Integrating Care Management and Supportive Housing for Chronically Homeless Frequent Users of Hospital Emergency Departments

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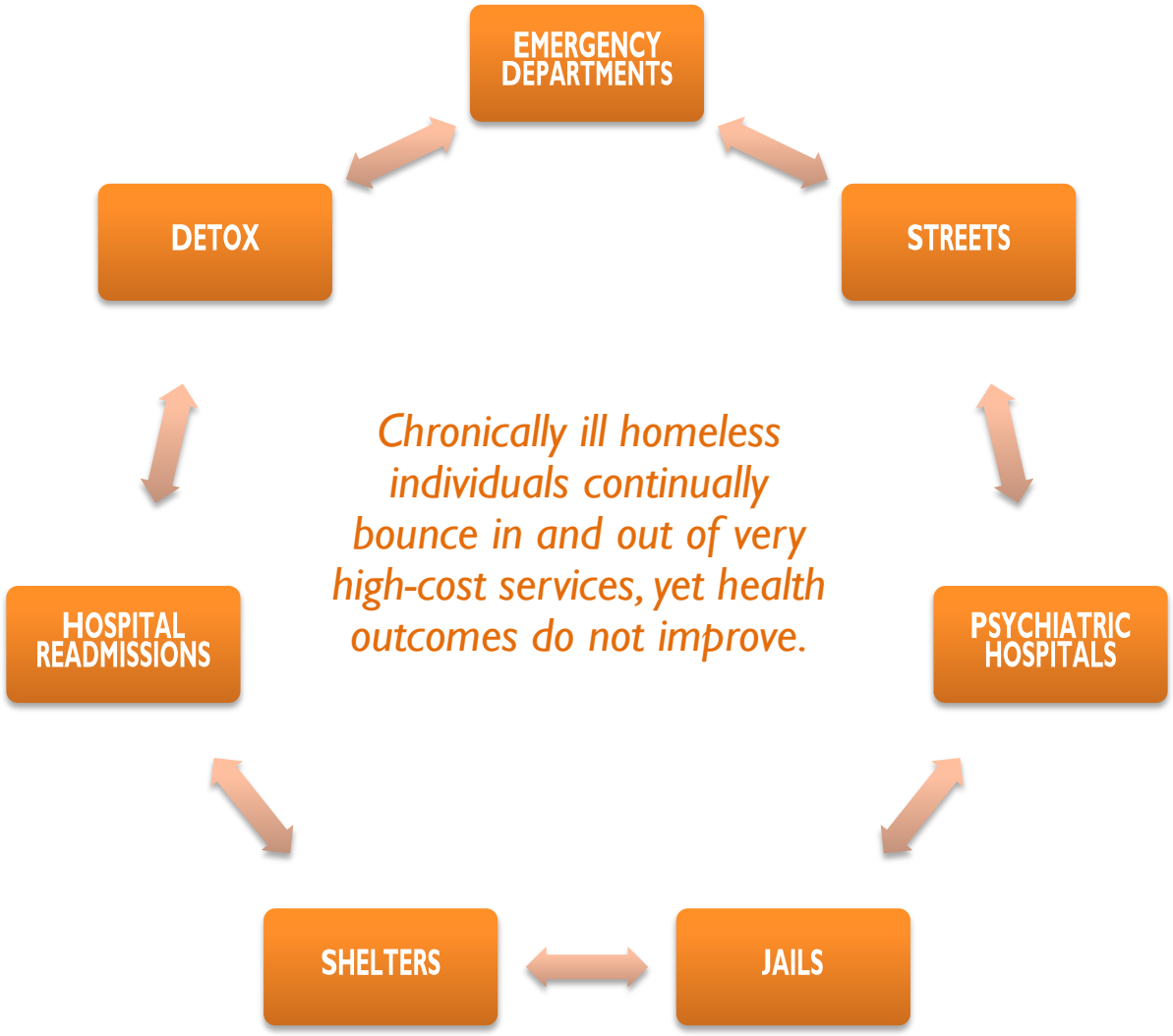
National Association of Case Management Conference, October 25, 2012

The cycle of chronic homelessness and crises services



Homeless frequent users of crisis services:

1. Present complex, co-occurring social, health and behavioral health problems
2. Are not adequately served by mainstream systems of care
3. Demand more comprehensive intervention encompassing medical and behavioral healthcare, housing, and intensive case management

Health and housing model: National evidence

- ✓ Reduction in emergency room utilization
  - 24% to 34% fewer visits
  - (Sadowski et. al., 2009; Perlman and Parvensky, 2006; Linkins et. al., 2008)
- ✓ Decrease in inpatient admissions and hospital days
  - 27% to 29% fewer admissions and days
  - (Sadowski et. al., 2009; Linkins et. al., 2008)
- ✓ Reductions in detox utilization and psychiatric inpatient admissions
  - Decreases up to 87% in use of detox services and decreases in psychiatric admissions (Larimer et. al., 2009; Mondello et. al, 2007)
- ✓ Reduction in Medicaid costs
  - 41 to 67% decrease in Medicaid costs
  - (Massachusetts Housing and Shelter Alliance, 2011; Larimer et. al., 2009)

Evidence from California

FUHSI "Frequent Users of Health Services": CSH initiative in 6 California counties 2003-08

Lewin Group Evaluation: Hospital Utilization Outcomes

- Intensive case management linked to housing dramatically reduced acute care use

	1 Year Pre-Enrollment	1 Year in Program	2 Years in Program	% Change in 2 Yrs
Average ED Visits	**10.3**	**6.7**	**4.0**	**↓61%**
Average ED Charges	$11,388	$8,191	$4,697	**↓59%**
Average Inpatient Admits	**1.5**	**1.2**	**0.5**	**↓64%**
Average Inpatient Days	**6.3**	**6.5**	**2.4**	**↓62%**
Average Inpatient Charges	$48,826	$40,270	$14,684	**↓69%**

	Placed in housing % Change 1 Year	*NOT placed in housing* % Change 1 Year
Average ED Visits	**↓34%**	**↓12%**
Average ED Charges	**↓32%**	**↓2%**
Average Inpatient Admits	**↓27%**	**↓23%**
Average Inpatient Days	**↓27%**	**↑26%**
Average Inpatient Charges	**↓27%**	**↑49%**

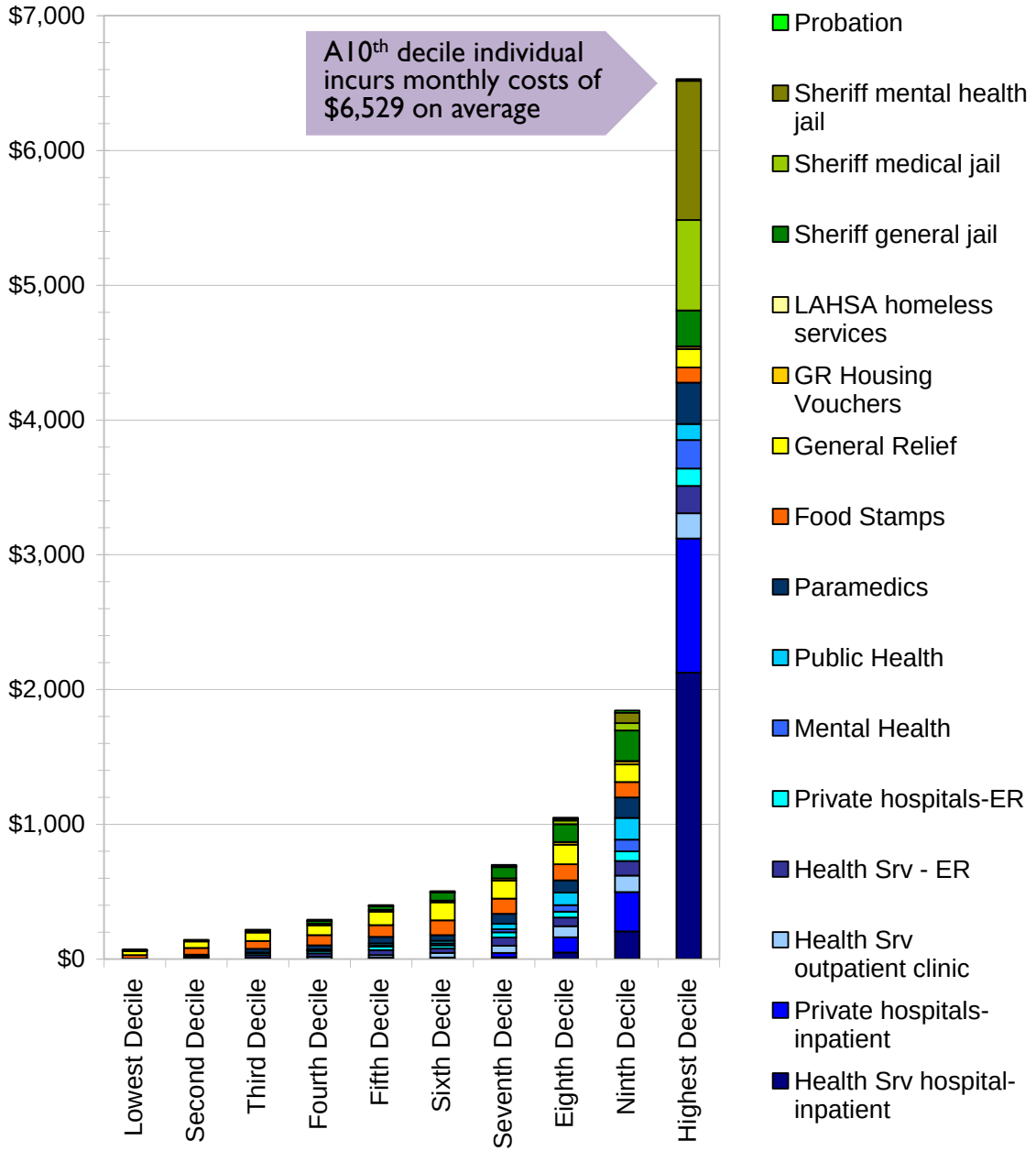
The 10th Decile: Los Angeles County

Economic Roundtable

Average Monthly Costs in All Months by Decile for Homeless GR Recipients

Source: 2,907 homeless GR recipients in LA County with DHS ER or inpatient records

LA County CEO office's Service Integration Branch (SIB) linked service and cost records across county departments for a representative sample of General Relief (GR) recipients to produce this exceptionally valuable data

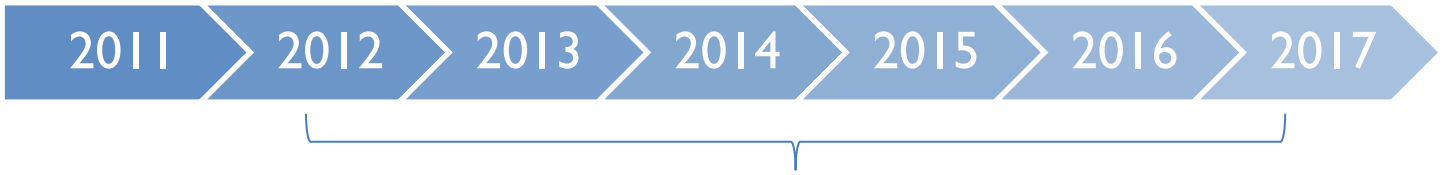


Two Concurrent CSH Frequent User Projects in Los Angeles

Frequent **U**sers **S**ystems **E**ngagement (FUSE)

Los Angeles County

April 2011- October 2013



10th **D**ecile **P**roject - **S**ocial **I**nnovation **F**und (SIF)

The Economic Roundtable

Los Angeles County

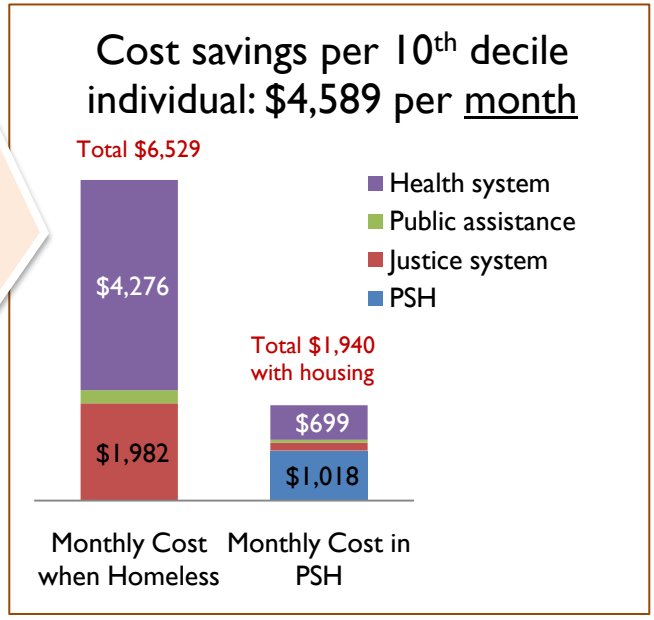
October 2012 – July 2017

Frequent Users Systems Engagement (FUSE) Pilot

Goals: To end the cycle of chronic homelessness and repeated use of hospital emergency rooms for the highest-need, highest-cost homeless persons in Los Angeles County.

To collaborate with government agencies, funders, healthcare networks, hospitals, FQHCs, and housing providers to secure adequate and coordinated public funding mechanisms to facilitate funding for PSH and housing navigator services for frequent users.

Pilot: Identify and house 80 homeless frequent users through hospital-FQHC-housing collaborations



Crisis Indicator: Triage Tool for Identifying Homeless Adults in Crisis. Economic Roundtable. August 2011.

Target Population:

The target population for the CSH FUSE initiative is the "**10th decile**," i.e., the highest-need, highest-cost homeless persons in Los Angeles County.

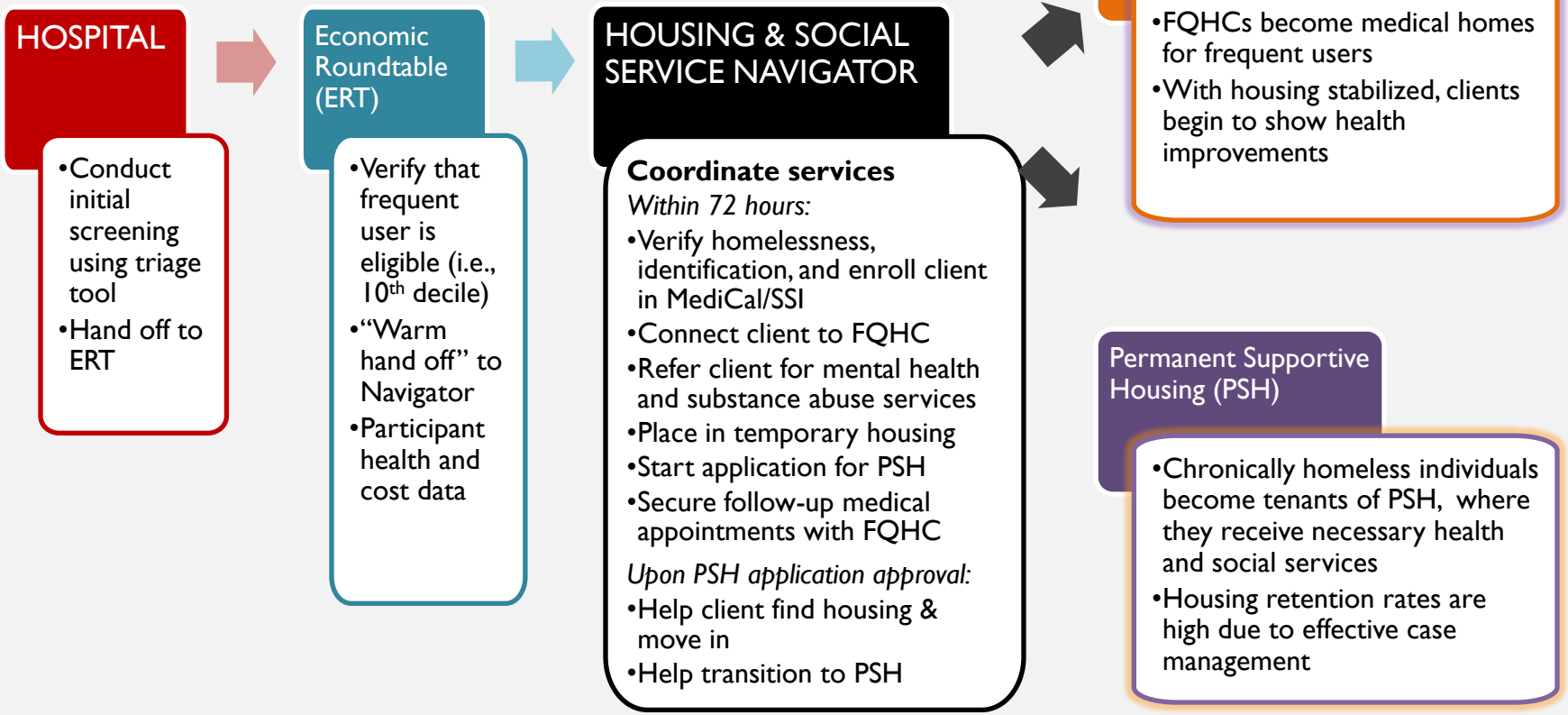
These individuals all have some *combination* of:

- chronic illness
- mental illness
- substance abuse
- multiple visits to hospital emergency rooms in the past two years
- inpatient stays in hospitals in the past two years.

Frequent Users Systems Engagement (FUSE) Process

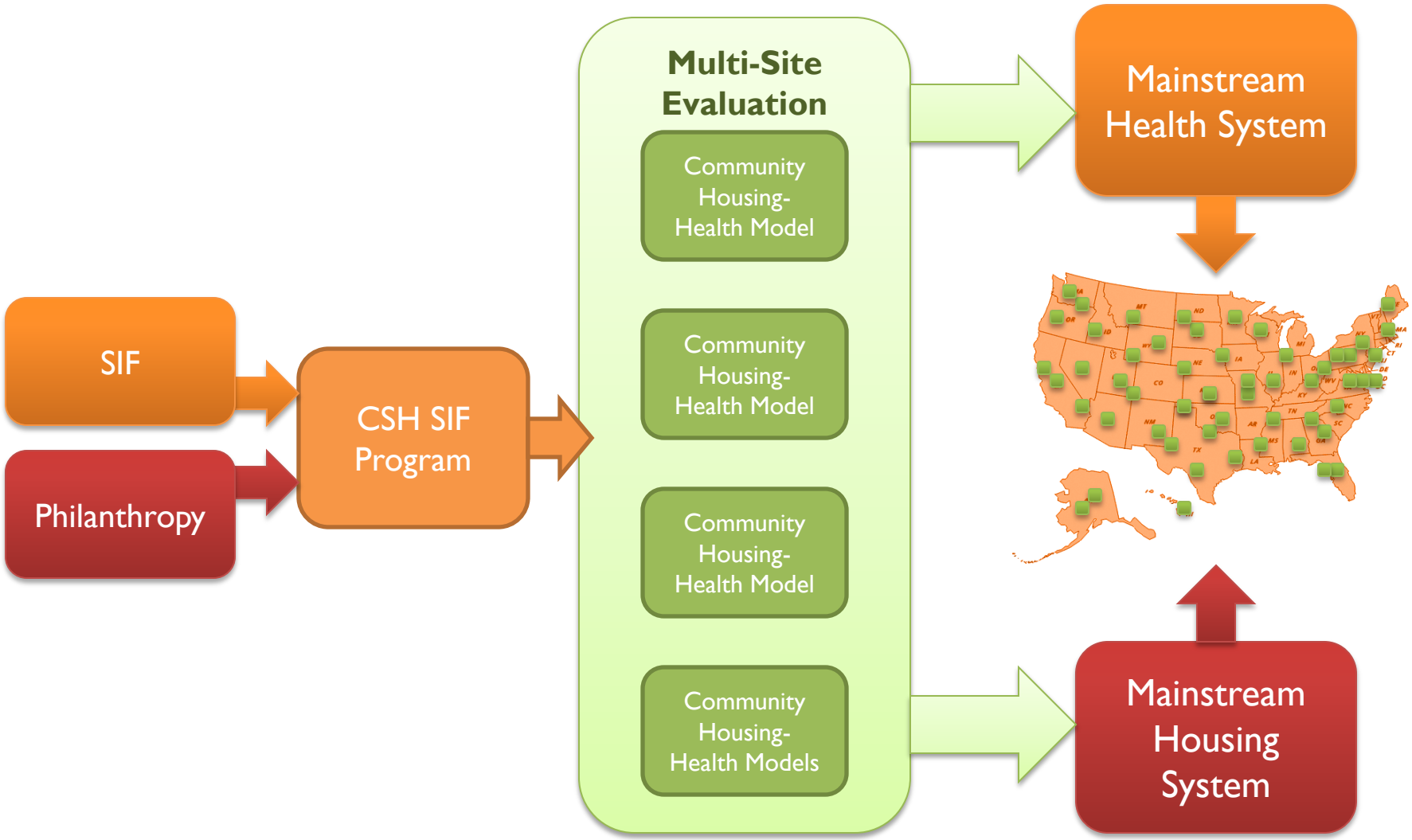
FUSE Process Model:

COLLABORATION AMONG HEALTH AND HOUSING SERVICE PARTNERS



10th DECILE PROJECT - Social Innovation Fund

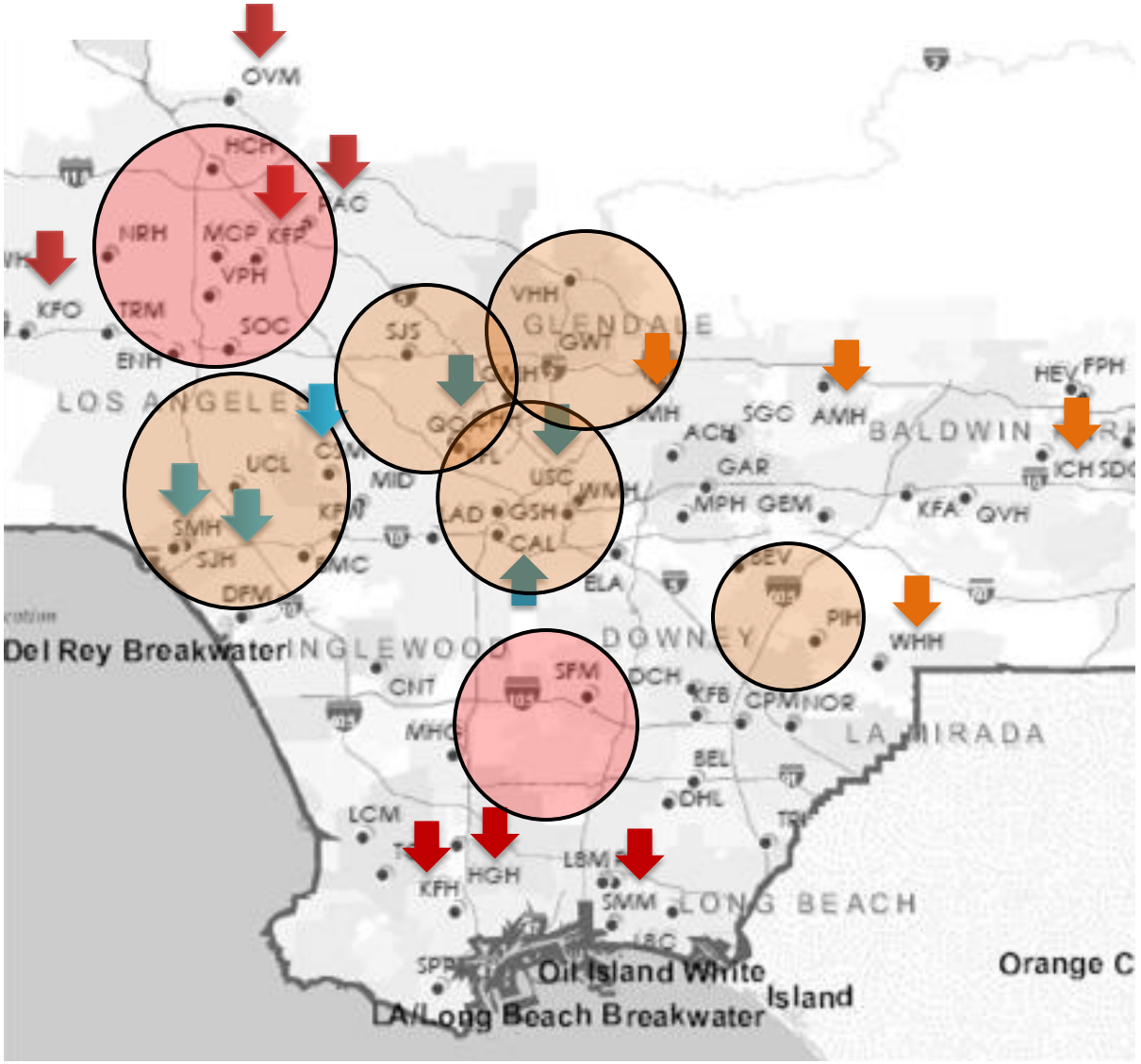
Using Public-Private Funding to Pilot Models, Demonstrate Success, Leverage Systems Change, and Scale Models



LA County SIF / FUSE Partner Matrix
6 Geographic Regions

	SIF/FUSE	SIF/FUSE	SIF	SIF	FUSE	FUSE
	Westside Target homeless frequent users: **27**	Downtown Target: **75**	Hollywood Target: **15**	Glendale-Pasadena Target: **30**	San Fernando Valley Target: **20**	South LA Target: **10**
14 Hospitals	Saint John's Health Center UCLA Santa Monica - UCLA	LAC+USC Healthcare Network California Hospital Medical Center A member of Dignity Health	Kaiser Permanente Los Angeles Medical Center Hollywood Presbyterian Hospital	Glendale Memorial Hospital A member of Dignity Health Glendale Adventist Medical Ctr Verdugo Hills Presbyterian Intercommunity Hospital Huntington Hospital	Kaiser Permanente Woodland Hills Panorama City Mission Community Compassionate Healthcare, Quality Healthcare Managed by Deanco Healthcare, LLC	St. Francis Medical Center Member of Daughters of Charity Health System
8 FQHCs	Venice Family Clinic	Clínica Monseñor Oscar A Romero JWCH Institute, Inc.	Homeless Health Care Los Angeles	CHAP Community Health Alliance of Pasadena Friends of Family Health Center CCHC	NEVHC People in Progress Tarzana Treatment Centers	Watts Healthcare Corp
7 Homeless Navigators	OPCC Empowering people to rebuild their lives	HW Housing Works Homeless Health Care Los Angeles PATH		Ascencia Lifting People Out of Homelessness HW Housing Works PATH	San Fernando Valley Community Mental Health Center	Watts Healthcare Corp
10 Housing Providers	A Community Of Friends Building Independent Lives	SRO Housing Corporation Opening Doors and Transforming Lives skid row housing trust A Community Of Friends Building Independent Lives	Hollywood Community Housing Corp WHCHC West Hollywood Community Housing Corporation	Union Station Homeless Services Housing + Employment + Life Skills First Day Shelter Compassion Center	L.A. Family Housing	WLCAC Watts Labor Community Action Committee

LA County FUSE & SIF GEOGRAPHIC REGIONS



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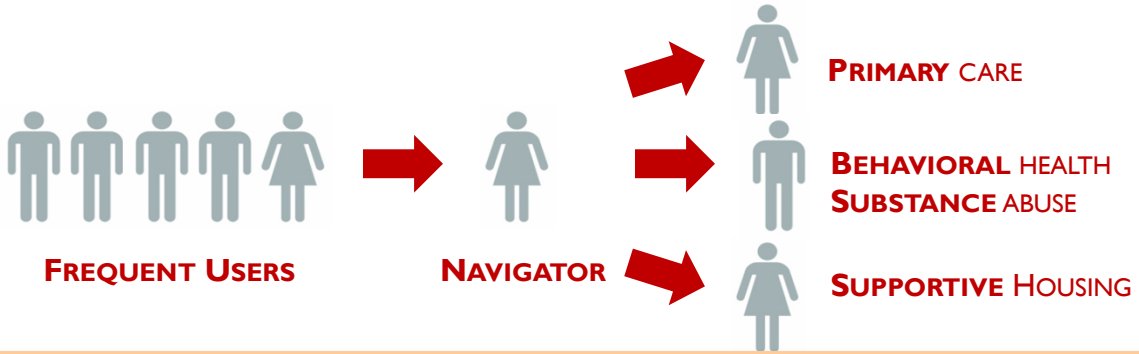
Model: Care Management Linked To Supportive Housing

What is a "navigator"?

- The navigator is responsible for all housing ***and*** social services (including primary and behavioral care) for frequent users. Essentially this person (or persons) is half care management coordinator and half housing navigator.
- The navigator must be capable of negotiating and bridging the healthcare and housing systems and coordinating a multi-disciplinary team. S/he collaborates closely with partner healthcare and housing providers.
- The navigator ensures good communication with/among providers, patients, caregivers in inpatient and outpatient settings. S/he must have strong skills for reaching out to, engaging, building trust, and forming lasting relationships with individuals who are chronically ill and chronically homeless.
- The navigator is usually housed at a homeless services provider, a hospital, or an FQHC.



Process:

1. **Care planning** begins with **assessment** at admission (using the Triage Tool).
2. **Warm hand-off** from hospital to navigator, with clear discharge instructions with attention to medication management.
3. **Patient engagement** encompasses includes motivational interviewing, client goal setting, and immediate placement in temporary housing.
4. **Enrollment** in SSI/MediCal and coordination of **medical and mental health care** with timely follow-up visits — with primary care provider and appropriate specialists; continuing chronic disease management and management of mental health conditions and substance abuse
5. **Preparation of housing applications** for permanent supportive housing (PSH) to housing authorities in LA County.
6. **Move-in / transition** to permanent supportive housing: continued case management and follow-up visits.

10th Decile

Triage Tools

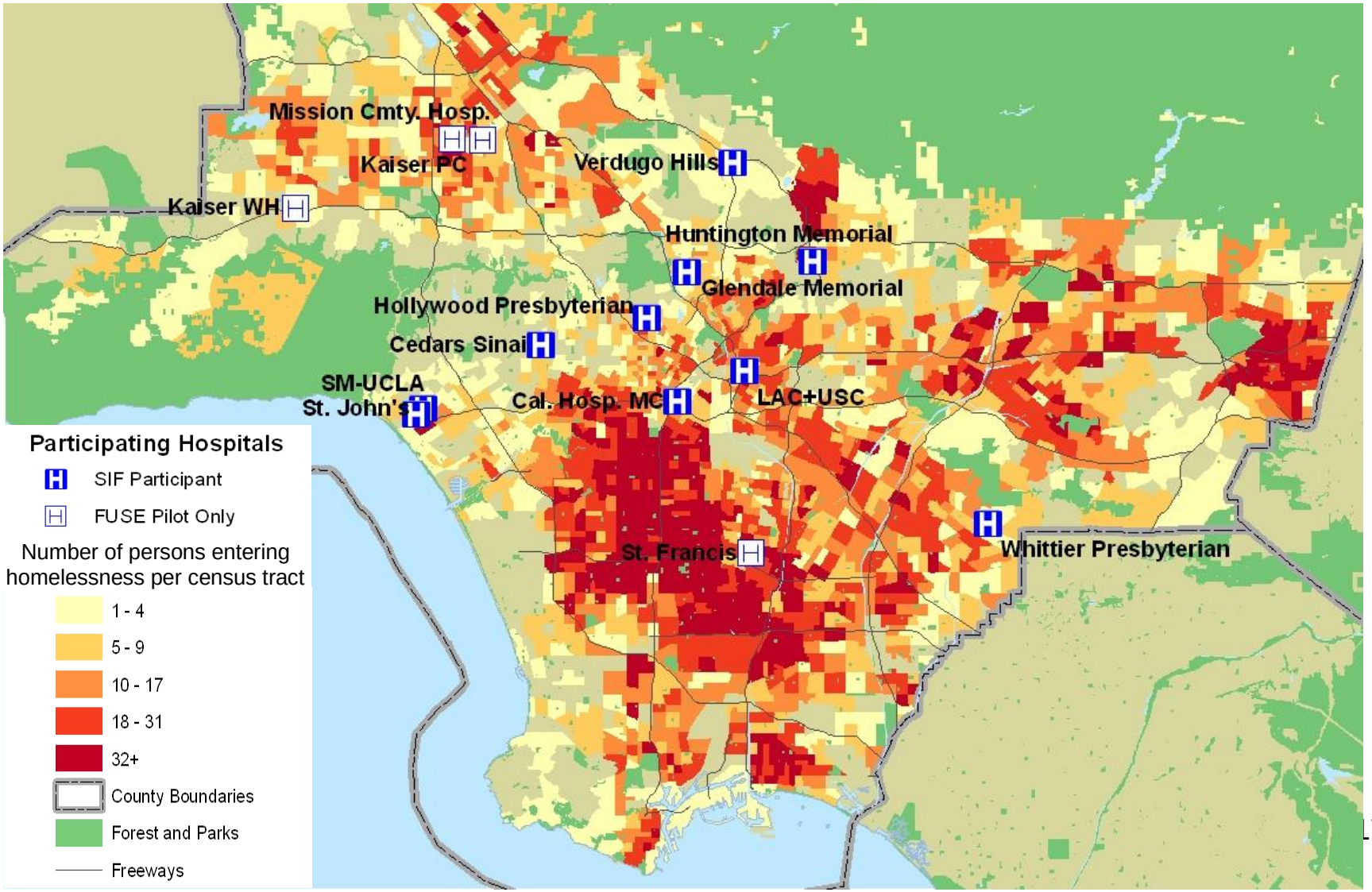
Identifying & Housing High-Cost, High Need Homeless Individuals

NACM
October 25, 2012

Road map

1. There number of homeless individuals needing permanently affordable supportive housing is far greater than the supply
2. There is a wide range of distress & public cost among homeless adults
3. The triage tools are *system based*:
    a. Use a wide range of in-depth information
    b. Identify people most likely to have continuing crises in their lives that create high public costs
4. The screening results:
    a. Provide a strong, objective argument for giving clients with the most acute needs & highest public costs first priority for access to PSH
    b. Identify the public agencies that can be called upon for support because they avoid costs when these high-need clients are housed

Hospitals using triage tool on map showing addresses prior to homelessness of LA County residents who became homeless in 2010



Public Costs for Homeless Single Adults

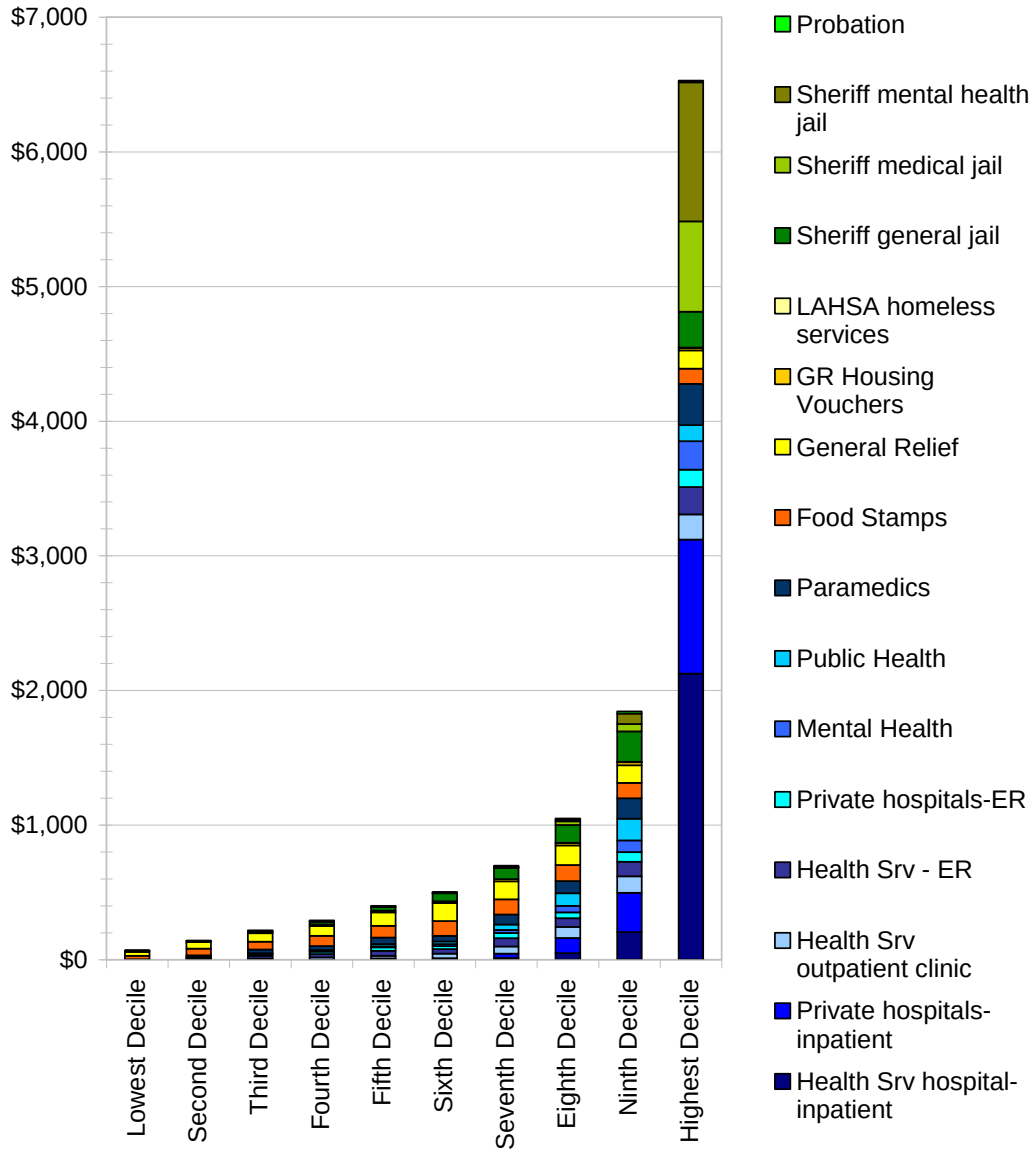
A Small Number of Very High Risk Homeless Persons

At risk for extensive need of health & justice system services

- The most expensive 10% of homeless persons have average monthly costs $6,529, regardless of whether they are homeless or housed
- LA County CEO-SIB linked service & cost records across county departments for a representative sample of GR recipients to produce this exceptionally valuable data

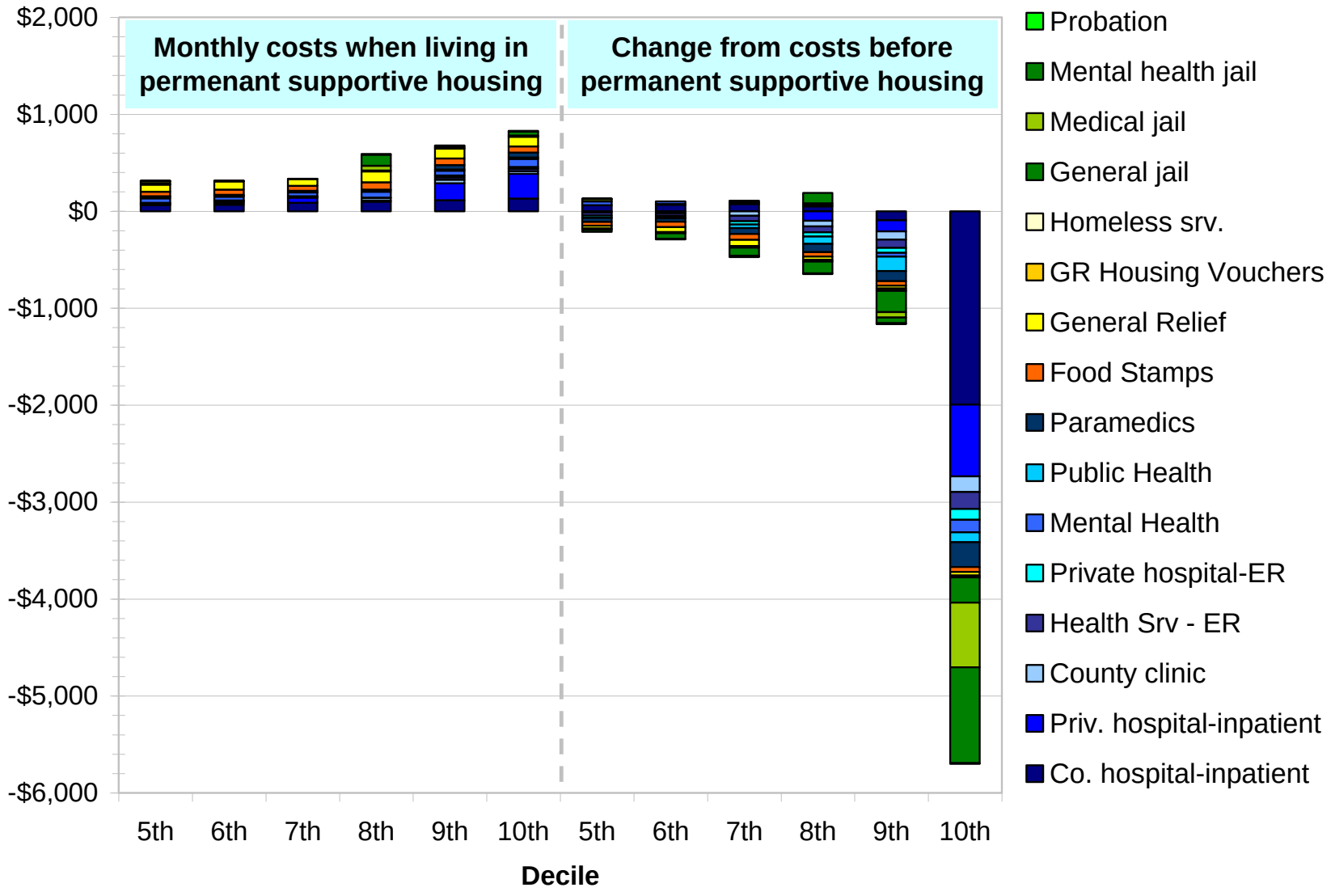
Average Monthly Costs in All Months by Decile for Homeless GR Recipients

Source: 2,907 homeless GR recipients in LA County with DHS ER or inpatient records
Deciles based on costs in all months whether homeless or housed



The greatest cost savings can be achieved by prioritizing high-risk individuals

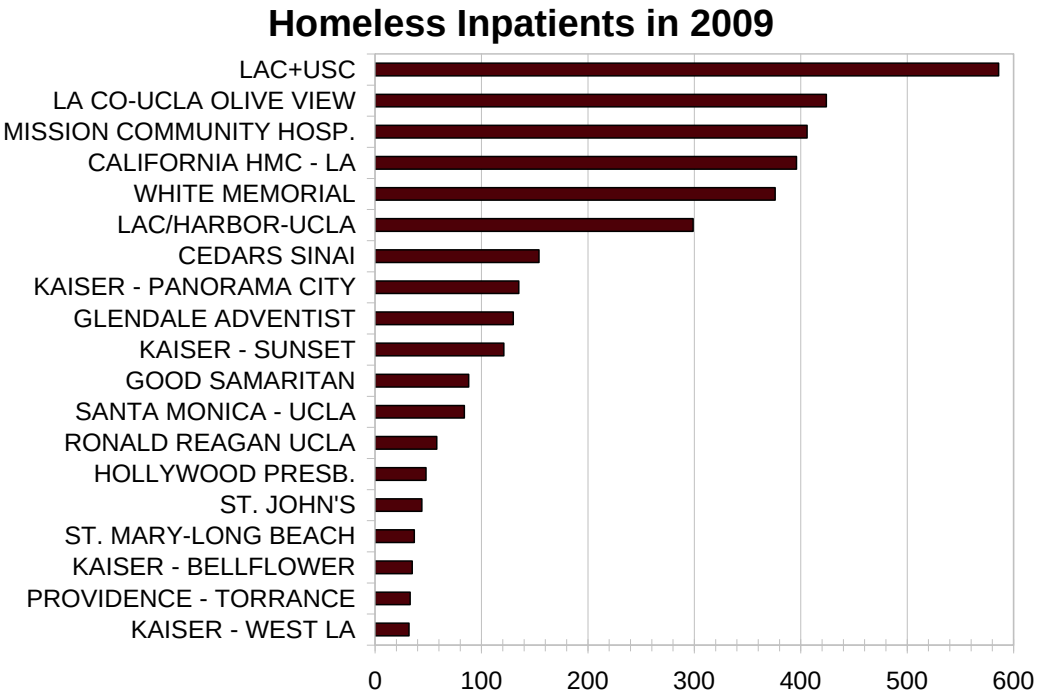
Housing homeless persons with disabilities reduces public costs

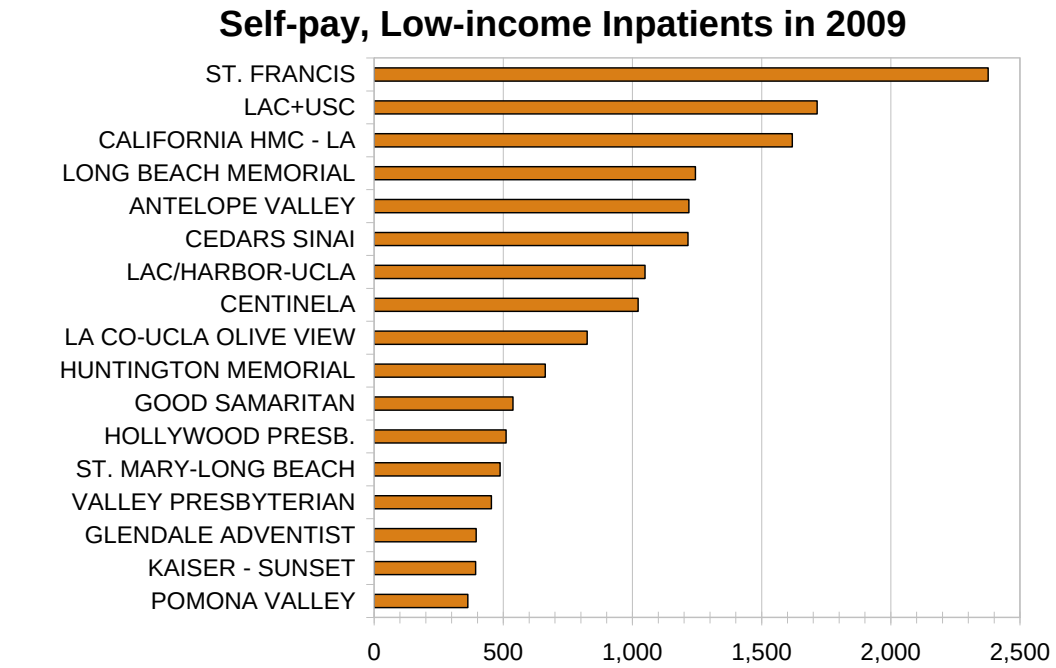


When people in the 10th decile are living in permanent supportive housing, jail costs decrease 97% & health care costs decrease 86%

High health care costs for a small number of very sick homeless patients

- In 2009, LA County's 76 acute care hospitals with emergency departments treated:
  - 25,818 low-income, self-pay inpatients at a cost of $917,839,334
  - 4,270 inpatients identified as homeless at a cost of $158,629,913
  - 321,865 low-income, self-pay emergency room patients at an estimated cost of $550,506,557





Source: California Office of Statewide Health Planning & Development (OSHPD)

Target Population

Target Population

- Homeless
- Treated at hospital in past 2 years
- Extensive use of hospitals or jails
- Disabled but able to live independently
- US citizen or permanent resident
- Not on parole for a violent crime
- No prior conviction for:
  - Arson
  - Operating a methamphetamine lab
  - An offense that requires registering as a sex offender
- Able to live with the level of support available in permanent supportive housing

Patients that require skilled nursing care rather than permanent supportive housing

- Individuals must be able to live alone in a hotel & then in permanent supportive housing. Health conditions that are barriers to living in permanent supportive housing & that indicate a need for skilled nursing care include:
  - Wheel chair - assistance is not available to move patients into & out of wheel chairs. Patient in wheel chairs are viable for the program if they are sufficiently ambulatory to be able to get out of the wheel chair & into a taxi, onto a toilet, & into a bed on their own.
  - Colostomy bag
  - Urinary catheter
  - Tracheotomy
  - Intravenous therapy
  - Serious wounds that impair mobility or that require ongoing wound care

Young Mentally Ill Male - Health Problems & Jail History

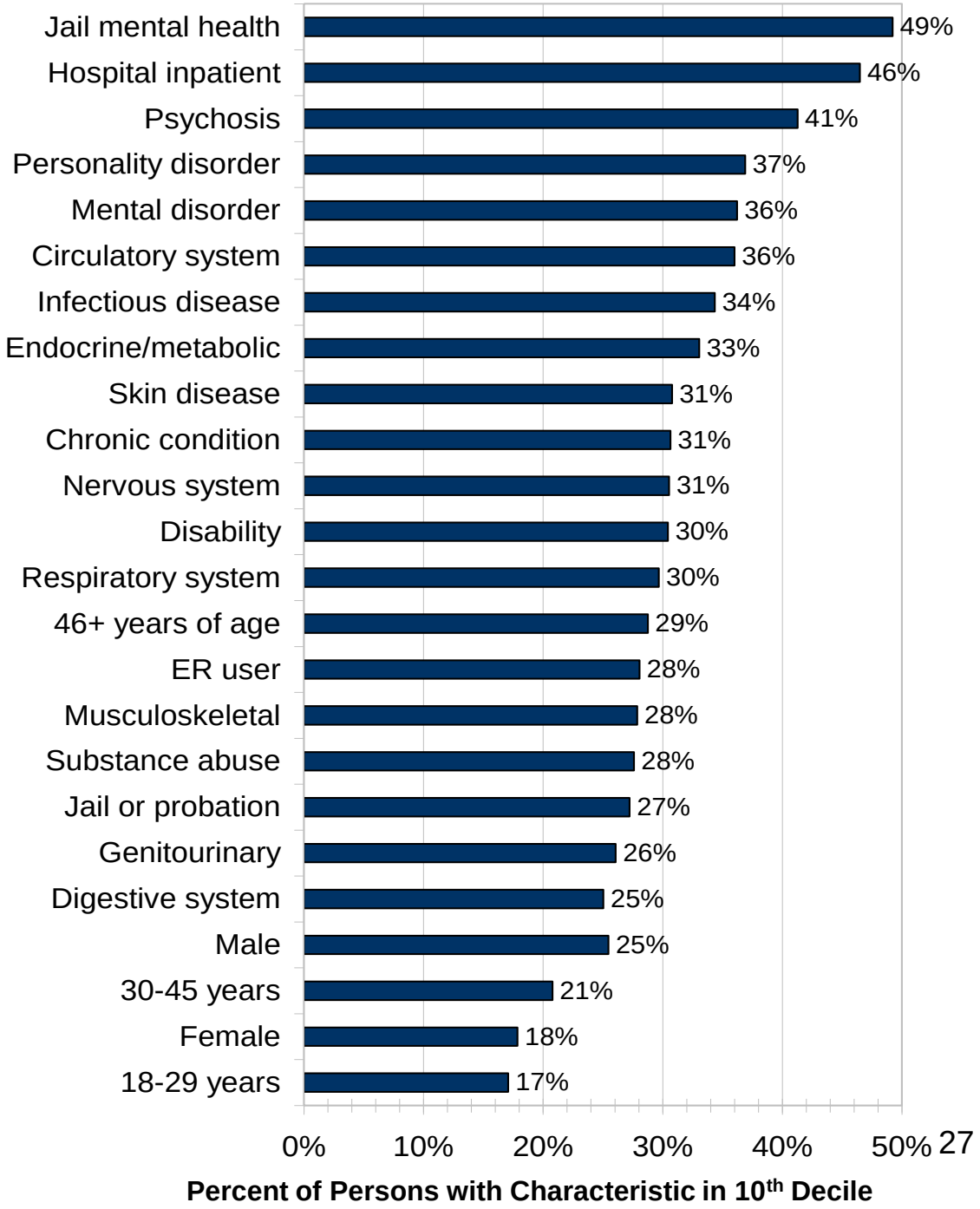
- Year of birth: 1987
- Place of birth: California
- Sex: Male
- Ethnicity: White
- Mental illness: Yes
- Substance abuse: Yes
- LA County DHS encounters in past 3 years: 26 – 4 outpatient, 11 ER, 25 inpatient days
  - 011.90 Pulmonary tuberculosis - Inpatient
  - 292.84 Drug-induced mental disorders - ER
  - 298.9 Other nonorganic psychoses - ER
  - 305.60 Nondependent abuse of drugs - ER
  - 311 Depressive disorder, not elsewhere classified - Outpatient
  - 465.9 Acute upper respiratory infections of multiple or unspecified sites - Outpatient
  - 680.6 Carbuncle & furuncle - ER
  - 682.6 Other cellulitis & abscess - Outpatient
  - 807.01 Fracture of rib(s), sternum, larynx, & trachea - ER
  - 882.0 Open wound of hand - ER
- Jail encounters in past 3 years: Yes
  - 71 days in general jail facilities
  - 8 days in jail medical facilities
  - 414 days in jail mental health facilities
- Average monthly public costs: $19,429

Older Diabetic Female with Jail History

- Year of birth: 1959
- Place of birth: California
- Sex: Female
- Ethnicity: African American
- Mental illness: Yes
- Substance abuse: Yes
- LA County DHS encounters in past 3 years: 13 – 6 outpatient, 6 ER, 13 inpatient days
  - 250.02 Diabetes mellitus - Multiple Outpatient & ER
  - 486 Pneumonia, organism unspecified - Multiple ER
  - 599 Other disorders of urethra & urinary tract - ER
  - 724.5 Other & unspecified disorders of back - Outpatient
- Jail encounters in past 3 years: Yes
  - 215 days in general jail facilities
  - 21 days in jail medical facilities
  - 170 days in jail mental health facilities
- Average monthly public costs: $10,628

No single factor reliably identifies people in the 10th decile

- Mental illness combined with incarceration is the strongest predictor
- Being a hospital inpatient is the next strongest predictor
- Age increases the probability



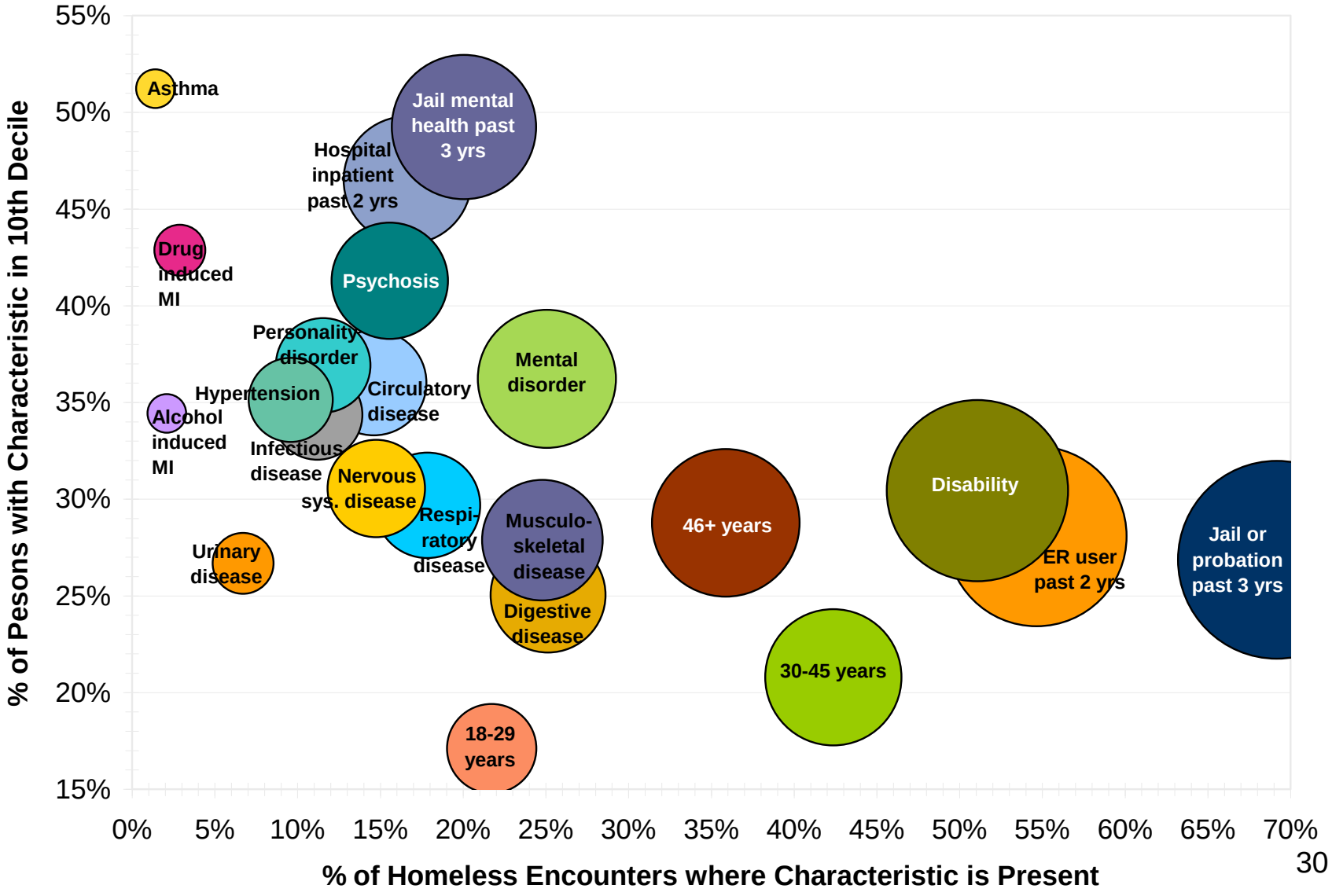
Patient Screening

Two triage tools

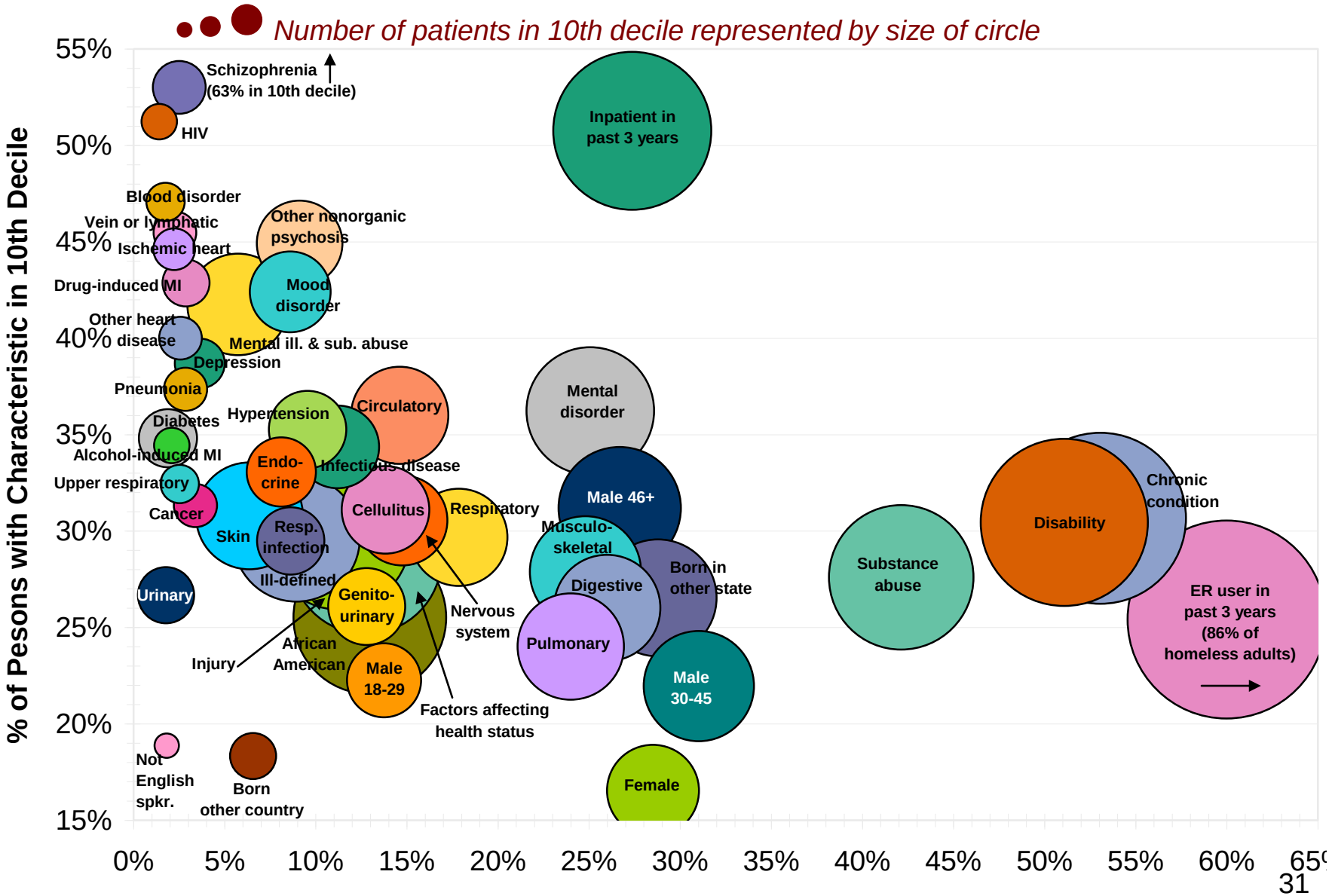
- Tool #1 should be used for patients who have been in jail in the past two years, when the amount of jail time is known
  - Model is partitioned by age: 18-29, 30-45, 46+
    - Each partition uses a different set of factors & weights for calculating probabilities
  - It is helpful to know if the patient was incarcerated in a jail mental health or medical facility, i.e., Twin Towers, because this more expensive & has more weight in the model
- Tool #2 should be used if just hospital data is available for patients
  - Uses more data to compensate for the absence of the predictive power of jail time
    - More diagnostic information, gender, African American ethnicity
  - Model is partitioned by age & gender: females, & males 18-29, 30-45, 46+
    - Each partition uses a different set of factors & weights for calculating probabilities
  - Produces more nuanced scores for the probability of being in the 10^{th} decile
- The hospital screening form collects the information needed for both triage tools
- The triage tools are formatted for use in Excel.

Triage tool #1 combines the predictive power of 27 pieces of information about homeless adults in hospitals & jails

Number of patients in 10th decile represented by size of circle



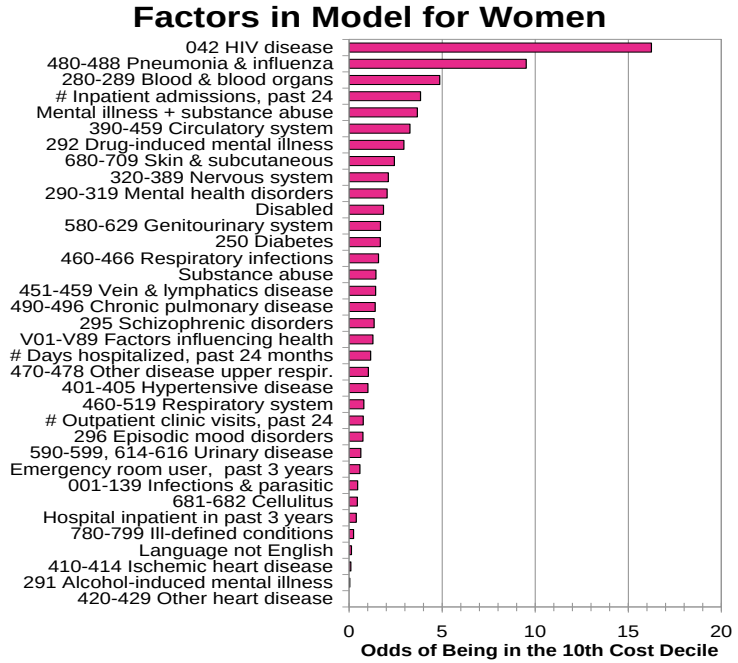
Triage tool #2 does not use justice system information – just 51 hospitals data items

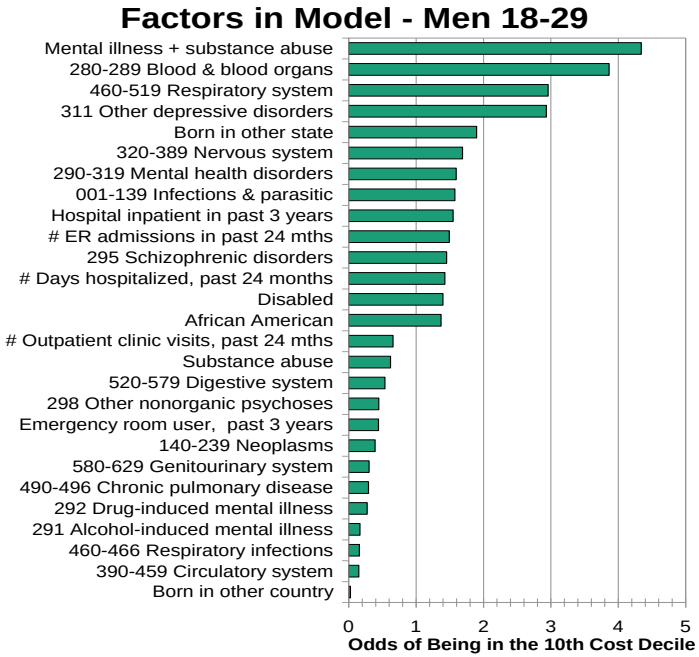


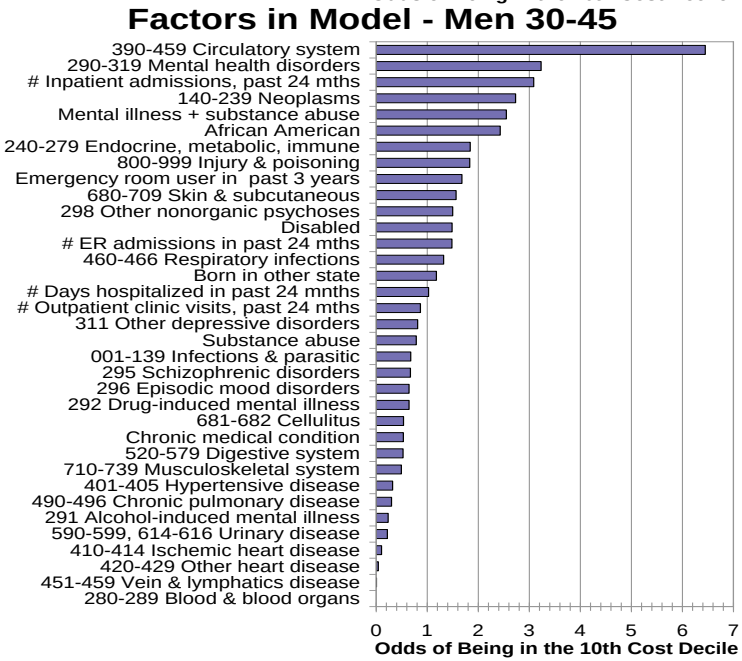
4 sets for risk factors for 4 groups in hospital tool

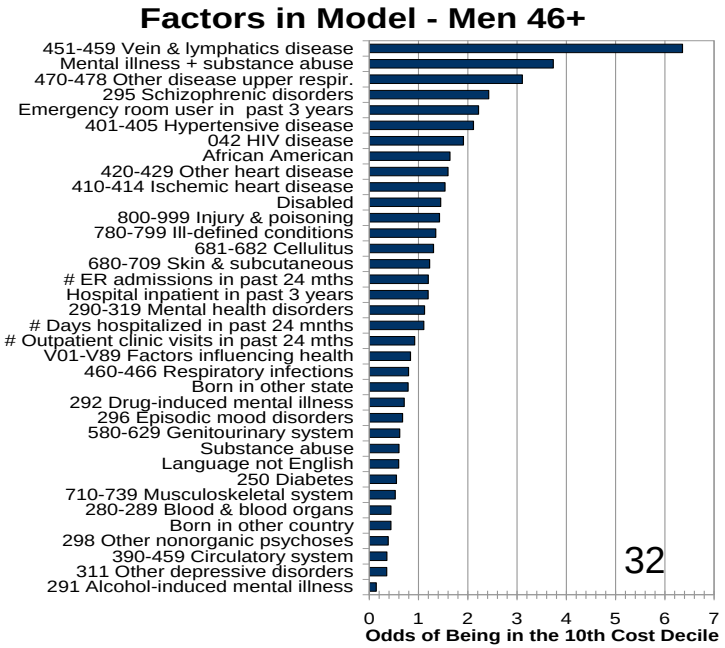
Factors with the most predictive power:

- Women
  - HIV+
- Men 18-29
  - Mental illness + substance abuse
- Men 30-45
  - Circulatory system
- Men 46+
  - Vein & lymphatics disease

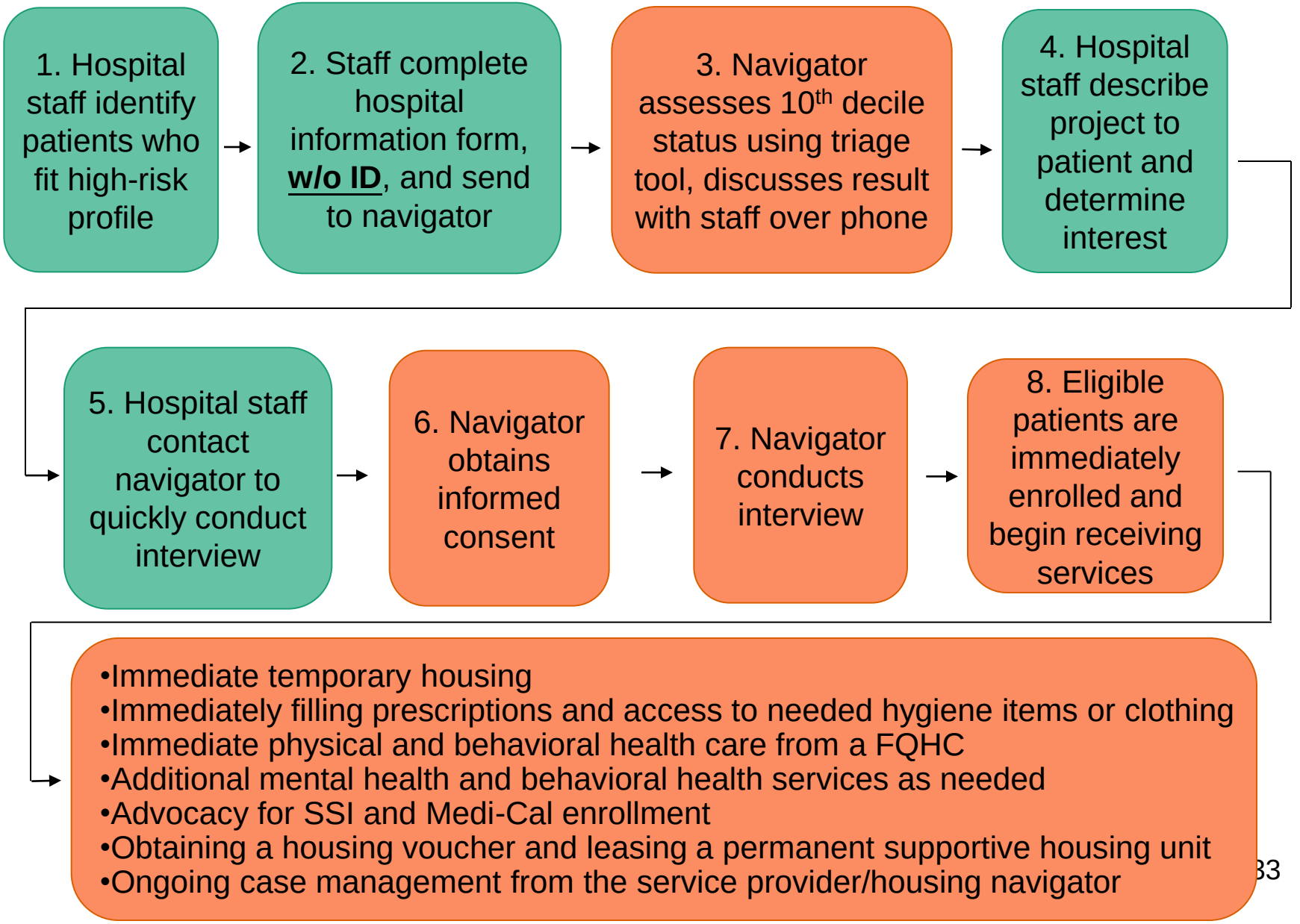








Flow Chart of Steps in Hospital Screening



Triage tool #1 uses information about age, health conditions & hospital/jail encounters

- Information about jail & hospital use has the most weight in the model
- Health conditions have a tipping effect
- **Very accurate:**
  - 1 out of 6 false negatives
  - 1 out of 6 false positives

27-Variable Tool for Estimating the Probability that a Homeless Person with Hospital and/or Jail History is in the 10th Decile

Preferred Tool when there is Jail History

CHOOSE ONE AGE GROUP PER CASE:	Case 1	Case 2	Case 3	Case 4	Case 5	Case 6
Age 18-29	y			y		
Age 30-45		y			y	
Age 46+			y			y
CURRENT HEALTH STATUS:						
Disability		y		y		
Mental illness (case records)	y		y			
Hypertension			y			
Drug induced mental illness						y
Psychoses				y		
Alcohol induced mental illness						
Personality disorder					y	
Urinary disease						
Respiratory disease			y			
Asthma						
Mental disorder (diagnosis)		y		y	y	
Disease of nervous system						
Disease of circulatory system						
Disease of digestive system						y
Disease of musculo-skeletal system					y	
IN PAST 3 YEARS:						
Jail or probation record		y	y			
Jail mental health inmate	y					
IN PAST 2 YEARS:						
Clinic outpatient, Dr's office (#visits)				4	1	
Emergency Room (#admissions)			3	8	6	3
Hospital inpatient (#admissions)		2		3	2	1
Hospital inpatient (#days)		8		12	6	7
Jail, mental health facility (#days)	30					
Jail, medical facility (#days)			20			
Jail, not med or mental facility (#days)					120	
Estimated probability for 10th Decile	**0.36**	**0.70**	**0.57**	**0.38**	**0.43**	**0.43**

Triage tool #2 uses information about age, gender, ethnicity, health conditions & hospital encounters

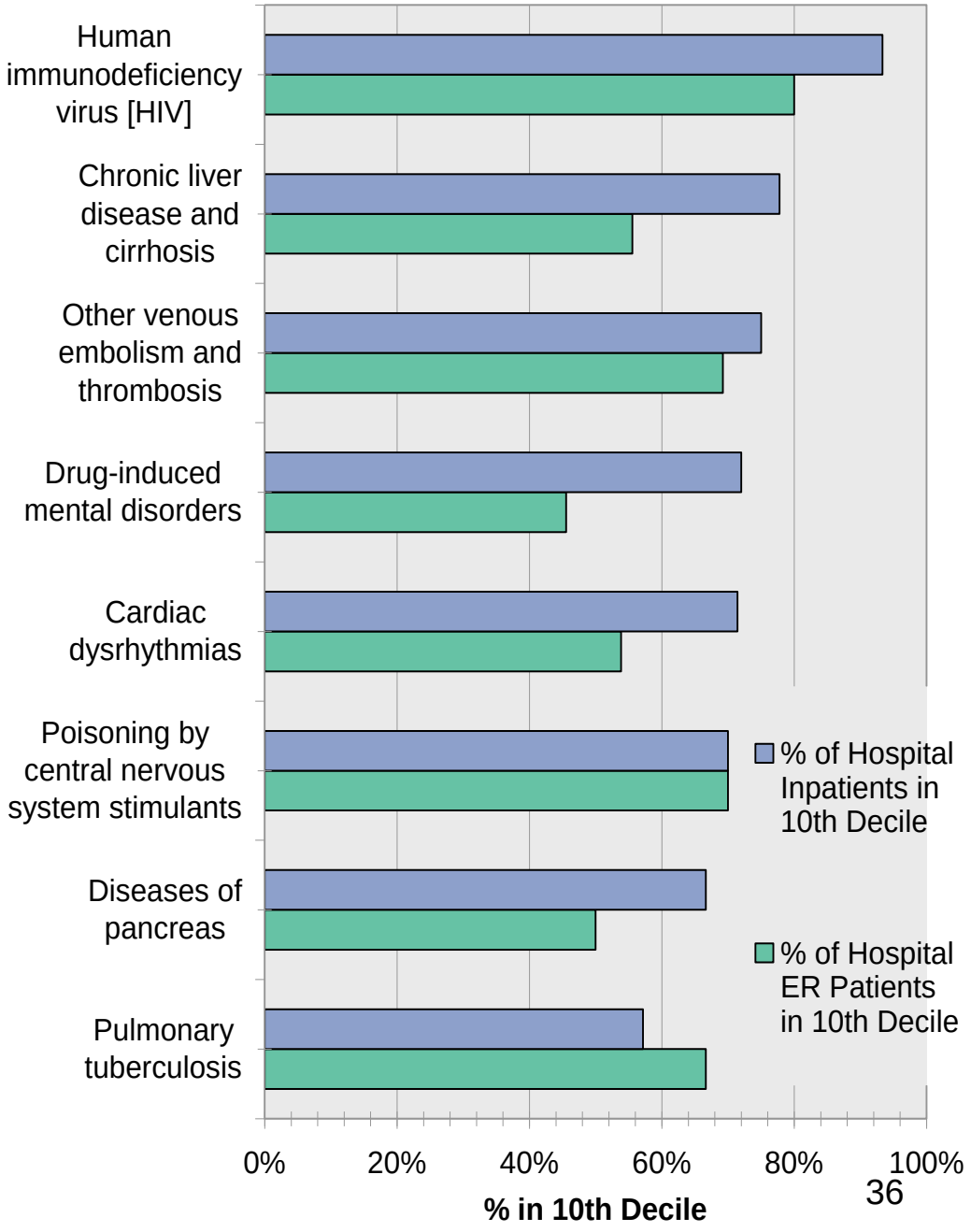
- Information about hospital use has the most weight in the model
- Health conditions have a tipping effect
- Less precise than tool #1 but still accurate
- Correctly classifies:
  - 92% of females
  - 86% of males 18-29
  - 87% of males 30-45
  - 82% of males 46+

51-Variable Tool for Estimating the Probability that a Homeless Hospital Inpatient is in the 10th Decile – *Preferred Tool when there is No Jail History*

	Case 1	Case 2	Case 3	Case 4	Case 5	Case 6	Case 7	Case 8	Case 9
ESTIMATED PROBABILITY FOR 10th DECILE	*0.96*	*0.36*	*0.65*	*0.87*	*0.57*	*0.48*	*0.64*	*0.39*	*0.45*
CHOOSE ONE GROUP PER CASE:									
Female	y	y			y				
Male, Age 18-29				y		y			
Male, Age 30-45							y	y	
Male, Age 46+			y						y
IN PAST 3 YEARS:									
Emergency Room User in Past 3 Yrs				y	y	y	y	y	y
Hospital Inpatient in Past 3 Yrs	y		y	y	y		y	y	
IN PAST 2 YEARS:									
Clinic outpatient, Dr's office (#visits)			3						
Hospital inpatient (#admissions)	2		4	3	1		2	3	3
Emergency Room (#admissions)	4			11	4	8	7	10	9
Hospital inpatient (#days)	6		8	14	10		4	12	10
CURRENT STATUS:									
Born in Other State	y				y	y			
Born in Other Country									
Language not English									
African American			y				y	y	
Disabled	y		y	y	y		y	y	
Substance Abuse	y		y	y		y	y	y	
Chronic Condition (HCUP)	y		y	y	y		y	y	
Mental Disorder + Substance Abuse	y		y				y		
001-139 Infections & Parasitic									
042 HIV Disease		y							
140-239 Neoplasms									
240-279 Endocrine & Metabolic & Immune									y
250 Diabetes									y
280-289 Blood & Blood Organs								y	
290-319 Mental Health Disorders	y	y	y	y	y	y		y	
291 Alcohol-induced Mental Illness				y					
292 Drug-induced Mental Illness				y					
295 Schizophrenic Disorders	y					y			
296 Episodic Mood Disorders			y				y		
298 Other Nonorganic Psychoses	y				y		y		
311 Depressive Disorders								y	
320-389 Nervous System				y			y		
390-459 Circulatory System	y				y			y	y
401-405 Hypertensive Disease								y	y
410-414 Ischemic Heart Disease									
420-429 Other Heart Disease									
451-459 Vein & lymphatic Disease					y				
460-519 Respiratory System			y						y
460-466 Respiratory Infections			y						
470-478 Other Disease-Upper Respiratory Tract			y						
480-488 Pneumonia & Influenza									
490-496 Chronic Pulmonary Disease									y
520-579 Digestive System				y		y			
580-629 Genitourinary System				y			y		
590-599, 614-616 Urinary Disease							y		
680-709 Skin & Subcutaneous									
681-682 Cellulitus									
710-739 Musculoskeletal System							y		
780-799 Ill-defined Conditions									
800-999 Injury & Poisoning				y					
V01-V89 Factors Influencing Health									

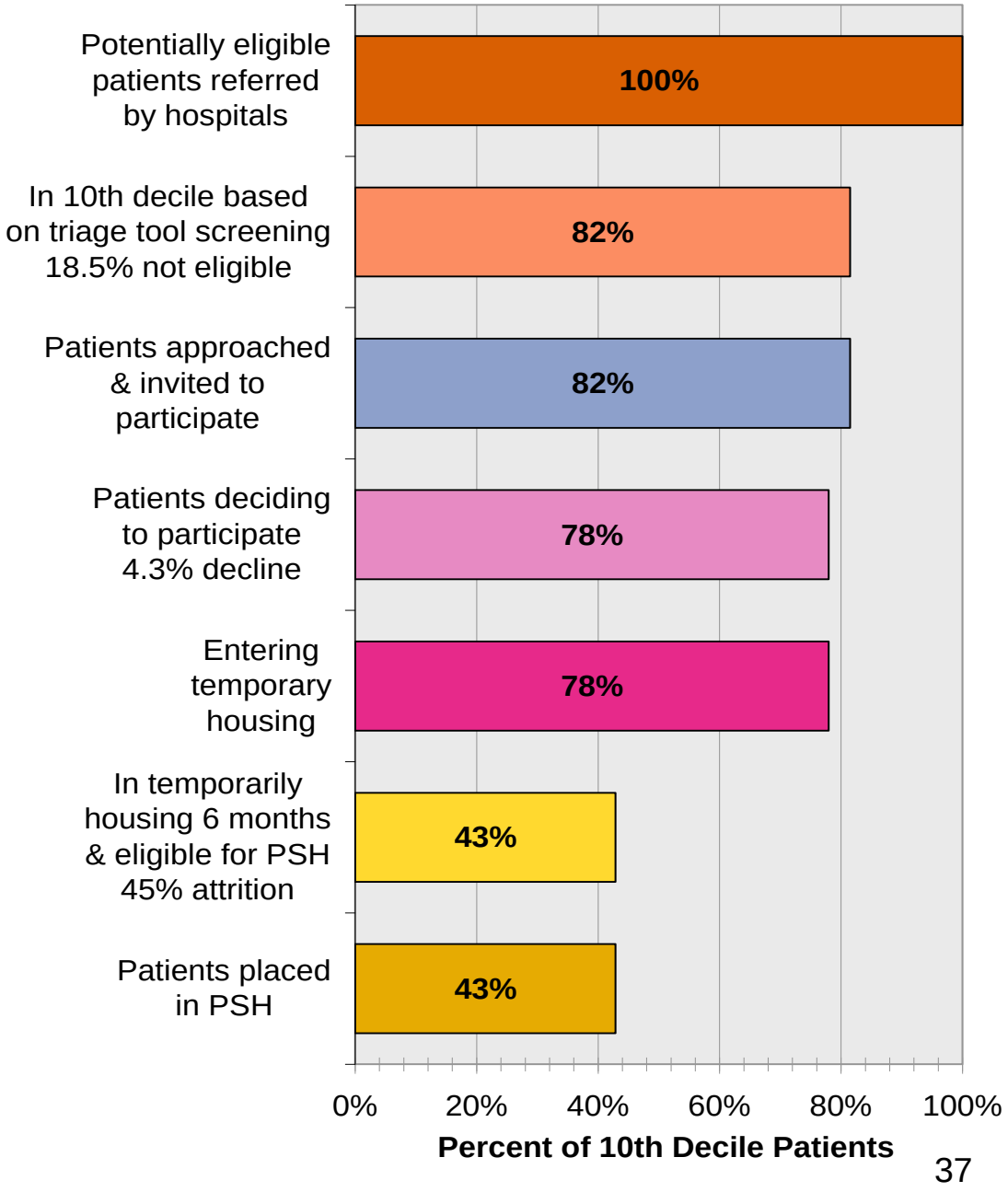
Clinical over-ride of model results

- The triage tool identifies people currently in the 10th cost decile
- The model does not flag people diagnosed with conditions that are highly likely to move them into the 10th decile
- The screening process includes an option for over-riding model results
- These 8 high risk conditions are flagged on the hospital information form



Challenges

- Most attrition occurs while in temporary housing, waiting for Section 8 vouchers
  - This often takes 6 months
- Keys to improving outcomes:
  - Strong ongoing client contact
  - Quick access to housing vouchers
- Sustainability
  - Building a bridge from hospital to permanent supportive housing costs ≈ $20k a patient
  - Keeping 10th decile individuals in housing requires ongoing support
  - More stakeholders, especially hospitals, need to provide support



Applicability and useful life span of triage tools

- The triage tools differentiate the cost spread among homeless adults based on health conditions and use public services. This cost spread is likely to be valid for metro areas across the U.S.
  - The ICD-9-CM medical diagnostic codes used in the tools are used by hospitals throughout the U.S.
  - These urgent medical or mental health problems have a similar course and require similar responses from hospitals in any metropolitan area of the U.S.
- The hospital-based triage tool III is likely to remain reliable until hospitalization practices change, or there are more effective treatments for medical conditions in the model.
- These tools can be validated and improved upon through record linkage initiatives in other regions. For example, the record linkage project underway in Santa Clara County.

Project FUSE-Westside

A collaboration with Venice Family Clinic, Saint John's Health Center, Santa Monica UCLA Medical Center, Economic Roundtable, and Corporation for Supportive Housing

Presented by
Debby Maddis, MPH
Director, Housing and Special Initiatives

Agency Overview

- **Largest provider of housing & social services on Westside of Los Angeles County**

- **Provides "wrap around" services to individuals facing multiple obstacles:**
  - Chronic homelessness
  - Mental Illness, addictions, physical health conditions
  - Battered women & their children
  - Veterans

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Agency Overview

- **Four core services:**
  - Housing (permanent & interim)
  - Behavioral healthcare
  - Medical care
  - Benefits assistance
  - Domestic violence services
- **Additional Services:**
  - Basic living assistance: food, clothing, transportation, hygiene (showers, washers), mail
  - Life skills/Wellness
  - Community Reintegration & Peer Programs

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Approaches

- **Meeting clients where they are: “whatever it takes”**
- **Interdisciplinary teams at each point in process:**
  - Street medicine and outreach, hospital *in-reach*
  - Onsite team care
  - Ongoing support after client is housed by multidisciplinary team members: “Go the Journey”

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Breakdown the Silos

with an integrated consortium model

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OPCC's FUSE Project

Goal: Create a 'warm handoff'

Hospital → **OPCC/VFC** → **New health home**

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Major Components

- Housing and social service navigation
- Business Associate Agreement with 2 hospitals, FQHC and OPCC
- FQHC Satellite – co-located on site
- Respite Care beds in shelter setting
- Interdisciplinary mobile health/behavioral health teams
- Transition to new health home following housing placement

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Staffing

- Interdisciplinary Care teams at each stage
- Housing Navigators and Care Coordinators – separated by function
- Nurse, MD and psychiatrist
- MSW and MFT Interns
- Psychology post docs
- Over 20% of staff – former consumers

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Integration At Each Stage

- ER ➡ Street medicine/outreach or Respite bed
- Establish temporary health home at VFC co-located at OPCC
- Interim housing – motel or shelter
- Permanent housing with mobile integrated health and behavioral health teams
- Establish health home in local community following housing placement, with ongoing support by OPCC care teams

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Integration of Health & Housing

Linkage to interdisciplinary mobile health home/care teams (FQHC, service provider)

Housing navigators arrange scattered site/ project based permanent supportive housing

Transfer dependency from hospital to new health home, FQHC, or community clinic

- Develop trust between social service providers, FQHC, and hospitals
- Business Associates Agreement to coordinate service delivery
- "Warm Handoff" to transfer the trust from hospital to provider

Obstacles/Challenges

- Long wait for housing (voucher issuance)
- Need for more disabilities accessible buildings
- Hard to engage
  - Clients disappear due to frequent hospitalizations and jail
- Mental health conditions, e.g., paranoia, can create barriers to gathering required documents for housing applications

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Lessons Learned

- Most hospitals are unable to care for individuals with chronic alcoholism, addiction, severe mental illness, and individuals seeking pain medications = 90% tri-morbidity
- Help clients ask for reasonable accommodations (not waiting in long lines at DMV, SSA office)
- Motel vouchers offer good incentive to participate
- Team needs to be mobile: a lot of transporting is necessary
- Intensive work requires low staff to client ratio

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HOUSING FIRST - PERMANENT SUPPORTIVE HOUSING - HARM REDUCTION STRATEGIES

interdependent and essential to the success of chronically homeless persons obtaining and sustaining a home

MOLLIE LOWERY, HOUSING WORKS

HOUSING FIRST = HOME FIRST

- Direct access to a home
- Having a home is a basic human right
- Tenant driven
- Tenant choice
- Acknowledges that a person can heal & recover at home
  (vs. on the streets)
- Does not *require* abstinence from drugs or alcohol
- Does not *require* participation in mental health treatment
- Not *necessarily* rapid re-housing

PERMANENT SUPPORTIVE HOUSING

- Housing “unbundled”, but linked to services
- Participation in services is *voluntary* & NOT a condition of lease
- Affordable
- On-site services are:
  - Flexible
  - **Pro-active**
  - individualized

- *NOT a program*
- Retention of housing is not contingent on participation in mental health treatment
- Retention of housing is not contingent on abstinence from drugs
- Retention of housing is contingent on abiding by the lease

PERMANENT SUPPORTIVE HOUSING

TO SUCCEED PSH RELIES ON:

- an effective partnership among property owner, property management, on-site service staff, *and the tenant*
- initially, utilizing the relationship between the new tenant and the service staff who has engaged and helped him/her obtain housing- to assist the tenant through the transition from streets to home

PERMANENT SUPPORTIVE HOUSING *RETENTION*

The *RELATIONSHIP* between service staff and tenant is a critical factor in housing retention.

CHARACTERISTICS & APPROACHES TO BUILDING THE RELATIONSHIP

- Ability to be consistent, reliable, authentic
- An understanding of *each* tenant's needs as s/he defines them
- As a *team*, assess & re-assess goals & plans
- Capacity to *facilitate change in behavior*
- A genuine enjoyment of time & interactions
- Mutual respect

- Obtain maximum benefit from any time or interaction- being fully present
- Being flexible and responsive- adapting and learning new tools and strategies
- Remaining a student- learning from the relationship
- A commitment to be **PRO-ACTIVE**