experienced long-term homelessness. Inadequate funding can jeopardize success by increasing staff turnover, limiting the capacity of organizations to sustain high quality projects that are effective in serving people with complex problems, or imposing significant financial burdens on organizations, making them unwilling to accept the chronically homeless as tenants, or to expand their participation in supportive housing.

In a national study of cost comparisons of permanent supportive housing in nine cities conducted by the Lewin Group in 2004 (http://documents.csh.org/documents/ke/csh_lewin2004.PDF), annual costs for PSH ranged from \$7,497 in Phoenix to \$15,366 in San Francisco.

The 2010 PSH Program & Financial Model determined the following as annual costs for PSH in Austin/Travis County.

Annual Service Costs for Supportive Housing Units (By Targeted Tenancy)			
<i>Note: This Table documents the services costs for the first year all units are online, based upon current data. It will be necessary to project service cost increases for future years of operations.</i>			
Targeted Tenancy	# of Supportive Housing Units	Annual Cost Per Unit	Total Annual Cost
Single Adults:			
High Service Intensity: CH	75	\$10,000	\$750,000
High Service Intensity: CH + Reentry	225	\$13,000	\$2,925,000
High Service Intensity: Youth Aging Out	10	\$8,000	\$80,000
Unaccompanied Youth:			
Medium Service Intensity	10	\$7,500	\$75,000
Families with Children:			
Medium Service Intensity	30	\$10,000	\$300,000
AVERAGE:	N/A	\$11,800	N/A
TOTALS:	350	N/A	\$4,130,000

**The data in the above table is to be used as an example of a potential costs. Actual costs will vary and further research is needed to develop exact cost estimates.*

Costs for Specific Services: Following are some of the local costs for specific services that could be included in an individual’s service plan:

Substance Abuse Costs		
Organization	Program	Cost
Austin Recovery (AR)	Detox – required for fewer than half the clients entering AR – average length of stay 5-7 days	\$2,450 for 7 days
Austin Recovery	Short-term – 30 days inpatient	\$5,500
Austin Recovery	Journey – 90+ days	\$13,500

Children’s Support Services: PSH settings estimate that the annual cost to provide children’s support services (after-school counseling and support groups) is between \$375 and \$575 per child. This does not include the administrative costs.

2009 Average Cost of Childcare in Travis County			
Licensed Centers		Registered/Licensed Homes	
Age of Child	Monthly Average	Age of Child	Monthly Average
Newborn – 11mos	\$832.00	Newborn – 11mos	\$624.00
12 mos-17mos	\$793.00	12 mos-17mos	\$611.00
18mos-23mos	\$732.00	18mos-23mos	\$589.00
2yrs	\$711.00	2yrs	\$581.00
3yrs	\$676.00	3yrs	\$576.00
4yrs-5yrs	\$667.00	4yrs-5yrs	\$572.00
6yrs-12yrs	\$269.00	6yrs-12yrs	\$295.00
6yrs-12yrs summer	\$624.00	6yrs-12yrs summer	\$550.00

Source: City of Austin Health and Human Services Department

Income Stability: The average local salary for an Employment Specialist is between \$40-50,000 per year and each specialist typically serves between 50 and 100 homeless clients per year.

Legal Aid: Legal service providers report that it costs approximately \$1,000 per case for representation for appeal of public benefits denial, specifically for SSI/SSDI. They have an 86% success rate of winning on appeal.

Potential Funding Sources

It was recommended that Austin/Travis County explore establishing a community endowment for homeless services and housing. It was recommended that the community use the Children’s Partnership as a model and identify how to maximize Medicaid for support services.

Identified Potential Funding Sources		
Local	State	Federal
City of Austin	Texas Department of Criminal Justice	HUD
Travis County	Department of State Health Services <ul style="list-style-type: none"> ○ DFPS ○ DARS ○ DADS 	Health & Human Services <ul style="list-style-type: none"> ○ SAMSHA
Central Health (Physical & Behavioral Health)	Texas Department of Housing & Community Affairs	Department of Labor (Income Stability)
St. David’s Community Health Foundation (Physical & Behavioral Health)	Foundations	Department of Veterans Affairs
Workforce Solutions of Central Texas (Income Stability)		Substance Abuse & Mental Health Services Administration
Housing Authority of Travis County and Housing Authority of the City of Austin (possible partnerships and joint grant proposals)		Department of Education
Local Foundations & Businesses		Health Resources & Services Administration

It was recommended that ECHO additionally explore policy and advocacy strategies that would allow strategies for adding fees, such as closing costs or using the local hotel tax/food and drink, etc. (Miami-Dade County).

Results of Local PSH Survey

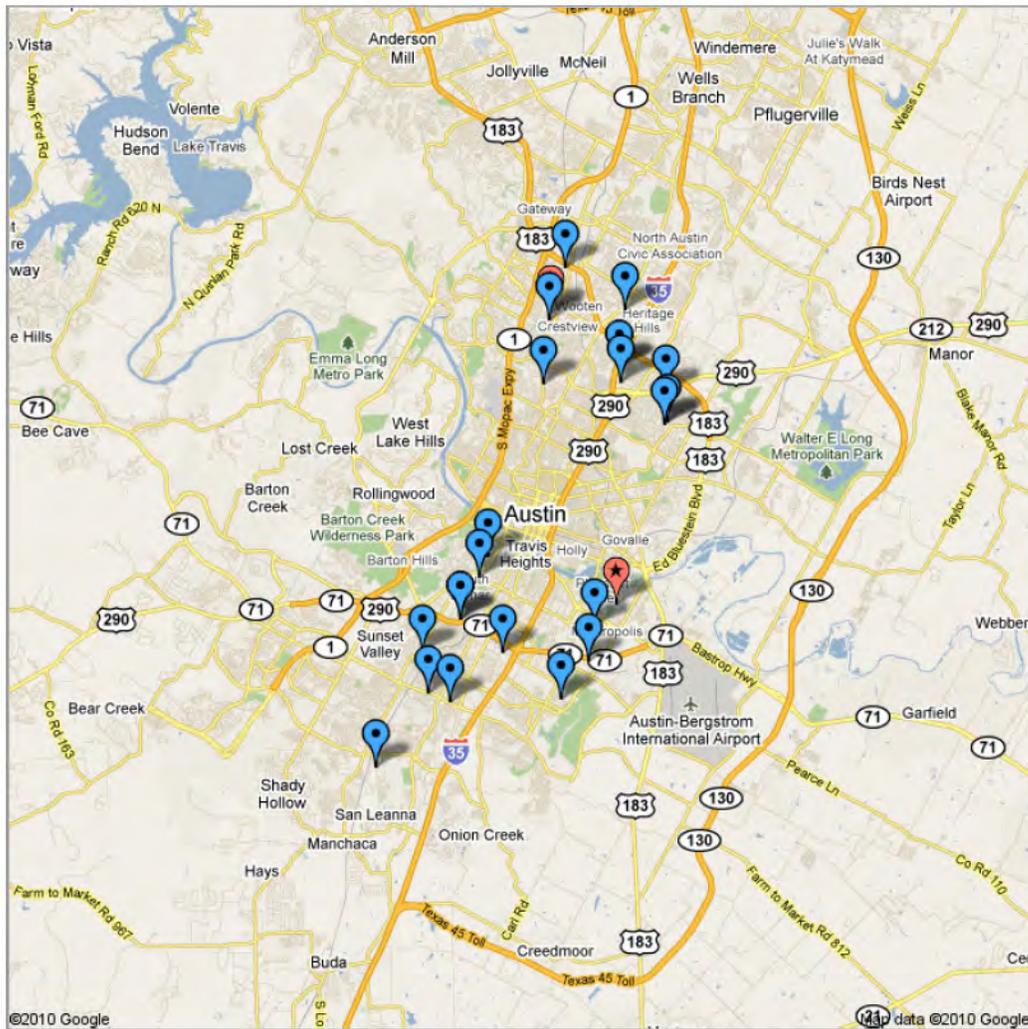
Local PSH providers were asked to submit information on PSH programs, as defined by the following:

- Unit available to homeless or at-risk for homelessness with multiple barriers
- Tenant pays no more than 30% for housing
- Tenant has a lease (note: some PSH may start out with a master lease)
- No limit on tenancy if conditions of lease are met
- Flexible/comprehensive array of services
- Proactively engage clients but participation not condition of tenancy
- Effective, coordinated, integrated services

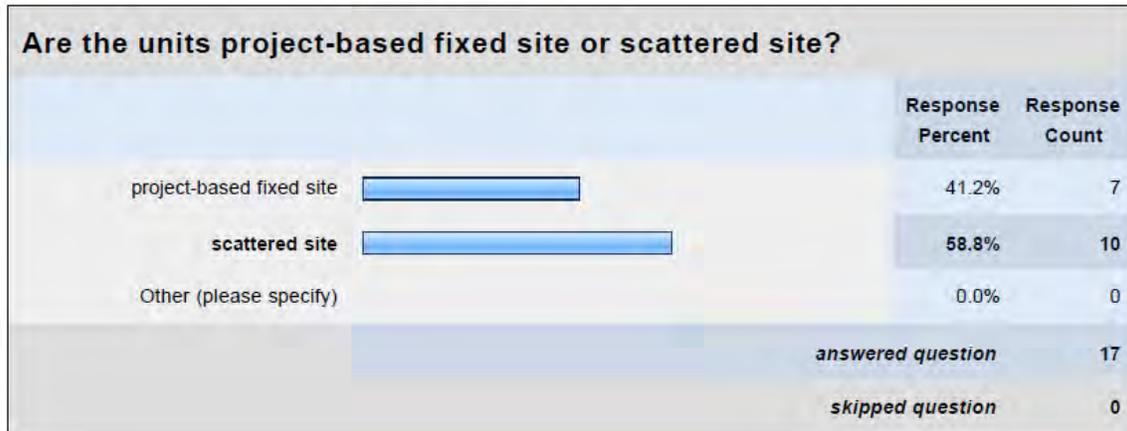
Map of Austin PSH - Locations were provided by the following agencies:

Burkes Supervised Living Center
Caritas of Austin
Easter Seals Central Texas
Front Steps
Foundation Communities

Housing Authority of the City of Austin
Housing Authority of Travis County
LifeWorks
Mary Lee Community
Saint Louise House



Fixed vs. Scattered Site - A survey of local PSH providers revealed the following:



Supportive Service Costs

According to CSH, the costs for supportive housing services vary in projects that have been established, but are generally in the range of \$7,000 to \$13,000 per unit. These costs assume that operating expenses (including maintenance, security, and property management services) are adequately funded and agencies have sufficient cash flow to fund supportive services.

Local providers are generally on the low-end of the CSH range, and they report that they are generally under-resourced and thus unable to provide the full-range of services that their clients need.

Costs:			
	Response Average	Response Total	Response Count
Average Annual Total cost of housing per unit	6,447.71	90,268	14
Average annual total cost of services per unit	4,984.42	59,813	12
<i>answered question</i>			14
<i>skipped question</i>			3

PSH Client Profile:

	Response Average
Average monthly income of clients at entrance to services	348.56
% of PSH clients currently working	25.55
% of PSH clients who could work if training/jobs available	25.88
% of PSH clients receiving public benefits	74.73
% of PSH clients that need assistance accessing public benefits	24.40
% of clients with co-occurring disorders	47.11
% of clients under criminal justice supervision	8.63
% of clients with a criminal history	59.38

Implications for Housing Location & Approach

During the course of the research and conversations with stakeholders, the following implications for housing location were identified:

- The chronically homeless and veterans both seem to do well in smaller communities such as 4 plexes and 8 plexes and/or other small living situations where they can create a sense of community.
- Zoning issues will need to be assessed to ensure that permanent supportive housing can be placed in the desired location.
- Community education about homelessness and especially the hardest to serve population needs to be conducted to address the concerns of neighborhoods .

- Local efforts to license and regulate boarding homes provide the opportunity to increase the quality of these housing settings. However, if the process is overly burdensome, it could have an impact of removing affordable housing resources.
- As a community, discuss and determine how to address the balance of housing availability for the most costly individuals in need of supportive housing, such as the chronically homeless and other vulnerable populations
- Several successful models use a variety of housing options that allow residents to move between floors, properties and levels of care.
- The community may want to consider a property that includes different types of housing options and on-site services.

Recommendations

Overall Recommendations

- Create an integrated services approach that incorporates as much client choice as possible
- Co-locate services whenever possible either at the housing site or at an easily accessible site to PSH
- Create living facilities that create a sense of community for their appropriate populations
- Utilize a common vulnerability and cost assessment tool
- Redefine success so that it concretely measures costs prior to entry to housing and once in housing as well as the benefits of social interaction and connection
- Facilitate community conversations about homelessness and PSH within neighborhoods
- Consider certification of permanent supportive housing case managers to ensure level of sophistication necessary to address complex clients needs is present
- Explore centralized intake and vulnerability assessment

Recommendations – Case Management

- Use a team approach to support services, i.e., ACT Model
- Low client to case manager ratios: between 1:8 and 1:10 for families & 1:10-1:15 for individuals
- Focus on housing stabilization and relationship building initially
- More intense services at beginning (if client wants)

Recommendations – Behavioral Health

- Use the harm reduction model with chronically homeless individuals
- Incorporate motivational interviewing
- Ensure that dual diagnosis services, including psychiatric support, are available and substance abuse services can be accessed for at least 90 days
- Identify mental health resources for individuals whose diagnosis do not qualify them for ATCIC
- Use cognitive approach with criminal justice involved
- Use peer support and address isolation – small communities also recommended
- Provide children-centered programming
- Ensure that housing is not lost if person enters in-patient treatment

- Provide mentoring and peer support opportunities
- Train case managers in how to identify and address trauma issues and increase the number of trauma treatment specialists

Recommendations – Physical Health

- Promote use of the Medicaider model for eligibility identification
- Create community conversations about homelessness within neighborhoods
- Create stronger partnership between MAP intake workers and case managers to ensure on-going services as a person moves from homelessness into housing
- Identify strategies to maximize Medicaid
- Create connections and maximize use of faith community physical health programs. Many congregations have physical health programs and there may be opportunities to connect those programs with permanent supportive housing units.
- Train physicians and healthcare professionals in motivational interviewing techniques
- Create a stronger connection and referral system between the EMS, CommUnityCare, criminal justice, Austin State Hospital, and permanent supportive housing providers
- Ensure that all PSH residents have easy access to health supports. This can be accomplished through a clinic or nurses/medical staff on-site and/or through ease of transportation to the nearest clinic. It was noted that often when someone first enters PSH, it may be most useful to have the services onsite and/or in-home
- Address diet, nutrition, and dental needs

Recommendations – Income Stability

- Train case managers how to use SOAR
- Ensure dedicated staff to employment/training
- Provide incentives for positive behavior, such as time on job
- Provide training that will lead to jobs that provide a living wage
- Create community service opportunities for clients to gain workforce related experience
- Create asset building opportunities
- Provide financial management information
- Provide child care
- Create a liaison between the local TANF office and homeless service providers

Recommendations - Other

- Collect demand and cost data of homeless individuals and families use of physical health services, emergency room services, and EMS. This can be done in collaboration with the City of Austin EMS and the Indigent Care Collaboration.
- Educate landlords and employers regarding how to engage residents/employees with behavioral health issues
- Reach out to employers to increase employment opportunities
- Increase connections between Workforce Solutions and PSH operators
- Conduct a local epidemiological study of the homeless to assess their health needs and identify successful protocols

Recommended Evaluation Measures:

- **Housing Stability:** ability to obtain and remain in safe and stable housing and, if exiting, document if they are exiting to a safe and permanent housing situation.

- **Involvement with the criminal justice system:** reduction in the number of days spent in jail (for comparison with previous 12 months)
- **Involvement with the emergency rooms and psychiatric:** reduction in number of ER visits (for comparison with previous 12 months) and reduction in number of psychiatric hospitalizations (for comparison with previous 12 months). Increased connection to primary medical care
- **Income stability:** increase in income, ability to obtain and maintain employment and/or connection and maintenance to mainstream resources such as SSDI
- **Social support and connection:** Participants report a sense of social support and reduced isolation. Participants report a sense of feeling hopeful and cared for and progress toward personal goals
- **Stability for children:** children remain with parents, if appropriate. Children and adolescents attend and remain in school.

Next Steps

Following the release of this report, ECHO will share the final results with the City of Austin and with its membership. ECHO will use the report information as it moves forward with the annual Continuum of Care planning. This report will also serve as the basis for the work of the ECHO Housing Work Group that focuses on long-term homelessness and permanent supportive housing.

Appendices

Appendix A

Critical Components for Assisting Homeless SSI/SSDI Applicants

Critical Components	Requirements	Strategies
1. Case managers and/or outreach workers; possibly benefits specialists	<ul style="list-style-type: none"> ▪ Provide sufficient staff to do outreach and engagement and assist applicants ▪ Professional clinical and writing skills are needed for case managers ▪ If benefits specialists assist, ensure they have the skills to assist homeless applicants 	<ul style="list-style-type: none"> ▪ Provide continuing training, locally-based, for case managers assisting applicants ▪ Arrange for local/state capacity to provide training by having trainers attend a <i>Stepping Stones to Recovery</i> Train-the-Trainer program and assign them to continuing training functions, area wide
2. Case manager maintains contact and communication with applicant	<ul style="list-style-type: none"> ▪ Interest in doing outreach ▪ Flexibility and ongoing effort to maintain contact ▪ Clarity on SSI/SSDI process 	<ul style="list-style-type: none"> ▪ Provide housing and other essential services ▪ Provide eligibility assistance to homeless people in hospitals and jails ▪ Provide immediate response to access services so applicants feel heard and understood and contact is maintained
3. Applicant signs for case manager to be his/her representative	Use SSA 1696 Appointment of Representative form	<ul style="list-style-type: none"> ▪ Provide training for case managers on how to engage applicants ▪ Provide assistance to applicants who appoint case manager as their representative; offer others information on how to apply for SSI on their own
4. Staff who assist applicants obtain records of prior treatment and write medical summary report	<ul style="list-style-type: none"> ▪ Assign trained staff to work pro-actively with medical records directors ▪ Inform them of information needs ▪ Offer to copy records ▪ Ensure medical providers are aware of what needs to be sent ▪ Staff write medical summary report that is co-signed by a treating physician or psychologist 	<ul style="list-style-type: none"> ▪ Use SSA and agency release for each treatment source ▪ Provide cover letter regarding sending on information to SSA ▪ Ensure agency release is HIPAA compliant
5. Assisting agency staff provides/arranges for medical assessment by physician or psychologist	If needed, provide or arrange for physicians or psychologist to conduct assessments, including diagnosis and functioning, for applicants on an outreach basis	Arrange for training of physician or psychologist regarding information needed by DDS
6. Agency reviews application prior to submission	Expert uses protocol to review application for accuracy, completeness and clarity	Expert receives special training regarding review techniques.
7. Agency submits information electronically to DDS	<ul style="list-style-type: none"> ▪ Access by case managers to hardware and software needed to do electronic submissions ▪ Clarity on electronic submission process 	Provide training on the use of SSA's electronic process
8. Agency communicates and collaborates with SSA and DDS	Request that SSA and DDS: <ul style="list-style-type: none"> ▪ Flag cases from assisting agencies ▪ Expedite the review ▪ Assign claims representatives to assist and disability examiners who specialize in applications from homeless people ▪ Communicate directly with assisting agencies about their information needs for particular applications ▪ Contact assisting agency if CE needed 	Request that SSA and DDS: <ul style="list-style-type: none"> ▪ Flag cases from assisting agencies ▪ Expedite the review ▪ Assign claims representatives to assist and disability examiners who specialize in applications from homeless people ▪ Communicate directly with assisting agencies about their information needs for particular applications ▪ Contact assisting agency if applicant needs CE

<p>9. Avoid need for Consultative Examinations (CEs)</p>	<ul style="list-style-type: none"> ▪ Provide or arrange for physicians and psychologists (outdoors, if needed) to conduct needed evaluations prior to submitting all documentation to DDS so that CEs are not necessary ▪ Ensure collection of all existing medical and functional information that is relevant to the claim. <p><i>If CE is required:</i></p> <ul style="list-style-type: none"> ▪ Re-examine approach to all components above. ▪ Request that applicant's treating physician (preferred, according to SSA policy guidelines) be allowed to conduct the exam ▪ Make sure applicant gets to the exam; have representative accompany if possible 	<ul style="list-style-type: none"> ▪ Provide and train the physician or psychologist who will conduct the thorough evaluation SSA needs to determine disability ▪ Prepare for needed diagnostic evaluations by having other clinical staff and case managers assist in collection of historical information ▪ Make least use of most expensive clinicians
<p>10. Need for representative payee must be resolved.</p>	<p>Develop representative payee services in existing or future SSI initiative programs.</p>	<p>Initially, many homeless adults with mental illness need payees. Goal is to become own payee</p>
<p>11. Agency provides integrated employability strategy</p>	<ul style="list-style-type: none"> ▪ Incorporate in case management training strategies for encouraging consideration of and participation in employment at earliest possible time. ▪ Ensure case managers are aware of work incentives under SSI and SSDI using <i>Stepping Stones to Recovery</i> training 	<ul style="list-style-type: none"> ▪ Invite DOL, vocational service providers to be part of SOAR initiative and to assist in helping case managers assist homeless adults in accessing and keeping employment ▪ Make referrals to DOL Disability Program Navigators (DPN's) in local One-Stop Career Centers, or Community Work Incentives Coordinator (formerly the BPAO's). DPN's are located in 30 States plus the District of Columbia and CWICS are in every State and US Territory. See: www.socialsecurity.gov/disabilityresearch/navigator.html for a list of States with DPNs and SEE www.socialsecurity.gov/work/whatsnew.html for a list of the 99 WIPA locations.
<p>12. Assessment of results</p>	<p>Track key data elements:</p> <ul style="list-style-type: none"> ▪ Date initial application submitted ▪ Date initial decision rendered ▪ Outcome of initial decision (approved/ denied) ▪ Housing status at time of application (housed/homeless) ▪ Use of Appointment of Representative Form 1696 (Yes/No) 	<ul style="list-style-type: none"> ▪ If SSA and DDS flag cases, they will have these data and can provide periodic reports on outcomes – allowance rates, length of time to decision, etc. ▪ Add data elements to existing HMIS ▪ Adapt/adopt tracking systems used for this purpose by other states (e.g., Ohio, Oregon)
<p>13. Sustaining your effort</p>		<ul style="list-style-type: none"> ▪ Use outcome data to make the case for sustaining or expanding SSI outreach ▪ Explore using retroactive Medicaid payments to fund reimbursement for medical evaluations ▪ Work with hospitals, State Medicaid and General Assistance offices to recoup money spent on uncompensated care and general assistance benefits; bring them to the table with the explicit understanding that as they benefit, their assistance in continuing or expanding SSI outreach efforts is needed

Assertive Community Treatment

Goals

- Stabilize Symptoms
- Prevent Relapse
- Enhance Quality of Life
- Optimize Instrumental and Social Function

Services

- Service Coordination
- Crisis Assessment and Intervention
- Symptom Assessment and Management
- **Medication Prescription, Administration, Monitoring and Documentation**
- Individualized Treatment Planning
- Dual Diagnosis Substance Abuse Services
- Work-Related Services
- Activities of Daily Living
- Social/Interpersonal Support Relationship and Leisure-Time Skill Training
- Peer Support Services
- Support Services
- Education, Support and Consultation to Client's Families and Other Major Supports

Staffing and Roles

- **Team Leader**-Clinical and administrative supervisor, and also functions as a clinical staff member of the team. At least Master's level health professional
- **Psychiatrist**-Provides clinical services, works with Team Leader to monitor each client's clinical status and response to treatment, supervises delivery of services and direct psychopharmacologic and medical services. Works on a full or part-time basis for a minimum of 16 hours per week for every 50 clients
- **Registered Nurse**-Provides medical assessment services, treatment and rehabilitation services
- **Master's Level Mental Health Professional**-Preferably with a Master's degree in Rehabilitation Counseling
- **Substance Abuse Specialist**- One or more mental health professionals with specialized training in substance abuse
- **Peer Specialist (Consumer)**-A person who has been a recipient of services for severe and persistent mental illness
- **Remaining Clinical Staff**-Bachelors level and paraprofessional staff who carry out rehabilitation and support functions
- **Program/Administrative Assistant**-Responsible for organizing, coordinating and monitoring all non-clinical operations

Intensity/Duration

- Provide minimum staff to client ratio of one FTE staff to 10 clients.
- Provide sufficient number of staff to provide treatment, rehabilitation and support 24 hours a day, 7 days a week.
- Have the capacity to rapidly increase service intensity when client status requires or when client requests.
- Provide an average of three contacts per week per client
- Have the capacity to provide multiple contacts a week for clients in acute crisis, experiencing a major life event, a significant change in living situation, employment or having ongoing problems with daily living. Contact may be as frequent as 2-3 times/day, 7 days a week.

Source: Allness et al, National Program Standards for ACT Teams, Revised 2003

Appendix C

Frequent Users of Emergency Medical Services (EMS) Among Transient Population

2010 (through July)

No. Patients (# Trips)	Trips	Charges	Total Trips	Total Charges	Percent Total Charges	Percent Total Charges
1580 (total)	2,369	\$2,125,237	2,369	\$2,125,237	100%	100%
62 (5+)	599	\$531,002	2,369	\$2,125,237	25%	25%
21 (10+)	344	\$304,329	2,369	\$2,125,237	15%	14%
7 (20+)	207	\$294,123	2,369	\$2,125,237	9%	14%
6 (25+)	123	\$111,885	2,369	\$2,125,237	5%	5%

2009

No. Patients (# Trips)	Trips	Charges	Total Trips	Total Charges	Percent Total Trips	Percent Total Charges
2008 (total)	3,177	\$2,320,259	3,177	\$2,320,259	100%	100%
76 (5+)	863	\$594,296	3,177	\$2,320,259	27%	26%
22 (10+)	506	\$347,495	3,177	\$2,320,259	16%	15%
7 (20+)	299	\$202,769	3,177	\$2,320,259	9%	9%
6 (25+)	278	\$187,958	3,177	\$2,320,259	9%	8%

2008

No. Patients (# Trips)	Trips	Charges	Total Trips	Total Charges	Percent Total Trips	Percent Total Charges
1589 (total)	2,558	\$1,353,722	2,558	\$1,358,407	100%	100%
62 (5+)	694	\$346,087	2,558	\$1,358,407	27%	25%
19 (10+)	433	\$213,212	2,558	\$1,358,407	17%	16%
6 (20+)	259	\$124,363	2,558	\$1,358,407	10%	9%
5 (25+)	215	\$113,144	2,558	\$1,358,407	8%	8%

2007

No. Patients (# Trips)	Trips	Charges	Total Trips	Total Charges	Percent Total Trips	Percent Total Charges
1778 (total)	2,855	\$1,528,458	2,855	\$1,528,458	100%	100%
62 (5+)	843	\$424,372	2,666	\$1,418,665	32%	30%
19 (10+)	613	\$308,693	2,666	\$1,418,665	23%	22%
6 (20+)	423	\$215,651	2,666	\$1,418,665	16%	15%
5 (25+)	360	\$181,577	2,666	\$1,418,665	14%	13%

2006

No. Patients (# Trips)	Trips	Charges	Total Trips	Total Charges	Percent Total Trips	Percent Total Charges
1526 (total)	2,305	\$1,163,461	2,305	\$1,163,461	100%	100%
49 (5+)	601	\$271,310	2,305	\$1,163,461	26%	23%
22 (10+)	428	\$191,528	2,305	\$1,163,461	19%	16%
5 (20+)	212	\$92,900	2,305	\$1,163,461	9%	8%
2 (25+)	146	\$62,352	2,305	\$1,163,461	6%	5%

Appendix D

**ECHO PSH Services Work Group
Research on Local Costs Associated with Income Stability
August 2010**

Strategy/Title:	Organization:	Cost:	Caseload:	Responsibilities:	Population Served:
Employment Specialist:					
Employment Specialist	Caritas (Jo Kathryn Quinn)	\$40,000 per year	1:75 Serve 600 clients per year with 5 specialist	Work individually with clients to develop an employment plan; includes a thorough assessment, numerous one-on-one meetings; sometimes transport clients to interviews, do interview coaching, and resume writing assistance develop job leads and connections to job training; develop and maintain relationships with employers	Serving mixed population/intensity levels (homeless, immigrants, reentry, etc)
Employment and Education Specialist	Crime Prevention Institute (Laura Smith)	\$50,000 per year (including supervision, equipment, etc.)	Serve 60 clients per year	Pre-release group job readiness workshops, post release individual job search assistance, follow up, maintenance of relationships with employers, etc.	Serving reentry population (from Travis State Jail)
Employment Specialist	Lifeworks (Steve Bewsey)	\$40,000 plus benefits	50 clients per year	Provides an employment assessment for using computer generated program (Aviator) which assesses 12 areas of employment readiness; provide	Serving youth aging out of foster care

Strategy/Title:	Organization:	Cost:	Caseload:	Responsibilities:	Population Served:
				hands on training around any deficits; upon completion the youth has a nationally recognized "Ready-To - Work Certificate" that is attached to any employment application that tells a potential employer what skills the youth possesses	
Employment Specialists	Goodwill of Central Texas (Steve Kaiven)	\$48,000 per year	1:35	Provides employment assessment and development of service plan, job matching, referrals to training,	Serving homeless individuals and families
Employment Specialist:	Easter Seals (Monica Elsbrock)	\$32,000-\$40,000 plus 16% fringe per year		Placed 32 clients in job	Serving persons with disabilities
Job Developer:					
Job Developer	Caritas (Jo Kathryn Quinn)	\$40,000 per year	NA	Works on development of job opportunities and employer relationships	Serving mixed population/intensity levels (homeless, immigrants, reentry, etc)
Job Developer	Easter Seals (Monica Elsbrock)	\$28,000-\$35,000 plus 16% fringe per year		Works on development of job opportunities and building employer relationships to help with placement of clients into job positions	
Job Coaches:					

Strategy/Title:	Organization:	Cost:	Caseload:	Responsibilities:	Population Served:
Job Coach	Easter Seals (Monica Elsbrock)	\$10-\$12 per hour		Provide support to clients during employment on an “as needed” basis	
Supported Employment:					
Supported Employment	Goodwill of Central Texas (Katie Navine)	\$5,500 to \$7,400 per client per yr (\$37 per hr per client/150 to 200 hrs)		Client “learns” work behaviors and skills while being employed; counselor on site during work day	Persons with significant disabilities

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