

Medicaid Redesign Team Supportive Housing Evaluation

IMPLEMENTATION STUDY REPORT



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Executive Summary

Overview

- The Medicaid Redesign Team Supportive Housing (MRT-SH) programs serve individuals who were previously homeless, at risk of becoming homeless, or institutionalized. Drawing from qualitative interview and focus group data, this report describes how several MRT-SH programs are being implemented, based on administrative, staff, and participant perspectives.
- Data sources for the report consist of semi-structured interviews with program administrators (n=40), as well as focus groups with program staff (n=65) and service recipients (n=90), which were conducted separately. The specific provider sites selected for qualitative data collection were chosen to ensure representation of the various agencies and programs that receive MRT-SH funding.
- The sites selected for inclusion in the study are diverse and varied, differing in populations served and housing and types of services provided. Sites included in the study were: ACR Health; Bridging Access to Care; Champlain Valley Family Center; East 99th Street; Norwood Terrace (Concern for Independent Living); CAMBA Gardens II; 86. Carroll Street (Opportunities for Broome); Evergreen Health Services; Living Opportunities of DePaul; BronxWorks; Unity House of Troy; Saint Joseph's Medical Center; Lexington Center; New York Association for Independent Living; Federation of Organizations; Rebuilding Together Saratoga County; and Ithaca Housing Authority.
- Across all providers, service recipient focus group participants had a mean age of 51 years. Forty-eight percent were female and 52% were male. The sample was racially diverse, with 38% of individuals self-identifying as African-American, 39% as white/Caucasian, 12% as Hispanic/Latino, and 11% as some other race.
- Prior to program entry, the service recipient focus group participants reported living in a homeless shelter (31%), being absolutely homeless/unsheltered (14%), living independently in the community (12%), living in the home of family or friends (12%), or living in a residential setting or program (10%). Other responses include living in a nursing home or long-term care facility (4%), another supportive housing program (4%), in a jail or prison (4%), psychiatric facility (4%), or in a different (unspecified) setting (6%).

Key Findings

- The analysis underscored how critical housing is in the lives of individuals who had been unstably housed or homeless, as well as those who were institutionalized. Housing allows many to reclaim a positive sense of identity, experience peace and stability, become independent, and address health and recovery needs. Support services, such as case management, are essential to fostering the skills needed for participants to become independent and to retain their housing. Case management is also critical to facilitating linkages to physical and mental health providers and other support systems.
- While supportive housing is positively impacting health and quality of life for most participants, it is not a panacea. Many individuals continue to struggle with mental health issues, chronic conditions, and addictions; others contend with social isolation and strained relationships. The participants described trauma and significant adversity prior to entering supportive housing, which is likely compounded by structural injustices, such as poverty, discrimination, racism, and marginalization. Thus, the complex needs they are experiencing when entering MRT-SH programs are unlikely to be fully ameliorated by supportive housing.
- The analysis underscored how programs should anticipate early adjustment challenges as individuals first enter the program. Many participants struggle to pay rent on time, maintain their apartments, remember and follow through with medical appointments, and navigate their new communities. Social isolation and loneliness were commonly reported by participants when first entering supportive housing. It is especially important for programs to provide intensive services at this stage, and to continually assess the specific supports each participant requires in order to retain their housing.
- A complex picture emerged in terms of the benefits and drawbacks of congregate and scattered-site supportive housing models. The analysis suggests that the characteristics, needs, and goals of the participants might suggest a better fit with a certain model. For instance, participants with acute mental health needs who experience signifi-

cant anxiety in an apartment environment might be best served by a congregate program with on-site staff. Those who can acclimate into the community and who wish to reclaim their lives with identities that are less stigmatized might prefer and be successful in a scattered-site program.

- Perspectives on the Housing First approach emerged as complex and nuanced. While the benefits of the model were widely described by administrators, staff, and service recipients, limitations and challenges were highlighted as well. Participants across the stakeholder groups endorsed the low-barrier approach to housing, indicating that housing is a human right and/or a basic need that needs to be met before service recipients can address other health concerns. However, program staff often struggled to address the addictions of individuals residing in the programs, which often complicate landlord relationships. Participants were sometimes hesitant to endorse harm reduction, as they indicated the possibility of becoming destabilized when surrounded by other individuals who are using. To address these challenges, it is important to have intensive supports in place for those with complex needs, such as addictions. Further, programs may benefit from promoting a respectful and safe environment for all residents, such that those who may be using are encouraged to do so privately, and in a manner less obtrusive and risky to others.
- Since a key goal of the MRT-SH programs is to reduce Medicaid costs, the programs reported a need for additional guidance about how to operationalize and validate high Medicaid utilization. The findings also highlighted the need to address bureaucratic hurdles to the extent possible, in order to expedite the process of enrolling participants into the programs. Administrators and staff of the programs described burdensome application processes and requirements (e.g., proving homeless status) that create hurdles to rapidly housing those who are most vulnerable. Often these hurdles resulted from the requirements of other funders outside of MRT. Further, some program staff requested greater flexibility within the budget to address the needs of participants, such as offsetting the cost of transportation and providing amenities that allow individuals to feel more comfortable and less anxious in their apartments (e.g., air conditioners, radios or DVD players, funding for an occasional movie outing, etc.).
- The analysis suggests that providers are eager for opportunities to interact and obtain feedback from one another, as well as from NYSDOH. One approach to achieve this would be to develop a learning community for the providers, consisting of virtual and in-person meetings to share ideas about innovative approaches. Learning communities can also be a forum for discussing challenges that the providers are experiencing, so staff can share ideas about approaches that others have found successful.

Report Overview

The Medicaid Redesign Team Supportive Housing (MRT-SH) programs serve individuals who were previously homeless, at risk of becoming homeless, or institutionalized. Drawing from qualitative interview and focus group data, this report describes how several MRT-SH programs are being implemented, based on administrative, staff, and participant perspectives. We describe the overall program context and key components, then present staff and administrative perspectives regarding program targeting and eligibility determinations, program changes or innovations since receiving MRT-SH funding, the nature of housing and services offered, strategies for decreasing Medicaid costs, perceptions of participants' progress, and staff and administrative views of program strengths and weaknesses. Participant perspectives are also presented, which highlight the participants' housing status and lived experience prior to entering the program, their perceptions of housing and services, any changes they may have experienced since entering the program, and their views of program strengths and weaknesses.

Data sources for the report consist of semi-structured interviews with program administrators, as well as focus groups with program staff and participants, which were conducted separately. The specific provider sites selected for qualitative data collection were chosen to ensure representation of the various agencies and programs that receive MRT-SH funding.

The main objectives of this report are:

- 1 To highlight specific and contextualized information about how the programs are being implemented, including the extent to which they are being implemented as expected or designed.
- 2 To synthesize stakeholder perspectives regarding factors that are facilitating or impeding successful program implementation.
- 3 To examine how participants are experiencing supportive housing, including how the program may be impacting their daily lives, health, service utilization, and perceived quality of life.
- 4 To provide recommendations regarding program implementation, with the goal of informing policy and practice.

This report is organized into the following sections: Section 1: Methodology; Section 2: Program-specific Findings; Section 3: Cross-Cutting Themes; and Section 4: Summary and Conclusions.

Methodology

The research team selected provider sites for qualitative data collection, in collaboration with DOH. We started by generating a list of potential provider sites for inclusion in the Implementation Study, based on responses to the Implementation Survey. The shortlist consisted of provider sites that were serving target populations of special interest to DOH, as well as those engaged in innovative practices. In some cases, preliminary evaluation findings were taken into consideration, such as if providers showed early indications of cost savings. Agency directors were consulted for their feedback on sites to include as well, based on their knowledge of program operations. Providers were chosen from almost all of the MRT-SH funded programs to ensure representation of the full complement of initiatives. The qualitative data collection consisted of program manager/administrative interviews, focus groups with program staff¹, and focus groups with service recipients, as detailed below.

The interview and focus group protocols with administrators and staff focused on the following content areas: program context and key program components; regional factors impacting the program; targeting and eligibility determinations for program enrollment; program changes and innovations associated with MRT funding; reflections on Housing First principles; perspectives on housing (e.g., scattered-site versus congregate models); service delivery; practices for reducing Medicaid costs; perceptions of participants' progress in the program; and program strengths, weaknesses, and future directions. Of note, NYSDOH does not require the funded programs to adhere strictly to the Housing First model. However, most providers indicated adhering to some Housing First principles. Thus, interview and focus group items on Housing First referred specifically to perspectives on providing low-barrier housing to participants and drawing from a harm reduction approach (e.g., not requiring abstinence from substances as a condition for entering or maintaining housing).

The information provided in the report is based on perspectives and experiences of administrators and staff. In some cases, NYSDOH indicated that certain services described by the providers (e.g., peer groups and supported employment programs) are not funded through MRT dollars but are likely supported by another funding source. In other instances, NYSDOH indicated that targeting or eligibility criteria described by the providers are somewhat different from what is was described in the Requests for Applications/Proposals or other program documents. In these instances, footnotes highlight potential discrepancies.

The focus group protocol with program participants elicited content regarding the following topic areas: housing status and lived experience prior to MRT enrollment; perspectives on the housing accommodations provided through MRT; perspectives on Housing First principles; perspectives on support services offered; changes experienced since entering the program; and perspectives on program strengths and weaknesses. Of note, the Housing First items were asked, even if the program under study did not adhere to Housing First principles (e.g., participants were asked about their understanding of program policies regarding substance use, as well as their opinions on harm reduction principles within supportive housing).

Interviews and focus groups took place between February, 2017 and April, 2018. Of note, the provider agencies detailed in this report may have undergone changes in policy and/or practice since the time of data collection. Further, some of the providers are no longer receiving MRT-SH funding following re-procurement. The table on the following page details the sites included in the study, including the MRT program, overseeing agency, provider name, and region or city.

¹ In some cases, sites participated in program manager interviews only, rather than focus groups. This situation occurred when additional sites were selected to further contextualize program implementation or when providers were small non-profits without a full staff. These details are noted in the report text where appropriate.

Table 1. Overview of Implementation Study Sites

MRT Program	State Agency Overseeing Contract	Provider Name	Region/ City
Access to Home for Medicaid	Homes and Community Renewal (HCR)	Rebuilding Together Saratoga	Saratoga County
AIDS Institute Rental Subsidies	New York State Department of Health AIDS Institute	ACR Health	Syracuse
Capital Funding: HCR	Homes and Community Renewal (HCR)	East 99th Street (SKA Marin)	Manhattan
Capital Funding: HCR	Homes and Community Renewal (HCR)	Norwood Terrace (Concern for Independent Living)	Bronx
Capital Funding: HCR	Homes and Community Renewal (HCR)	CAMBA Gardens II (Camba, Inc.)	Brooklyn
Capital Funding: Homeless Housing Assistance Program	Office of Temporary and Disability Assistance (OTDA)	86 Carroll Street (Opportunities for Broome)	Binghamton
Capital Funding: Homeless Housing Assistance Program	Office of Temporary and Disability Assistance (OTDA)	Evergreen Health Services	Buffalo
Health Homes Supportive Housing Pilot	New York State Department of Health (NYSDOH)	Living Opportunities of DePaul	Niagara County
Health Homes Supportive Housing Pilot	New York State Department of Health (NYSDOH)	BronxWorks	Bronx
Senior Supportive Housing Pilot	New York State Department of Health (NYSDOH)	Ithaca Housing Authority	Ithaca
Nursing Home to Independent Living	New York State Department of Health (NYSDOH)	Federation of Organizations	Long Island
OASAS Rental Subsidies	Office of Alcohol and Substance Abuse Services (OASAS)	Bridging Access to Care	Brooklyn
OASAS Rental Subsidies	Office of Alcohol and Substance Abuse Services (OASAS)	Champlain Valley	Plattsburgh
OMH Step Down/Crisis Residence	Office of Mental Health (OMH)	St. Joseph's Medical Center	Staten Island
OMH Rental Subsidies Statewide	Office of Mental Health (OMH)	Unity House	Troy
Olmstead Housing Subsidy	New York State Department of Health (NYSDOH)	New York Association on Independent Living (NYAIL) and Independent Living Center of the Hudson Valley, Inc.	Troy
OPWDD Rental Subsidies	Office for People with Developmental Disabilities (OPWDD)	Chautauqua County ARC/ The Resource Center	Chautauqua County
OPWDD Rental Subsidies	Office for People with Developmental Disabilities (OPWDD)	Fulton County ARC/Lexington Center	Fulton County

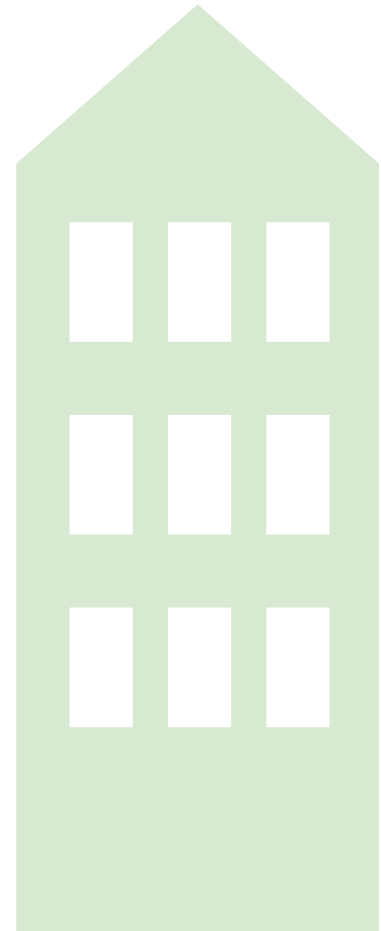
Program Manager/Administrative Interviews

Program manager and administrative interviews were conducted by phone. A member of the research team reached out to the program manager of each site via email and provided a description of the study. The program manager was asked to participate in a phone interview and to extend an invitation to other administrative staff, as relevant.

The interviews, which were guided by a semi-structured interview protocol, lasted between 1 hour and 1.5 hours. In addition to the items that all program managers were asked, the interview protocol had specific questions tailored to each program, as appropriate. Probes were used as appropriate to yield further information. The interviews were audio-recorded, with permission of the individuals interviewed, following an informed consent procedure. As described in the table below, 40 administrative staff (program managers and other administrators) participated in the interviews.

Table 2. Number of Administrative Staff Interviewed, by Site

Site	Number of Staff
ACR Health	2
Bridging Access to Care	2
Champlain Valley Family Center	2
East 99th Street	2
Norwood Terrace (Concern for Independent Living)	1
CAMBA Gardens II (Camba, Inc.)	3
86 Carroll St. (Opportunities for Broome)	2
Evergreen Health Services	5
Living Opportunities of DePaul	1
BronxWorks	2
Unity House of Troy	2
Saint Joseph's Medical Center	2
Chautauqua County ARC	3
Lexington Center	1
New York Association on Independent Living (NYAIL)	2
Federation of Organizations	3
Rebuilding Together Saratoga County	1
Ithaca Housing Authority	4
Total	40



Focus Groups

The focus groups were conducted in person at the provider locations. Staff² and service recipient focus groups were held separately. Program managers facilitated recruitment for the service recipient focus groups. Participants were informed about the study via a flyer provided by the research team, and the program managers facilitated the logistic details for the subsequent site visits. Service recipient focus groups were capped at a maximum of twelve participants.

The focus groups were guided by a semi-structured focus group protocol, tailored to the specific stakeholder group (staff or service recipients) and the nature of each program, as appropriate. Sessions typically lasted between 1 and 1.5 hours. Focus groups were audio-recorded, with permission of the participants, following an informed consent procedure. At the start of the service recipient focus groups, a short questionnaire was provided to obtain demographic information. Service recipients were provided with an incentive (a \$20 gift card) to acknowledge their time.

² In several provider sites, only two or three staff are employed within the MRT-SH funded program components. In such cases, group interviews (interviews with both or all staff together) were conducted rather than focus groups.

As indicated in the tables below, 65 program staff participated in the staff focus groups, and 90 service recipients participated in the service recipient focus groups³.

Table 3. Number of Staff and Service Recipient Interview/Focus Group Participants, by Site

Site	Number of Program Staff	Number of Service Recipients
ACR Health	2	5
Bridging Access to Care	4	5
Champlain Valley Family Center	6	10
East 99th Street	5	7
Norwood Terrace (Concern for Independent Living)	6	12
CAMBA Gardens II (Camba, Inc.)	5	11
86 Carroll Street (Opportunities for Broome)	3	9
Evergreen Health Services	2	5
Living Opportunities of DePaul	3	5
BronxWorks	4	4
Unity House of Troy	2	1
Saint Joseph's Medical Center	2	--
Lexington Center	5	5
New York Association on Independent Living (NYAIL)	2	3
Federation of Organizations	10	7
Rebuilding Together Saratoga County	--	1
Ithaca Housing Authority	4	--
Total	65	90

Participant Demographics

Across all providers, service recipient focus group participants had a mean age of 51 years, relatively consistent with the overall mean participant age for the MRT-SH evaluation⁴. Forty-eight percent were female and 53% were male. The sample was racially diverse, with 38% of individuals self-identifying as African-American, 39% as white/Caucasian, 12% as Hispanic/Latino, and 11% as some other race.

A broad set of responses emerged regarding an item about where participants were living prior to program entry. This variety was expected, given the nature of the different program types. The most common response was a homeless shelter (31%), followed by homeless/not sheltered (14%), independent living (12%), and living in the home of family or friends (12%). These demographics are summarized overall, and by program, in the tables below.

³ Within two provider sites, Unity House and Rebuilding Together Saratoga, interviews were conducted with a single participant, rather than a focus group.

⁴ The mean age of MRT-SH participants was 47.1, per Outcomes Report 1.

Table 4. Demographics of Service Recipients Participating in Focus Groups

Age (N=76) (Mean=51)	20-29	8%
	30-39	13%
	40-49	22%
	50-59	32%
	60-69	18%
	70-79	7%
Gender (N=83)	Female	48%
	Male	53%
Ethnicity (N=84)	Black/African American	38%
	White/Caucasian	39%
	Hispanic/Latino	12%
	Other	11%
Where living prior to program entry (N=75)	Independent living	12%
	Home of family/friends	12%
	Nursing home or LTC facility	4%
	Residential setting/program	10%
	Shelter	31%
	Other supportive housing program	4%
	Jail/prison	4%
	Homeless (unsheltered)	14%
	Psychiatric Facility	4%
	Other	6%

Table 5. Where Service Recipient Focus Group Participants were Living Prior to Program Entry, by Provider

ACR Health (N=3)	Independent living	33%
	Home of family/friends	33%
	Jail/prison	33%
Bridging Access to Care (N=4)	Home of family/friends	25%
	Shelter	75%
Champlain Valley (N=9)	Residential setting/program	22%
	Shelter	22%
	Other supportive housing program	11%
	Homeless	11%
	Jail/prison	11%
East 99th Street (N=7)	Home of family/friends	29%
	Nursing home or LTC facility	14%
	Shelter	29%
	Other	29%
Norwood Terrace (Concern for Independent Living) (N=11)	Shelter	73%
	Other supportive housing program	9%
	Homeless	18%
CAMBA Gardens II (N=9)	Shelter	78%
	Other supportive housing program	11%
	Homeless	11%
86 Carroll Street (Opportunities for Broome) (N=7)	Home of family/friends	14%
	Homeless	43%
	Jail/prison	14%
	Other	29%
Evergreen Health Services (N=4)	Independent living	75%
	Homeless	25%
Living Opportunities of DePaul (N=4)	Independent living	50%
	Home of family/friends	25%
	Residential setting/program	25%
BronxWorks (N=4)	Independent living	50%
	Shelter	25%
	Homeless	25%
Unity House of Troy (N=1)	Home of family/friends	100%
Lexington Center (N=5)	Residential setting/program	100%
New York Association on Independent Living (NYAIL) (N=3)	Nursing home	100%
Federation of Organizations (N=7)	Independent living	14%
	Home of family/friends	29%
	Nursing home or LTC facility	29%
	Shelter	14%
	Homeless	14%



Data Analysis

Focus group and interview notes were reviewed by the research team. Audio tapes were partially transcribed for the analysis. Three researchers from the team coded the data; the team coded several transcripts together to ensure consistency.

Analytic matrices were developed for each provider site, consistent with Miles, Huberman, and Saldana's approach, which explicates processes of data reduction, data display, and conclusion drawing (2013). Summary matrices were used to synthesize data collected from the program manager interviews, staff focus groups, and service recipient focus groups relevant to issues of access. Then a cross-program matrix was developed to assess emergent themes, as well as areas of consistency and divergence across sites. Using this approach, data were triangulated across both provider sites and stakeholder groups (Stake, 1995). Emergent themes were then developed inductively from the data, drawing from the constant comparative method (Charmaz, 2006).

Findings

Study findings are presented by agency, and then by program. Within each program, findings are presented by stakeholder group: first administrative and staff perspectives, then participant perspectives. Cross cutting themes are presented after the program-specific findings.

ACCESS TO HOMES

Rebuilding Together Saratoga

Administrative and Staff Perspectives

Program Context and Key Program Components

Rebuilding Together Saratoga provides home modifications to individuals receiving Medicaid in Saratoga County who are experiencing accessibility challenges. The goal of the program is to allow people to remain in their homes, instead of moving to a nursing home or assisted living facility. Participants typically experience a combination of physical and mental health disabilities. In some cases, participants need to “age in place”, and thus require modifications to their home to ensure continued safety.

The program is funded through grants, including MRT-SH funds. The MRT funding stream is specifically for individuals on Medicaid, though individuals not on Medicaid may be able to use the program through other funding streams. According to the Executive Director, Rebuilding Together Saratoga was initially run completely by volunteers. At this time, the program is able to hire contractors to complete the work on people’s homes, meaning the projects undertaken can now be bigger and more extensive, as needed.

The Executive Director (program manager) has the charge of coordinating the program and overseeing all program activities. A Project Manager coordinates the work of the paid contractors, with the help of an Assistant Project Manager. An office assistant helps to manage details of the program and required paperwork. There is a part-time Project Manager/Volunteer Coordinator as well. The program manager plans to open a store in the near future to help to fund program operations.

Regional Factors

As noted above, the program serves individuals in Saratoga County. As the program manager explained, the median income in Saratoga County is high, leading to a perception that there is not a lot of need for such a program; however, individuals in rural areas of the county have significant unmet needs. Many of the participants receiving home modifications reside in mobile homes. As the program manager explained, affordability challenges create difficulties for eligible individuals to keep up with their homes through repairs, or to modify their homes as needed, due to medical conditions or the aging process, impacting the ability of eligible individuals to safely reside in their homes:

A lot of these people in the county have mobile homes. A lot of these folks are aging, so they can't keep up with repairs....[for example] they can't access their homes safely, because their floor is caving

in or the linoleum is coming up and creating a tripping hazard. The status of the stairs can be an issue, and if wheelchairs are needed, the life of the door and the landing [are concerns].

The rural character of the county creates some challenges, according to the program manager. Potential participants may be unaware of the program due to their geographic isolation, and individuals may be less aware of neighbors who require help from the program. As the program manager reported:

They aren't as connected, they are more isolated, so maybe they aren't aware of our services. So, for example, if I were living in your neighborhood and you saw someone fixing up my home, you might ask me [as your neighbor], 'hey, who's fixing that up?' But in a rural neighborhood where you are a mile away from a neighbor, you aren't going to see this.

Targeting and Eligibility Determinations

As reported by the provider, participants need to be on Medicaid, own their homes⁵ and anticipate staying in their residence for the next five years, and meet income guidelines to receive home modifications through the program (50% of AMI). According to the program manager, most program participants earn income in the range of \$15,000–20,000. Participants must have a disability and receive Medicaid in order to receive home modifications through the MRT funding stream. The program confirms Medicaid status and obtains a copy of the participants' Medicaid cards, though there are no guidelines regarding Medicaid service utilization (e.g., requiring that the individual is a frequent user of high cost services).

In Saratoga County particularly, the program manager noted that elderly individuals, especially elderly women, are often served by the program. Low income families with children are also served from other funding streams (non-MRT). According to the program manager, elderly individuals typically require modifications due to accessibility issues, whereas low income families require repairs due to affordability challenges resulting from poverty.

As the program manager explained, when the program first began, there was a need for outreach activities to reach eligible individuals. As of now, social service agencies in the area are aware of the program and often provide referrals. Brochures and a website are current mechanisms for outreach as well. One challenge to the referral process, according to the program manager, is that there is a great deal of staff turnover at the referring social service agencies, creating a need to continually inform new workers about the program.

Home Modifications

Rebuilding Together Saratoga completes the following home modifications most frequently: ramps, bathroom modifications (e.g., grab bars), floor repairs, and exterior stair and landing repairs/modifications. The program manager's perception is that certain home modifications are more likely to divert individuals from nursing homes and to prevent hospital admissions due to falls and accidents. Bathroom modifications are particularly important in this regard, as well as modifications to flooring that allow individuals to move about their homes with walkers. She also indicated that lighting repairs are important to fall prevention.

The program manager indicated that it would be helpful for an Occupational Therapist to provide feedback on proposed home modifications:

We have an OT who is a volunteer, and I would love to expand on this part of our program....they can go in and assess the whole house for safety- lighting, where to put light switches, [if we should] get rid of carpeting or use scatter rugs...they can make suggestions about the modifications.

Perceived Program Benefits, Outcomes, and Challenges

According to the program manager, the most important benefit of the program is ensuring the safety of individuals who are aging, and those with disabilities. The program is successful at enabling individuals to age in place. When reflecting on the program's ability to help individuals in need, the program manager noted that the program has internally

⁵ Per personal communication with NYSDOH, participants who rent can receive assistance as well.

considered becoming more involved in case management to better address participants' needs within their homes:

One of the things we have talked about internally, is how comprehensively can we be involved in [participants'] care? We do refer to other programs. How involved can we get in their case management? If someone is going to the ER a lot, especially if it's for breathing issues, what can we do internally within their home [regarding air quality]?

The program manager indicated that being a small, non-profit agency comes with challenges. It is difficult to perform "on the ground" work to the extent needed while also managing significant administrative needs and requirements. Additionally, the program manager noted that reaching poor, rural populations is challenging. She welcomed feedback and help from the State in this regard.

Participant Perspectives

Given the nature of the Access to Homes program (e.g., participants receiving one-time home modifications across various regions of the state), one participant of RT Saratoga was interviewed by phone. The participant described having Multiple Sclerosis, which developed when she was in her late teens. She is currently wheelchair-bound. Prior to receiving services through the program, she did not have a ramp and had to wait for others to come and get her. She was unable to leave the home on her own:

They built me a beautiful ramp, I mean a really nice ramp. So that I was able to get out of my own home all by myself. I never was able to go to the mailbox or wave goodbye to my kids or anything. I always had to do it through a window. This way, I have a motorized wheelchair, I was able to open the door, go down the ramp, out to the garage, it was a wonderful feeling.

The participant received modifications to her current home, which included a wheelchair ramp, grab bars, a new roof, yard work, new flooring in her kitchen, and a stair lift. She learned about the program through the MS Society in Albany, New York, which provided her with a home visit. The home visit workers referred her to RT Saratoga. The participant explained that she filled out an application and provided tax forms in order to be approved. Following financial approval, she reported that someone from the program came out to assess her needs for a home modification. The findings of that visit indicated that the home was unsafe, given the participant's physical disability. The program initially intended to provide one modification, but then determined that others were needed to enhance safety and the opportunity for mobility.

The participant indicated that she is grateful that she can now be independent due to the home modifications she received. She was very satisfied with the program and had no suggestions for improvement. As she explained:

Everything that Rebuilding Together did for me has such an impact on my life. I got a lot my independence back.

The independence realized from the program has facilitated the participant's health and abilities in other domains as well. As she explained:

See...MS...just kinda, you never know how, you never know when its gonna come back and it robs you of your independence along with your physical and mental abilities... Since they did all of this for me, they have improved my physical ability as well as mentally. Cause I can do so many things on my own...so many little things that people don't even know about it.

The participant noted that without the help of the program, she would have continued to sit at home without her independence. She believes that this would have further contributed to feelings of depression. As she explained, MS can be a debilitating and progressive disease; without modifications to the home, quality of life is adversely impacted:

I would definitely not be who I am today [without the program]. They have totally changed my physical ability as well as my mental state. It's amazing.

The participant noted that she is now able to more successfully work from home due to the mobility improvements provided by the home modifications. She is able to more readily access the phone and the computer using her stair lift,

and she is also able to transfer herself from the wheelchair, which she could not do previously.

In terms of changes in the utilization of health services, the participant described how in her personal circumstance (a recent cancer diagnosis), she is now using more frequent services. However, she has reduced services for in-home therapy, since she is now able to complete more physical exercises on her own:

I was getting in-home therapy. Therapy in my home. I don't need that any more, I try to do the exercises on my own, I'm much more independent.

This independence has also contributed to positive changes in her relationships as well. As the participant described, she is now able to engage with her family more effectively:

I can actually participate. You know walk, if they go for a walk, I can actually go with them. You know in my motorized chair. So yeah, there are so many things, different aspects of my life that they have changed.



AIDS INSTITUTE

ACR Health

Administrative and Staff Perspectives

Program Context and Key Program Components

ACR Health is located in Syracuse, New York. As described by administrative staff, the ACR program serves people living with HIV/AIDS who are unstably housed or homeless and high users of emergency services. These individuals typically have no primary care providers and are not receiving routine HIV care. Most have a history of mental illness or substance use disorders.

The program provides a rental subsidy, which is designed to support individuals who require support in order to maintain their housing. Participants need to contribute 30% of their adjusted monthly income toward rent. According to administrative staff, successful outcomes occur when participants are able to leave the program and maintain their housing, often using DSS subsidies or Section 8. Other successful outcomes include participants staying connected with primary care providers, maintaining a social life, and stabilizing their health.

The ACR program employs two housing retention specialists, who tend to work in the capacity of case workers (e.g., performing home visits and assisting participants with their needs, in addition to housing outreach). The case workers recruit and develop relationships with landlords, and assist with coordinating rent payments. They also work with participants on service planning, referrals, and coordinating with Health Home care coordinators and other providers.

Regional Factors

The ACR program covers fourteen counties in Central New York, which include both urban and rural areas. As the staff described, participant housing needs differ greatly based on the geographic area. For instance, program administrators described transportation as especially challenging in the rural counties. In some areas, it is difficult to locate accessible housing for people with physical disabilities. Per the program manager, in rare instances, ACR has allotted money in the budget to defray the cost of home modifications for accommodating participants with disabilities, with approval of the contract manager.

Within the catchment area, the administrators noted that it is difficult to find landlords who are willing to rent to individuals who have a housing subsidy. Additionally, each county has a different fair market value for rent, and administrators described difficulties locating safe and adequate apartments (e.g., meeting HUD regulations) for participants that are within the rental allowances:

Every county there is a fair market rental amount... we have to go by that amount if we are housing people... that can be very difficult. Let's just talk about Syracuse, we have a client in Syracuse who has public assistance and they are for only one person so there rental allowance for one person is \$380. It is basically impossible to find a safe, adequate housing, which had to include utilities for that amount of money... Without our subsidy or with a subsidy, it is virtually impossible. Even then it is still hard. Then if you go to Ithaca, Ithaca is in our catchment areas. It is very difficult to find a one bedroom apartment within the FMR (fair market rent), they are way above the FMR rate.

Targeting and Eligibility Determinations

ACR is one of the largest agencies of its kind in the Central New York area. Providers in the catchment area in contact with eligible participants readily refer them to ACR, though the administrators noted that referrals have proved more challenging in counties in which the provider was just beginning to provide housing. Within these newer counties, the program is focused on performing outreach activities to develop stronger connections with referral sources. The administrators noted that with the DSRIP initiative, they anticipate improvements in this area due to better linkages across health care settings.

ACR administrators and staff noted that in addition to HIV positive status and housing vulnerability, inappropriate use of or overreliance on emergency departments is an important component of eligibility determinations, adding that they target participants who are not using primary care and mental health treatment regularly. The program works closely with Health Home care managers during the enrollment process and obtains information on Medicaid usage through the RHIO system, though this is not yet operational in the newer counties. Information about Medicaid usage is compiled from several sources, including clients and case manager contacts and interviews, in addition to the RHIO system.

The ACR administrators generally find the eligibility criteria appropriate, but noted that “housing vulnerability” can be difficult to explain and define for referral purposes:

I think [the criteria] are fairly appropriate but think they are hard to measure sometimes. For example, 'housing vulnerable'. A lot of people don't know what that means and it is very hard to explain that to providers and other support service agencies for referral as to what really qualifies.

While a risk assessment available by the AIDS Institute (a point system based on the program's eligibility criteria), both the administrators and case managers perceived that it does not seem appropriate for all participants, especially those who do not use the emergency department frequently. An administrator and staff reported:

That's a big thing, whether they even qualify, because we want the high users of Medicaid, someone going to the ER constantly, not taking their meds, we have those instant qualifiers... The automatic qualifiers are on the risk assessment, if they are a sex offender, if they are homeless on the street...HIV positive...don't their mental health meds...if you aren't participating in their mental health treatment.

There are people who don't go to the ER a lot or at all and don't seek any care. When we are using scales or systems like that to see if eligible, it doesn't work for everyone. The good thing is that our contract managers have allowed us to make a case for them. Maybe they don't score well or don't look eligible, but actually here is what going on. In the future, it would be great to have more wiggle room to kind of capture the people that we know that desperately need these services.

The risk assessment has a score on it, but to be honest the score doesn't tell the story because they can score a 2 but be a high utilizer...they could get a 6 but if you get in depth it could feel like they have a 30...I think the tool of the risk assessment should be revised or revisited because it is not helpful...If they are going to the doctor, they get a minus 1 [indicating lower risk], however it doesn't speak to the story because they may have gone to their appointment but they may have gone to the emergency room 3 times that month. Or they go to the doctor because they are drug seeking...

Program Changes and Innovations⁶ from MRT-SH Funding

With MRT funding, ACR has expanded its catchment area and developed welcome items for participants (e.g., cleaning and personal care products, mattresses, sheets, kitchen supplies). Funding was also used to provide modifications for handicap accessibility. Additionally, ACR now offers participants groups that provide education on life skills, including how to be a good tenant. Transportation is provided to the groups on a limited basis. As an administrator explained:

⁶ The innovations reflected throughout the report were reported by administrators and staff at the programs. These innovations may be funded, in full or in part, by funding sources outside of MRT. The individuals interviewed may not have had complete information about the nature of each funding source.

[With] the MRT clients we really encourage them to come where we talk about tenants' rights, how to be a good neighbor, how to talk to your landlord, how to be a good tenant, how to self-advocate... that's another piece of the puzzle that isn't necessarily part of this program but we encourage them to go.

The program administrators noted that they are opting to keep as much funding as possible for the rent subsidies, but noted that they would like to be able to purchase more items to facilitate the health and comfort of the participants, such as air conditioners for individuals with COPD.

Placing Participants into Housing

According to ACR administrators, some participants are already housed (in non-MRT housing) prior to entering the program, while others are not. Some participants are in the process of being evicted, while others are staying in a shelter, living with family or friends, or hospitalized. As an administrator explained:

Some of our clients are already housed. We might get a referral from a care manager, a Health Homes care manger, hey I have this client that is really struggling, do you think MRT would be good for them?

Those who are not housed undergo an assessment, and staff work with them to tour and select an apartment. Staff complete an inspection modeled after the HUD Housing Choice Voucher Program inspection and work with landlords when apartments do not meet HUD standards. According to the administrators, the longest it takes to house a participant is approximately one month. The timing typically depends on the geographic area, in that it is often more difficult to find appropriate housing in rural areas. It is also more difficult to secure housing in counties that are new to the program, where ACR does not yet have established relationships with landlords.

Perspectives on Housing: Reflections on Housing First⁷

When reflecting on the Housing First approach, ACR administrators emphasized that in their view, housing is a critical need that must be met before participants can attend to their physical and mental health needs:

Housing first is starting to be housing as healthcare...if a client has to worry about where they are going to lay their head at night or where they are going to go, everything else suffers. Everything. They don't go to their medical appointments, they don't take their medication because they have no place to put their medication much less take it, they can't access transportation, their money, they are in danger, a lot of times in the situation that they are in. It is recognized that if they have someplace to go they will hopefully be able to take care of themselves...their care managers know where to find them. If they are on the streets they don't know where to find them.

The administrators also acknowledged how the population served by the program has complex needs, including previous evictions and housing instability, criminal histories, and poor credit histories, as well as mental health and other needs. These complex needs can create challenges to providing barrier-free or low barrier housing, as landlords are often hesitant to rent to these individuals.

In contrast to the administrators, program staff expressed more hesitation about Housing First. While the staff acknowledged the theoretical basis for Housing First, they articulated that it can be very difficult in practice, particularly without having the proper supports in place. They described how this approach can become overwhelming to those working directly with the participants:

Housing First is a wonderful, wonderful idea, wonderful movement. But once again, when you have a person that is so strong in their use, you can house them, mental health issues, you can house them. The issue is, can you keep them housed?

⁷ Some of the MRT providers included in the sample reported adhering to Housing First principles, while others did not. These items were asked within all of the sites, regardless of perceived adherence to Housing First, in order to examine the rationale for substance abuse policies. These items also elicited perceived strengths and limitations to low-barrier and harm reduction practices associated with the Housing First model.

And we don't have the supports to deal with the other stuff. We don't have the time! And when you begin to do that, you get a little bit reprimanded, 'you're doing too much,' well...I don't want to look for housing for him in a month...or you are constantly making deals with the landlord, 'please don't evict, I'll try to get a payee'...They can't handle their own finances because they spend it on substances. I've become the advocate to get the payee, the advocate the landlord to keep them housed, oh my God! Did you go to your doctor's appointment?

Perspectives on Housing: The Scattered-site Model

The ACR administrators noted that the scattered-site housing model is beneficial to participants, in that it is empowering and presents them with the ability to make choices about where to live. They also pointed out that scattered-site housing is less stigmatizing than congregate housing settings, and presents participants with the opportunity to become independent. As one administrator explained:

We are really utilizing the opportunity for them to really start to be self-empowered from the moment they come into the program. To have the choice to go to a private landlord, to learn how to do this on their own. I do think this is extremely important and it really does help people move forward and to be able to successfully live on their own. To be able to negotiate, to be able to look at the living skills that they need ...a lot of clients don't have that.

The ACR case workers concurred that scattered-site housing has the benefit of promoting independence and responsibility. They also discussed the alternative of congregate housing, and highlighted how some clients may be more appropriate for such a setting, since supports can be more intensive and are often offered on-site. However, the case workers also suggested that congregate housing can be problematic for participants, due to clients sharing drugs, and also perceiving that they are being monitored. This impression may cause them to disengage from providers. A case manager highlighted a particularly high-need client who might be better served in a congregate setting:

Some clients aren't so ready to live on their own. I have a lady. She is 57 years old. I feel bad. She hasn't been given the skills to live on her own. Her version is clean, you would say, 'oh God this is so messy,' but it's her version of clean. Where would she go? She is newly diagnosed with HIV. She has been living under a bridge for 10+ years. Her family is [far away]. Sexual abuse as a child...smokes crack. It is my goal to house her but it is not her goal to be housed...I have 6-7 messages from her at night. I see the benefit of those congregate with high rises [for high need participants].

Overview of Service Delivery

There are currently fifty slots in the program, divided between the two case workers. The role of the case workers in the program is to focus on obtaining housing (scattered-site apartments) for the participants, and work with the participants to maintain housing. Once or twice per month, case workers perform home visits. They also ensure that rent is being paid in a timely fashion, develop relationships with landlords, assist participants with medical appointments, and encourage participants to access support services that might be helpful to them. The case workers described working with participants to understand their needs, goals, and housing preferences. As one case worker explained:

When we first get a referral, find out what they need, find out the situation they are in, whether they are taking their meds...that's a big thing, whether they even qualify, because we want the high users of Medicaid someone going to the ER constantly, not taking their meds, we have those instant qualifiers.

The case workers noted that on paper, the roles revolve around acting as a housing specialist. However, they described how in reality, their roles encompass much more. Their roles often become a "catch-all" for meeting client needs, particularly if clients cannot obtain needed services or a required service intensity elsewhere. This situation is often the case, due to high-intensity client needs revolving around complex and co-morbid conditions. As a case manager explained, "you become their readers, transporters, listeners...it's not just about housing". More specifically, a case manager described the following:

Because our clients are high need they aren't just the regular HIV positive clients. They are ALL high need, they all have the co-morbidities. Most of it is mental health and substance abuse. I have a

client...you can't read to write...I literally...you said to define my role, I can't. They say it is a SMALL case management component...how do I say this in the most respectful way...there are care managers here and we collaborate with health care managers but I think what the State doesn't realize because we are with them more than anyone else. Meaning when we are in the home, when we are driving...we are riding on dark two lane roads...and we get there this client in the last three weeks has dealt with a diagnosis of bone cancer, Crohn's disease, so I can't just focus on the housing need because I can't get past the other stuff. I can't get to the housing stuff until I talk to them about the other stuff. We are the closest thing to them besides their family.

Given the complex needs of the program participants, the case managers expressed frustration with the size of their caseloads, as well as the expanded catchment area of the program. Additionally, paperwork requirements were described as burdensome for the staff, given the needs of the clients. The case managers described positive and close working relationships among program staff, which they believe enable them to more effectively meet the needs of the participants.

ACR provides case management to clients. Clients are frequently connected with their Health Home care managers to assist in coordinating overall health care needs. ACR also provides transportation to clients. As an administrator explained, the connection and support provided by case workers is important to the participants:

Some of those people way up north, our staff are their connection. They don't have transportation. That monthly home visit is really important to them. They call. If they are having issues for anything—it can be health issues—it can be anything. They have a connection with their housing worker.

ACR case managers concurred that home visits are especially important to the participants, particularly those who are socially isolated. As a case manager explained:

The home visiting is very important. You get more than a note off of a computer...they talk to us more than they do any other worker that they work with. Not because they have to but because they may not get another visit to spill, until we come back again.

While administrators acknowledged the importance of case management, they noted that the housing subsidy is the most critical component of the program, as stable housing facilitates the participants' ability to better address their health and well-being:

Housing is healthcare. Without that they can't actually get to where they need to be. They actually are worried more every single day where they are going to sleep, rather than take their medication or going to their doctor's appointment or figuring out what to get for income. That is one of the things that is most precious about this program.

Staff indicated that reasons for unplanned discharges include non-payment of rent, participant disappearance, and evictions due to vandalizing property or other problematic behaviors. Given the nature of their health conditions, some participants pass away while in the program. When discharges are planned, the process typically takes place over a couple of months and staff work with landlords to find new tenants for apartments. Staff assist in the transition process for those who are discharged for negative reasons.

Reducing Medicaid Costs

The ACR administrators noted that reducing Medicaid costs is a priority for the program. The program works toward this goal by communicating closely with Health Home care managers and by working closely with participants to provide them with consistent medical care. As one administrator explained:

The main way to do that is to make sure clients are consistently getting their medical attention, their medical needs met, taking their prescription that is prescribed, they are housed, stably housed, so they can concentrate on those things so that they can maintain their health...in other words, less emergency rooms, less hospital stays.

The administrators noted that medical clinics serve an important function to some clients. They explained that

some participants are less open to seeing a regular primary care provider. This reluctance is especially the case for participants who are actively using drugs, due to the experience of stigma. These participants may feel more comfortable using a less formal medical clinic, where they feel more anonymous.

Perceptions on Participants' Progress

Program staff noted that participants' progress in the program is closely tied to the complexity of their needs. High acuity clients struggle most in the program, particularly if they had histories of chronic homelessness.

I have a client who literally where four walls to her is abnormal. I can house her all the time and you will see in her file, I have housed her two times in two years. The goal to house them is not their goal and it isn't functional to them...I have a client that has a beautiful apartment but she lives under a bridge. When I have to go find her...I go to under the bridge. I think the program was made with good intent but it has some confines. Especially with us as workers... I can drive to Utica and the client says they forgot. Some of them are not in the place, they don't want the case management just the subsidy.

In general, staff indicated that clients do not necessarily wish to be discharged from the program. Those who are discharged for positive reasons often move on to Section 8 or a different type of housing. As a staff member explained:

I am finally getting to a place where I am seeing some movement in my caseload... I have had the same clients for three and half years... and even though they don't feel like they are ready, they are getting Section 8 and HOPWA which is much more long term, they are doing better with their meds, they are going to their regular physician more than they going to the ER. They advocate on their own behalf very well on their own, to the point where you don't need me!

The ACR administrators noted that the participants who are the most ill (medically fragile) tend to benefit most from the program, specifically from the knowledge that they have a stable home when they are discharged from the hospital. The administrators explained that some participants may not require the intensity of the program, but are benefitting from the rental subsidy. ACR case managers noted that some participants who seem to benefit the least are those who are non-compliant with the program and those who do not wish to engage, but who wish to have the housing subsidy.

Program Strengths, Weaknesses, and Future Directions

The program administrators described how they love their jobs and believe in the work of the program. A key strength of the program is the ability to successfully house vulnerable individuals, and to provide them with a strong support system. Staff described how housing allows the participants to concentrate on other aspects of their lives, such as health and returning to school or work.

The administrators described a program challenge regarding the ability to serve participants with mental health issues. These participants often have a hard time trusting others, hence creating obstacles to establishing relationships with the case managers. Additionally, these participants struggle to acclimate into the program. Participants with substance abuse issues can create difficulties as well, according to program staff, as these participants often go missing for a time when in the midst of using.

ACR staff noted that the state agencies have been open and helpful. However, the ACR administrators and staff reported that greater flexibility is needed regarding program regulations. For instance, some clients may be more open to monitoring over the phone, rather than in person. It might also be necessary to rent at above fair market rent prices. Paperwork and requirements can be burdensome, and interfere with the staff's time to serve program participants. Staff also indicated that the program would like the ability to provide transportation and to be reimbursed at the federal rate for mileage. Additionally, the administrators indicated that more funding is needed.

Participant Perspectives

Housing Status and Lived Experience Prior to MRT-SH Enrollment

Most participants in the ACR Health program reported being unstably housed or homeless prior to their enrollment in the program. In addition to being HIV+, several participants reported co-occurring conditions, such as mental health problems, substance use disorders, and chronic medical conditions. One participant described experiencing a sense of desperation prior to enrolling in the program, due to a significant history of trauma, housing instability, and homelessness:

I was homeless, I was house to house since I was 15, since I had my child. I came to find out in 2010 that I had HIV. I came to find out that I had mentally, depression....all of that. I found out I had cervical cancer...so when I was living in Massachusetts when I found out, I moved to Utica in 2012. I was sharing an apartment with another person and the lights came to \$900...I was in a depression mood. The clinic found out that I was trying to kill myself because I didn't know what to do.

Some participants reported residing in residential group homes or rehab facilities prior to entering the program. It was not uncommon for these participants to also describe periods of homelessness prior to these residing in such settings. Others described periods of living with family, as well as periods of incarceration prior to enrollment.

Most participants found the enrollment process to be seamless, with wait times between a week and a month. The participants were able to choose an apartment from a couple of options. One participant noted that staff began searching for an apartment for her while she was still incarcerated. The participants typically learned about the program from a case manager or from a group home worker.

Perspectives Regarding MRT-SH Housing Accommodations

Most participants reported satisfaction with their housing accommodations. They generally liked their apartments and neighborhoods. Many felt a sense of pride in their housing:

I love where I'm [living] at.

A couple of participants noted that their apartment buildings allowed them to keep a pet, and also remarked that they are able to maintain hobbies that are important to them, such as keeping a small garden out on the apartment balcony. A few participants highlighted problems with their current housing accommodations. Two described neighbor disputes (e.g., neighbors who are unclean, loud, or who cause trouble) and mice infestations, which they noted exacerbates their feelings of depression. One participant described how other tenants were bringing drugs into the apartment complex, which created difficulties:

I have a very nice apartment. A very nice view. Light and gas is included. But the it's just the people they are putting in there that's messing it up...if they can straighten that out, it would be a great place. I feel very comfortable in the apartment. There was a little drugs coming in and out of there...I got them out there and all three of us on our floor are complaining. Kept complaining until they got them out of there. We organized and got them drugs out.

Another participant described living in an apartment where the elevator breaks down, which present a problem, since he is on oxygen and has chronic medical issues:

I want to find something a little more secure. When the elevator breaks down, I got to go up and down the steps. That don't work too well for me.

All participants described having the opportunity to select an apartment that met their individual needs. Several participants noted that landlords are sometimes uncomfortable accepting subsidies, especially for participants with HIV. Some participants with criminal backgrounds noted that it was more difficult to find an apartment in an area where they wished to live due to this history:

Criminal background checks, stops us from getting an apartment. Because what we got charged with, we might not be that same person. But that is a stigma. Not only you are getting subsidy for HIV,

and have criminal background check...That's two strikes against you.

When asked where they might be living if not for the program, most participants believed that they would be in a shelter, or living in substandard housing conditions (e.g., apartments with problematic “slumlords” or living in crack houses). They also indicated that their behavior would be health-compromising in such a places:

[My life would be] a mess. A mess! I mean I'm into a whole lotta things. Doing things, having people come in and out, up all night, sleeping all day.

All participants indicated that their current housing situation is far better than their alternatives would be, both in terms of housing stability and their overall health. However, the participants reported that the program could do more to ensure confidentiality of their HIV status. Several participants noted that landlords receive checks from a payee that is a known HIV services provider, thus disclosing their status while some would prefer it not be.

Perspectives on Housing First

The participants were asked about harm reduction practices associated with Housing First. Most reflected on natural consequences of substance use from the perspective of landlords, rather than the program itself. Several participants described that landlords are hesitant to allow drug use; other participants noted that they do not like to live around individuals who use substances, as it interferes with their own recovery or quality of life.

Perspectives on Support Services

The participants reported positive feedback regarding the support services offered by the program. Most found relationships with the caseworkers to be especially helpful, noting that the caseworkers help with mental health referrals. They also described support groups as helpful, as well as access to the helpline.

Several participants noted that it would be helpful if the program could assist with the cost of utility bills. They also wished to have a “pantry bag” with food and basic cleaning supplies provided once per month, especially to those who may not qualify for nutrition assistance. As a participant described:

In MRT you give money for the rent, the security deposit...they should offer to help people who have to pay \$75-\$100 a month (to electric company). Because it's hard to find a place where everything is included...for you to be comfortable to get ahead, you can't because you got this bill...can run you \$2-300 a month. Even just help \$75 a month from MRT funding [would help]. If you get a place where heat and light are included [within a reasonable rental cost] then you have an infestation of people doing drugs. My sanity and safety mean a hell of a lot to me!

Changes Experienced Since Entering the Program

When discussing their typical days, the participants reflected most on the independence that comes with housing. Several noted being able to close the door and not be bothered by others as needed, leaving things out without fearing that someone will steal them, and having general “peace of mind”. As one participant reported, “living on your own is a beautiful thing”.

The participants widely described improved physical and mental health, which they attributed to housing and case management received through the program. One person did note that his health has declined since enrollment, but attributed the decline to his HIV status combined with numerous chronic conditions. As a participant described:

Yes, [health changes have been] positive. My health got better. I was able to stabilize it. I was able to put in place and keep it. Like in the mornings before I take my meds, I gotta eat. I gotta eat what I want to eat. Then after that I gotta take my meds. Sometimes side effects from the meds keep you home. You wanna lay down. Now if you living with somebody else, that won't be easy because people coming around. You might not want to be bothered by nobody. Because of the pain and aches that you have going. [In supportive housing] you ain't got open your door if you don't want to... and peace of mind, like the gentleman said, peace of mind. Ain't got no distractions.

The participants reported that their case managers are helpful in terms of connecting them with primary care and other needed health services. They also described how having their own place is helpful to their overall health and use of services (primary care versus emergency care), since they are better able to adhere to medication regimens and to eat healthier diets.

Some participants described improved relationships since becoming housed. For instance, a participant noted that she and her sister are now getting along better with one another since they are no longer living together. Another noted that since getting an apartment, her grandchildren can now visit. Other participants, however, described ongoing relationship challenges with family members that did not improve since entering the program, or noted that they do not have close relationships to begin with.

All of the participants described looking to the future since enrolling in the program and developing goals. Several would like to find a job, continue to focus on their health, or help others with similar life experiences. As one participant explained:

I wanna show other people that they can improve their life the way I improved mine. And those people that have my condition (HIV positive) and cervical cancer, and who would like to lose weight. I would like them to know they can do it. They can get strength the way those guys give me strength.

Perspectives on Program Strengths and Weaknesses

Overall, all of the participants described being satisfied with the program, and hope it continues into the future. They would like to see the program house individuals in the long term. They hope that more individuals in similar circumstances can learn about the program and feel safe disclosing their HIV status.

The principal weakness described by the participants is that the program does not currently provide assistance with utility costs. A couple of participants felt that services through the program can benefit from greater consistency, highlighting that case managers should call back when they say they will. Some participants noted that they should have choices in terms of their case managers, noting that it is most helpful to work with someone who can relate to them.

Evergreen Health Services

Administrator and Staff Perspectives

Program Context and Key Program Components

The Evergreen Health Services program provides housing and support services to participants. A variety of services and supportive counseling are offered to help clients remain stably housed, and housing is intended to be permanent. The target population of the program is individuals living with HIV/AIDS, and LGBTQ individuals experiencing housing instability⁸. Prior to entering the program, the majority of the participants were staying in a homeless shelter or with family and friends. The program does not require chronic homelessness for eligibility, but works with an outreach team when individuals who are chronically homeless want to enter the program. A typical trajectory for participants is to have cycled between settings, such as jails, shelters, couches (couch surfing), and rehabilitation facilities before enrolling in the program.

Evergreen staff include a Director of Housing Services, who oversees the program, and housing retention counselors, who build a caseload by obtaining referrals, completing housing searches, moving clients into housing, and assisting clients in the adjustment process. The housing retention counselors are also responsible for providing a significant amount of documentation throughout the process. The Director manages all grant- and reporting-related duties.

Participants receive home visits once per month, and also meet weekly with program staff. Services and supportive counseling are offered to participants to facilitate housing stability. According to program staff, successful outcomes

⁸ Per a personal communication with NYSDOH, the target population of LGBTQ individuals may be provider specific.

for participants of the program include avoiding hospitalization, making regular rent payments and having a stable income, and living independently (both financially and in terms of the ability to manage one's health).

Regional Factors

The program serves a large catchment area, and thus faces challenges specific to both rural and urban environments, including lack of transportation and high rent. The program currently serves six counties in the state. According to program managers, high rental prices are challenging; this issue is becoming increasingly difficult with gentrification. As program staff explained, they would ideally like to engage participants in the housing search and provide several choices in housing; however, affordability challenges restrict this ability. As a staff member described:

We serve a wide range of area in Western New York – six counties, some are rural, some are urban. Our Buffalo office obviously serves Erie and Niagara Counties. The barrier we see there is the amount of rents that landlords are asking for apartments. And it creates sort of a barrier to sometimes conducive environments for sobriety and maintaining physical health.

Buffalo is going through a huge renaissance right now, which is great for the city, but it's horrible for our population, because there's a lot of gentrification going on. So, our fair market value is like 670 dollars but trying to find an apartment that's in the city where someone has access to transportation and all their services, it's becoming very, very difficult. And one of the things is we always want our clients to have a choice in where they're living, but they're honestly not getting much of a choice because of those limitations.

Further, the program faces challenges with discrimination within the catchment area, as many landlords are unwilling to accept a subsidy or to work with vulnerable populations. Rural areas pose unique challenges to the program, according to program staff:

[We also serve] Chautauqua and Cattaraugus Counties. They have their own unique challenges... transportation definitely is one of those. They don't have as much of a challenge with the amount of rent being charged down there.

Targeting and Eligibility Determinations

The program targets individuals living with HIV/AIDS as well as LGBTQ individuals who are high Medicaid utilizers. In terms of eligibility criteria, HIV+ status typically assumes high Medicaid use. The program does not currently have access to potential participants' Medicaid costs in making determinations. As the program manager described:

Serving the population we see, they're assumed to be high utilizers of Medicaid services, being HIV positive. Even if they come in not accessing those services, we link them to those services – to those health services which are high cost...they're frequently visiting doctors and impacting and using their Medicaid in order to treat their disease.

The program provides a housing risk assessment. This assessment consists of additional indicators that the program considers, which might qualify an individual even if they have a relatively low score on the risk assessment. This process is used to prioritize potential participants for the program.

In general, program staff believed that the eligibility criteria are appropriate. They identified some limitations to the criteria as it applies to those with complex medical needs, noting that individuals who might otherwise be eligible for a higher level of care (e.g., nursing home) are not typically served by the program. They also perceived a lack of clarity regarding what defines a "high Medicaid user". As a staff member explained:

There's just not a lot of clarity on the requirements. So, two of the requirements are being HIV positive – fine, that's easy to confirm – but being a high Medicaid utilizer, that's what becomes very difficult. And from the very beginning I've suggested that we want to wait to see if someone actually is a high Medicaid user because we just go based on what the client tells us. If they say they've been in the hospital, yeah, we consider high Medicaid utilization. But if there was actually a way we could see this is what Medicaid is spending on someone, that would be great.

The program's connections with Health Homes and local providers facilitates referrals to the program. However, staff discussed issues revolving around client engagement beyond the assessment stage. The program receives most of its referrals from the agency's Health Home and sees little turnover among individuals who are enrolled. According to staff, a challenge with enrollment is that eligible participants sometimes do not stay engaged throughout the process of entering the program, since they do not have a fixed address:

One challenge that I have targeting clients is they'll engage for the assessment and then I don't hear back from them again. And their phone numbers change all the time, they just sometimes they'll move to New York City and we never find out about it until months later. But to kind of combat that we work with some of the other housing providers in the area. So, a lot of people doing outreach, going out for Code Blue and things like that, they'll contact me when they find someone. But that doesn't always happen.

Participant targeting and determining eligibility falls heavily on the Housing Retention Counselors. While most referrals are received in-house, the agency's housing department also networks with other community agencies who sometimes reach out with referrals. Staff noted that they are typically able to house new clients within 30 days. However, it can sometimes be more challenging to find housing when the lease is in the client's name rather than the agency's name, as is the case in the agency's other housing program, because it is up to the landlord's discretion to accept a client.

Program Changes and Innovations from MRT-SH Funding

MRT-SH funding created the program (e.g., staff salaries, rental stipends, services). Program staff are also using the funding for starter kits for participants, such as beds, pots and pans, and basic necessities for living in an apartment. Funding provides security deposits as well as utility assistance. Participants received rent payments through the program in their first year even if they had a source of income, so they could build up their savings.

Placing Participants into Housing

Staff strive to uphold client choice throughout the housing placement process. After a suitable apartment is found and the client settles in, staff have noticed clients experiencing several challenges in this initial period, including money management, establishing new relationships, and navigating the social services system. Maintaining engagement is important once participants are housed, though staff try to balance client engagement with supporting client independence. A staff member described the process of placing participants into housing as follows:

After our client is enrolled, we complete something call a service plan, which really outlines the client's main goals and obviously, as I mentioned, that is finding stable housing. So, I encourage both my client and myself to kind of find what they'd be interested in living in, and together or if a client feels strongly enough they can go look at an apartment on their own, or we can go together, and we'll take a walk through, discuss the benefits of the housing. And then once an apartment is found that a client feels good about and is within that fair market value, that's when engagement with the landlords begins in regard to paperwork. And then from there, basically signing and that's really it.

The program manager noted that housing is designed to be permanent, though staff work with participants to determine appropriate next steps:

[Housing is] permanent for as long as the person needs it. The funding is permanent housing. However, we do work with the individual through the support plan to have a path to independence, whether that be enrolling back in school, working on employment goals. Like [another staff member] said, one person down in Southern Tier now has a factory job and doing well so he'll have some time in order to build up some savings and learn some budgeting skills. And then we'll send him on his way so we can help somebody else who's in need.

Perspectives on Housing: Reflections on Housing First

The Housing First model allows for quicker and more inclusive access to housing, according to program staff. An advantage is that it doesn't exclude anyone from entering the program. Housing First principles also allow staff to build trust with participants, in that they will work with them regardless of what is going on in their lives. Access to housing is

low-barrier and participants are thus housed relatively quickly– within about thirty days. As a program manager and staff member described:

It doesn't exclude anyone from getting into one of our programs. A lot of clients are afraid that if they tell us they're using, that we're going to say no you need to be clean first. That's not the case with this. And I think it builds up a lot of trust with the clients. And it's probably a good reason why we don't have a high turnover rate in our clients, because we will work with them no matter what's going on in their lives.

It's hard to tell someone that they need to be sober before we give them a house and they have no place to actually go back to. There's a lot of stress being homeless and using is oftentimes a way to get away from it. I think the whole trend of not having abstinence-based housing programs is a clear indicator of the success.

Staff also reported disadvantages and challenges to Housing First principles. They perceive that they don't always know what to expect with new clients, which can lead to safety concerns. This can be difficult when building relationships with landlords, in that program staff cannot tell them what to expect from each participant. However, they build relationships with landlords by emphasizing that they will be responsive and will try to help should any concerns arise.

Perspectives on Housing: The Scattered-site Model

Through scattered-site housing, participants are able to select where they want to live and are as active in the housing search and placement processes as they are capable. Staff work with clients who are less independent to teach them the skills needed to obtain their own housing and to practice those skills.

According to staff, scattered-site housing promotes community integration, as well as a homelike feel. However, they remain at the mercy of the landlords, which can be a disadvantage at times. Staff try to maintain connections with landlords who are willing to work with participants, but typically need to continue establishing new relationships with different landlords to meet the need. A staff member described the advantages and disadvantages to scattered-site housing as follows:

The disadvantages, like we talked about before, are being at the mercy of landlords that are in the area. But there's also a big advantage because the clients – as much of a choice as we can give them – they are making the choice to be in these places, we're not putting them there...They're in the community, they're not in an institutionalized place, they don't have the stigma hanging around them because of a certain building that they might live in. So, I think it can feel more like home.

The staff members reported that they try their best to educate landlords about the clients and their challenges in order to gain buy-in. When they successfully engage a landlord, they attempt to secure other units from that individual. As a staff member described:

We try to do like a bundle with some landlords, where we go and see an apartment and we like the landlord and they're willing to rent to one of our clients, and we say, "Hey, do you have any other apartments?" And they'll show us some more, and we do have those landlords we refer to as saints sometimes and they will bend over backwards to try to get our clients in and they love working with our agency. But then their apartment fills up and they don't have anything left and we can't just go to them, so we've got to try to make those new relationships which is very time consuming and pretty much the luck of the draw.

According to staff, participants often struggle to manage money upon entering the program, as this is a new responsibility for many. Participants also struggle to handle relationships with neighbors and landlords. Clients who have never had their own place tend to struggle most. Staff members noted that many participants also struggle to navigate social services in order to obtain benefits, as this process is often unclear.

Overview of Service Delivery

Housing Retention Counselors are participants' primary contacts and supports through the MRT program. In addition to the range of supports the counselors provide through case management, clients receive additional assistance from the program through move-in kits to begin setting up their apartments, as well as full financial support to stabilize themselves during their first year of supportive housing.

Case management was identified as both the supportive service used most frequently and the service most critical to achieving positive outcomes. Staff indicated that client engagement is central to their work, noting that they work closely with participants to develop a plan of action for maintaining housing and managing their health. As a staff member explained:

I would say there's no typical day. Every day is different, which is part of why I love my job. You never know what you're going to come into work to. But if I had to say, I would say definitely client engagement, working with clients on whatever our plan of action is – either completing stable housing searches, maybe getting their utilities on, and just things like that.

Without the consistent progress monitoring, support, and continuity of care that is upheld through case management, staff noted that clients are less equipped to maintain stable housing and are being terminated from their leases. Thus, maintaining engagement with participants is critical. As a staff member described:

A big part is just keeping engaged with them because sometimes the clients fall off a little bit after they get housed and they get kind of comfortable so we take a back seat unless they need something, just so that they can build their own life where they are now. But then I think in some situations they get a little too comfortable and they say, "Okay I'm housed now, I don't need substance counseling, I don't need mental health counseling. I'm stably housed. I wasn't before and that's what was making me have a substance use problem." But a lot of times they're still using. So basically, just staying connected with their providers once they get in.

Staff also work closely with the agency's on-site medical group to monitor clients' health and identify problems in managing their medical conditions. They use this information to further support the participants, as a staff member explained:

We have a medical group on site that we work very closely with. Just being able to see when something's not going well with a client. On a monthly basis, we look at our core indicators like CD4 count and viral load, and if we start seeing a decline in that, because we're getting that information from the medical group, we can have that conversation with the client – "Are you having difficulties taking your medication? Because I see that your viral load is increasing by a lot." Because our clients do have a lot of physical health needs that need to be addressed. And so being able to get them into services and coordinating those services with them is a big plus of the program.

Reducing Medicaid Costs

To approach the goal of reducing Medicaid costs, staff described their close working relationships with Health Home care managers. A Health Home is located in the same building as the program office, allowing for a convenient and close relationship between care managers and MRT staff. Program staff tend to pick up duties that the Health Home care managers are too busy to fulfill, in addition to communicating client needs that some participants are less willing to express directly to care managers than MRT staff. As a staff member explained:

That is the ultimate goal of our program. We do that through the coordination of care and making sure, if an individual is not linked with a primary medical doctor, to get them linked with a primary medical doctor so that they use that service rather than going to the ER for the common cold and any other issues they have. We also work with them on their medication compliance, so that they are taking the medications that are necessary to maintain their condition, and therefore take less trips to the hospital, ER, that kind of thing.

The staff further described how the Health Home uses "Healthy Link", which means that care managers need to follow up with clients who enter the emergency department within 24 hours. Program staff also follow up with the client to

determine helpful ways to intervene, and ways to prevent future hospitalization.

Of note, despite the program having an ultimate goal of reducing Medicaid costs, staff do not have access to Medicaid data, so they cannot accurately track decreases in Medicaid expenditures.

Perceptions on Participants' Progress

While housing is intended to be permanent, participants may graduate from the program but keep their unit. In a recent case, a client who graduated from the program was able to maintain the supportive counseling she was receiving to help with the transition from supportive housing. For some, success in the program leads to a discharge to Section 8 housing, as well as links to employment. In these cases, participants are allowed to continue engaging in support services with the program. As an administrator explained:

One of my clients has just recently landed a position in a factory and he's making much more money than the program allows so he'll graduate, actually, from our program. But we were able to assist him in getting into his house; he was homeless when he first got into the program and then we helped him get stably housed, which allowed him to search for a job, and that's our ultimate goal.

Interestingly, the program manager indicated that participants who seem to be doing the best in the program are those with limited social supports beyond program staff. Those who are most challenged in spite of the help provided by the program are those who are hesitant to trust staff, as well as those with the most significant mental illnesses. Staff members indicated:

The clients that seem to benefit the most are the ones who have no other social supports around them. So, if their family has kind of stopped talking to them for either their HIV status or their drug use, behavior issues, they have no one else to go to and we are the only ones that have been willing to help them.

It's mostly a mentality. So, if...they don't trust us when we start or they're not willing to engage, those are the ones that don't benefit too much from it and they eventually get discharged, usually on their lack of engagement.

Unsuccessful exits from the program include self-initiated discharge, incarceration, loss of Medicaid status, and return to former living situations. If participants lose housing due to eviction, program staff attempt to assist them. If it is a legal eviction, they work with lawyers to keep the client housed as long as possible while they seek a new apartment for the individual. As a staff member described:

We have had people evicted, and our first step with an eviction is making sure it's legal. So, we'll stick up for the rights of our clients and advocate for them. We have two or three housing lawyers that work with us and specifically the HIV population here in Buffalo. So, we'll try to fight it as much as we can, to start with, because we don't want to uproot someone and start the whole process all over again if they don't actually need to. And that kind of keeps our landlords in the area honest too.

Program Strengths, Weaknesses, and Future Directions

Staff members indicated that participants benefit from the independence and sense of self-confidence that they develop from living independently. Clients' willingness to engage is key to being successful in the program. Individuals with chronic medical conditions also reap the benefits of participating, as they are equipped with the supports to manage the long-term effects of their illnesses. Small caseloads enable staff to provide individualized attention to clients, which staff viewed as one of the program's greatest strengths:

I think having the funding available to keep caseloads small because on our HOPWA programs, we have 30 people caseloads compared to 10 or 12, whatever MRT is now. And you don't get that individualized attention. You might talk to someone on the phone once a month. Those clients are not as high need, but at the same time, there could be more stuff that those counselors could be working on with them. So, I think that was one thing I've really enjoyed about the program.

Staff indicated that another program strength is the unconditional support they provide to clients, even if clients need to leave the program temporarily to treat addictions. As a staff member explained:

One of my clients who was able to actually enter into a 30-day drug treatment program probably wouldn't have done so if he did not have the support behind him and the knowledge that his home was going to be safe and he'd be able to return to the same apartment. I don't think that he would have entered into that treatment facility if we weren't there to support him.

In discussing areas for improvement, staff noted that a clear definition and verification process of high Medicaid users would be valuable, as well as expanding the program to serve non-HIV positive individuals. Moreover, increased collaboration with the State would enable staff to manage the program better. They would also welcome the opportunity to meet with similar providers to learn from each other and share innovations and best practices. Some also suggested more funding for infrastructure to build housing for participants, as this would ease the process of providing housing for this high-risk group. Some staff members noted that they would appreciate more collaboration between OTDA and the Social Security Administration. As a staff member noted:

We could definitely use more collaboration with OTDA and Social Security Administration, because there are some things that we could manage our program so much better if we collaborated with them. Getting to talk to someone is like pulling teeth.

Staff also suggested providing more flexibility with grant funding so providers can implement creative ideas.

Participant Perspectives

Housing Status and Lived Experience Prior to MRT-SH Enrollment

Participants of Evergreen Housing Services indicated that prior to enrolling, they were either homeless or unstably housed. Those who were unstably housed described cycling out of living situations with family members, motels, or jail. Individuals who were homeless struggled with chronic health conditions, including HIV. One individual noted that he was living under a bridge, routinely experiencing seizures.

The participants described the program interview as relatively straightforward. However, they reported that they needed to be homeless in order to be eligible, and several described a perception that they needed to exhaust other possibilities in order to be eligible for the program. The participants described learning about the program through the local City Mission or through other programs associated with Evergreen. Some described a seamless process, with a case manager assisting. This was particularly helpful for one participant, who described being illiterate.

While the interview process was relatively seamless, the wait time before entering the program created significant problems for a number of participants. Some individuals perceived that staff could have done more to facilitate the process. One participant described a problematic situation prior to enrollment in the program. While waiting to enroll, he was staying at a City Mission. According to the participant, the congregate nature of the Mission is such that one can "catch anything", particularly if their immune systems are compromised by HIV:

When I first got into the program it didn't seem they were really helping in terms of caring. I told them exactly what was going to happen and it actually happened. I said I was going to go to City Mission and I was going to end up catching something and it was going to end up to really bad. So, I ended up going to the City Mission and ended up catching a virus. I got real, real, real sick....it seemed like no one cared, until I got other agencies involved.

Another participant concurred, and expressed that staff could have been more helpful at facilitating housing:

I love the program but some of the staff is kind of lazy with their job. Because if a person...you know if you need housing, they should take that as a priority. Get that person housing because you know that person's condition. You can't go to City Mission because City Mission isn't built for certain things that we have that for us. Me, myself, you can catch anything in the City Mission.

Perspectives Regarding MRT-SH Housing Accommodations

In general, the participants reported liking their apartments. One participant described the sense of community she enjoys through her housing situation, including how it positively impacted her life:

Right now, I am really happy. My neighbors, everybody's willing to help me. I'm so happy. Like I got the kids in the neighborhood coming to my house, saying hi. Knocking on my door, bringing flowers for Mother's Day. They brought me roses. I am so happy with my place...these people make my life so pretty.

The participants described other positive aspects of their housing, including having responsive landlords, having the opportunity for family members to visit, and enjoying positive aspects of their neighborhoods.

In contrast, several participants noted that their neighborhoods are not ideal, due to safety concerns and noise. One participant noted that his housing conditions are unsafe, and that his housing was not properly inspected. Other concerns including living close to the police, which prompted safety concerns, and residing close to bars that play loud music.

The participants reported mixed experiences in terms of their ability to choose an apartment. While three participants described having a choice, another felt that she had to look herself (through Craigslist), and to then get help from the program, which was frustrating. Two participants believed that staff moved them to parts of town that are racist, unsafe, or inconvenient for them. As one participant reported:

You know what I hate about that? I told them I didn't want to go to [a particular neighborhood] and that's all they kept finding me places in—Until I said I will look for my own housing. Once I started looking for my own housing, they stopped looking...I tell you I don't want the Eastside by you all are going to look there anyways until I start doing something, then you all are going to help me.

Another participant who is currently living in a rooming house (awaiting an apartment) reported that available apartments are undesirable, due to being located in neighborhoods perceived as racist:

We got apartments in [a particular neighborhood]... they are racist, we got apartments on the Eastside. I'm not moving to no Eastside. I'm not moving to them places because everything I want is down here. Because I can get to group. Transportation is easy...and it is better for me.

Several participants noted that it would be helpful for the program to provide more money toward housing, as it would allow them to live in better neighborhoods. As one participant described:

The State should pay more for housing because they pay a certain price range. The way the rent, the property value is now, there is no way you can find a house for under \$600. Especially down here (downtown) everything is \$1000.

The participants reported that if they were not housed through the program, they would likely be in an institution such as a psychiatric hospital or jail, in the throes of serious addiction, or dead. The participants reflected on the importance of housing for their mental health, for preventing recidivism, and for sobriety.

Perspectives on Housing First

The participants generally concurred with Housing First principles, including the importance of harm reduction over sobriety requirements for housing. The participants indicated that a lot of individuals would end up homeless again due to using substances while housed. They also noted that individuals with addictions cannot be forced to abstain, if it is not what they wish to do. As one participant explained:

[Sobriety requirements] wouldn't be good. They would lose a lot, a lot of people. You can't force an addict to do what he don't want to do. You do that, you are going to lose the addict altogether in the program....scare them away from the program.

Several participants noted that when individuals are using substances while housed through the program, they can fall

behind in rent payments. Two individuals experienced this issue and felt that the program allowed them to catch up on rent rather than evicting them. Other participants, however, did not find the program helpful in this regard. As one participant reported:

What I don't like about the program...everybody messes up especially when you doin' drugs. And if you mess up to where you can't pay your rent, your portion of it. They have no kind of help to help with arrears or anything like that. I'm not saying to help me every month with my rent...the housing worker that I got the first thing outta her mouth was 'if you can't pay the rent, we don't cover arrears.' That don't make sense because that makes a person...that makes them go off on the deep end or makes them think why am I in the program anyway.

Perspectives on Support Services

The participants described several aspects of support services that are helpful, including their care coordinators and counselors. The participants reported that the support offered by staff makes an important difference. Several participants noted that staff check up on them if they are isolating themselves or dealing with medical concerns.

However, in contrast to the positive aspects of working with a helpful staff, some participants felt that there are unnecessary barriers to receiving help. They noted that staff do not go out of their way to help participants:

When you need [program staff]—'oh you have to have an appointment'—I need you right now, I can't wait until the 5th of next year. I need something right now. I need your help right now. I need help with housing, or I am sick, or I have no food. When you need them, they always pushing you back and saying, 'oh you have to have an appointment,' that's the case manager and at the medical building. They are actually good, but they need to think more about what if this person is really sick and about to die and we just pushed them back into next month. You got all of these nurses and doctors, why can't you have a nurse for walk-ins?

They should be more concerned about our feelings. They should open up more doors for us, instead of shutting the blinds on us...like housing. If a person has been on the streets and you all have got the funds to help that person get housing, then that's what they should do. Instead of saying you got to meet this criteria and you got to do this...instead of just saying we are going to help you do this.

While not directly related to support services through the program, one participant noted that programs that help with detoxing can interfere with entry into housing:

They got a program (Evergreen). Suboxone program. And it takes time to get into housing here. So, it affects your housing. The longer it takes an addict to get on the suboxone program, it affects their housing. The addict ain't got time to deal with this...used to be get on the suboxone in two days— now it's 2 weeks.

Changes Experienced Since Entering the Program

The participants described how their typical activities have changed since entering the program. They described increased independence, as well as an improved ability to care for themselves. In contrast to living at the City Mission, the participants now can come and go as they wish without a curfew, cook for themselves, and avoid individuals they do not wish to see. They can also associate with more positive peer groups and neighbors. As one participant described:

I don't have to look at men, a thousand men, anymore because of City Mission. So, I don't have to sit around and this guy is coughing, this guy is sneezing, this guy is farting, this guy has got a skin...I don't have to be on a time frame, you have to get up at 6 in the morning, gotta be out before 8 and then back in before 10. Now I can come and go as I please, which gives me a better outlook on life.

For some, these changes lead to a sense of peace and improved quality of life:

I feel at peace. I go to sleep when I want to. I get up when I want to. I cook if I want to. I don't cook

if I want to. Watch TV, take a shower...I don't need to worry about anyone else coming into my apartment...have my own key. My neighbors...we don't have people coming in and out. My neighbors are really friendly.

Several participants described improvements in their mental health since entering the program. Others, however, continue to struggle with mental health issues due in part to continued difficult life circumstances that cannot be addressed by the program alone.

A few participants noted that they are using hospitals and psychiatric facilities less since receiving housing, in part because their lives are now less chaotic. They also attributed these changes to reduced stress:

Since I got my place it has been less...the hospital, psych wards... for me cause when I was homeless, people say 'yeah you stay with me, pay me this much money,' then they come and say, 'my landlord say you have to go' but I say, but I paid for the whole month. Now, I don't have to worry about none of that.

Some participants described using outpatient behavior health services more frequently since receiving housing, to address mental health issues and stress:

I find myself using behavioral health clinic more (mental health). I use it more because now I have a lot of worries. I have to worry about balancing my money, I got to worry about paying the rent, worry about if I going to have lights and gas. I got to worry about this and worry about that. And then I got to worry about my kids. I have family here, but I don't talk to them. So, I got no one here to run to vent. So, I use (behavioral health) more than ever before.

The participants reported mixed experiences with family relationships since entering housing. While some indicated that their relationships are improving since family can now visit them in their apartments, others noted that their relationships continue to be difficult and strained.

Perspectives on Program Strengths and Weaknesses

According to the participants, the greatest strength of the program is the housing itself. The participants described the importance of housing to their health and well-being. In terms of program weaknesses, some indicated that there is a need to improve medical services for HIV and shorten the time required to enter suboxone programs. The participants indicated that it would be helpful to have more money toward rent, which would allow them to afford better housing in safe neighborhoods. Some participants expressed that staff should be more responsive to their needs, including addressing needs in a timely manner. As one participant described:

The agency itself is good, they just have to work out some kinks...I don't understand why they have to wait for a person to be at to be homeless to go to the City Mission or sleeping under a bridge to help them. If I come to you and tell you I am living with a person that's a heavy drug user and I have to get out before I beat down that road. I think you should help me just like that (snaps fingers)...Now I went to the top, once I was in the City Mission but when I was living down the street with people doing drugs constantly.

CAPITAL PROJECTS

East 99th Street

Administrative and Staff Perspectives

Program Context: Key Components and Regional Considerations

East 99th Street is an HCR Capital program (i.e., a building) in Manhattan that provides housing to high users of healthcare services transitioning from long-term care facilities, skilled nursing facilities, or from the acute care hospital system. Some clients also transition to the program following periods of homelessness or housing instability. A support service or case management component is not included, though participants with certain insurance plans can participate in an adult day program if they wish. East 99th Street is funded through a public-private partnership.

According to staff of East 99th Street, the key program component is providing independent housing for participants. In contrast to most of the funded MRT-SH programs, East 99th Street does not offer support services as a part of the model. The Carter Burden Center for Aging provides a social adult day center on the premises for MRT-SH participants to utilize. This program is voluntary, and not all participants are eligible to participate, based on their insurance. The Carter Burden Center provides opportunities for social interaction, as well as health promoting activities, such as meals and telehealth workshops. The building is located across the street from a Health and Hospital Corporation facility, and the program works with the hospital to facilitate workshops, screenings, and outreach. A hospital is also located across the street from the building, and hospital services are often coordinated by a social worker and nurses.

Housing through the program is intended to be permanent. Tenants have their own leases, and renewal takes place annually through Section 8. According to program administrators, successful outcomes for participants include engagement and reduced social isolation, improved health, and decreases in the use of high cost Medicaid services (e.g., ER visits).

Regional Factors

The program administrators and staff highlighted contextual factors in the New York City area that impact the program and population served. The affordable housing crisis in New York City impacts the ability of the population served to obtain housing:

Without those government subsidies, the rent quite honestly is not affordable and these are all Medicaid beneficiaries. And when you look at Medicaid caps, these are individuals that are on SSI or some type of welfare cash assistance. So their income, I would say 95%, is below \$10,000. They are individuals who are below the poverty rate.

The administrators and staff also noted that ADA compliant buildings are scarce, particularly within affordable housing contexts. This often necessitates that individuals with health problems and disabilities that require accessible housing move into institutions, even though they may be capable of community living. As an administrator reported:

In NYC, one of the biggest challenges is finding housing that can accommodate the needs of individuals living in wheelchairs, using walkers; and having a building that is totally ADA compliant is a huge, huge help for many of these individuals which may have contributed to why they were

inappropriately housed or why they were in the shelter system or why they were even in extended long-term care facilities, due to the inaccessibility or the inappropriate housing to meet their needs.

Targeting and Eligibility Determinations

Participants are targeted from New York City Health and Hospitals. These participants are Medicaid beneficiaries and high Medicaid spenders. Many individuals enter the program from a long-term or skilled nursing facility, or from an acute care hospital setting. However, other participants come to the program from homeless shelters or other precarious living situations.

According to the administrators, individuals in long-term care facilities are targeted, as they account for very high Medicaid costs. Most participants have multiple chronic medical conditions, as well as mental health conditions. In addition, homeless individuals are targeted for the program:

Emphasis is on homelessness and homelessness is defined in the very strict way. As individuals are institutionalized for a long period of time, they don't meet the homeless criteria... since the homeless criteria as living in homeless shelter and for a prolonged period. It doesn't view someone in an institutional setting—it terms of a hospital or a skilled nursing facility as homeless—even though we know that a healthcare facility is by no means someone's home, especially when that person is medically cleared for discharge.

Program Changes and Innovations from MRT-SH Funding

MRT-SH funding was used to construct the building. According to the administrators, ongoing costs are managed through a variety of governmental funding sources and private funders.

Placing Participants into Housing

According to the administrators and staff, once participants are determined to be eligible, there is an internal review of the application packages, which include Section 8 forms, identifying documents, and a variety of supplemental documents, which are required by the developer and the Housing Development Corporation. Applications come from the facility to the Central Office, which is where verification of Medicaid status and the NYCHA background checks take place. Participants typically do not choose an apartment, but get what is available, since the building is fully occupied.

Perspectives on Housing: Reflections on Housing First

According to the administrators and staff, advantages associated with Housing First include the focus on housing as a critical social determinant of health⁹. As they described, after participants are stably housed, they are able to then attend to stabilizing their health conditions and becoming connected with health and support services.

The administrators and staff also highlighted disadvantages associated with Housing First. Within the East 99th Street program, support services are not offered on site. The issues that participants need to address must be met through referrals. Case management is not part of the program, so it was unclear how such referrals are made for program not in contact with the Carter Burden Center.

Perspectives on Housing: The Congregate Model

The East 99th Street program provides a congregate building. Participants have their own apartments, which staff describe as quiet, clean, and well-maintained.

I say we have a community within a community. When they come to the day program, the tenants are very supportive of one another. We have been able to reduce isolation, instead of sitting in their apartments. Many do not have family or family in the area. We offer that sense of engagement.

⁹ The individuals interviewed did not make clear if they view the program as Housing First adherent. Rather, they reflected on particular aspects of the model, per the questions asked.

Overview of Service Delivery

The East 99th Street program provides housing only. However, the day program located within the building is available to participants who have the required insurance (but is not available to the full population). Staff from the Carter Burden Center reported focusing on supporting participants through social opportunities, health education, and referrals to needed support services. The staff noted that the program reduces social isolation, which positively impacts participant's health outcomes. As the Carter Burden Center staff described:

We have actually been able to see some significant results. Such as, one of our participants have been able to reduce diabetic medication...since the telehealth along with the wraparound such as physical fitness, health and wellness education workshops, and cooking/nutritious cooking has reduced his A1C level. He no longer on diabetic medication...

According to the administrators, participants address their health and mental health conditions through health care providers, located off site. Though not part of the program, participants sometimes use home attendant services. The hospital social worker who is associated with the program works with tenants to create linkages with home attendants. Some participants require the services of lawyers when they fall behind on rental payments; these lawyers often coordinate with the participant's case manager, if one is involved.

Reducing Medicaid Costs

According to the administrators, reducing Medicaid costs is a goal that is built into the selection criteria. Several noted that it would be helpful to streamline the application process, which is long and burdensome. Some suggested a role for technology (e.g., saving previous responses from paperwork to populate new paperwork). Participants have Health Home care managers, if they are in fact enrolled in a Health Home, who also connect participants with primary and preventative care services.

Perceptions on Participants' Progress

Staff indicated that the participants who are benefitting most are those who have been connected to care and who have regular connections with a social worker or case manager. However, as noted earlier, these services are not provided by the program. Participants who are doing less well are those who fall behind in rent and become entrenched in legal issues to resolve this situation.

According to the administrators and staff, the majority of exits from the program have occurred due to participants passing away; there have been no evictions to date. Some individuals have left voluntarily, due to wanting to move closer to family. One participant left the program to move into a more traditional supportive housing program.

Program Strengths, Weaknesses, and Future Directions

Administrators and staff of the East 99th Street program reflected positively on the role that the building is playing in the participants' lives, noting that it is a setting that provides a sense of dignity. They indicated that the building allows individuals to begin addressing their health and well-being, due to the sense of security that is associated with stable housing. They also noted that the building is "a community within a community", where participants socialize and have opportunities to prevent social isolation. As an administrator suggested:

It is important to point out that for the significant part and a majority of the building, these are patients that came from institutional settings and primarily these were patients who were very long term stays. It is remarkable when you look at the transition able to make with the appropriate supports.

In terms of weaknesses, the administrators and staff indicated that not all participants have access to the Carter Burden Center. Additionally, the hospital social worker noted that participants can fall through the cracks due to not having case management and services to ease the transition to housing. For instance, participants may not have the skills needed to pay rent on time and to perform other skills of daily life. These individuals often end up in rental arrears, which creates a burdensome and time-consuming legal process. Participants who had been homeless in particular are likely to have early adjustment issues, which are not currently addressed by the program in a comprehensive way.

Participant Perspectives

Housing Status and Lived Experience Prior to MRT-SH Enrollment

The participants described residing in precarious or otherwise undesirable living situations prior to enrolling in the program, including halfway houses, nursing facilities, or shared apartments with friends or family. Housing accommodations prior to entering the program were described as cramped and sometimes chaotic:

I came from a [halfway] house. It was like unbelievable. It was a 2 bedroom apartment but they had 11 people living in this 2 bedroom apartment... Beds in living area and kitchen... There were no rules, no anything, as long as people paid their rent. A lot of drug use and all kinds of craziness going on... thank God [I'm out of there]!

I was in drop in center, it was horrible, 9 months horrible.

Those who described enrolling in a program from a nursing home noted that chronic conditions led to their placement in the nursing home from previous accommodations:

I was in rehab nursing home because I took sick and lost the apartment that I was living in, because I had a heart attack and a stroke.

Many participant described how significant health struggles associated with chronic conditions created complications for them prior to entering the program:

I was going through medical problems. The doctors emphasized no stress...I was staying with my brother, they wanted me in a stress free environment...that's why ended up in a halfway house. The treatment that I was having, I couldn't take it...I wasn't doing well at all, could hardly move, walk. I could take 4-5 steps and stop...get my breath back... It was heaven sent to get here... having the stability and stress-free environment. You had control of who and what you were and what you did.

I have asthma bad. I had apartment but had to help my son because he was sick. I lost my apartment because my brother took it over but didn't pay rent... so had to move in with my sister; I had more applications all over the city, even had an attorney...nothing, nothing, nothing. It was like God was watching over me... I got this apartment.

Every focus group participant noted that they were the first round of residents for East 99th Street when the building initially opened. The participants described attending several interviews, but did not describe encountering any significant obstacles. The participants described learning about the building through the Metropolitan Hospital, or through a social worker or therapist. The participants expressed gratitude for the opportunity to move in:

I got the application...I had interviews...I am happy to say the day I got the call telling me...you have an apartment...I was...I never won the lottery, it was like I won the lottery. I thank God. It is not an apartment I have to worry about, after renting a room, that's my castle, it's my castle. If I need to speak to management, even without an appointment, I can see them. Nothing like having your own space.

My therapist saw I was getting worse from living with family. I need my privacy. She said bring all your paper and application. She filled out application for me...she was there with me during interview... when she called me...on such and such a day you are going to get your apartment...oh my God! I feel on the floor, I was screaming...I thank God every day for apartment, everything is good.

Perspectives Regarding MRT-SH Housing Accommodations

Overall, the participants reported that they are satisfied with their apartments. The participants reported that their apartments are quiet, clean, and most importantly, their own private spaces. They further described the building as well maintained:

[The building is] well maintained... something broke, tell the super and it is fixed. No problems.

However, several participants noted that security is sometimes an issue in the building, particularly during weekends. They noted that people enter the building who should not be there:

Security is an issue. People come and go... we are afraid.

Though it was less common, some participants noted that parking outside of the building is often difficult for their guests, due to the presence of garbage trucks.

Most of the participants reported feeling a sense of community within the building, noting that the tenants check up on one another. Tenants tend to socialize with one another. The participants further noted that staff located at the adult day program are helpful and friendly when encountered in the building.

When asked where they might be living if not at East 99th Street, most participants reported that they would likely still be looking for an apartment while being precariously housed. There was consensus that without East 99th Street, living environments would continue to be stressful and chaotic. A couple of participants believed they would be residing with family. Some noted that they would likely be using drugs. As the participants reported, this situation would be far from ideal:

I'm too old to live with my grandchildren.

Still at the drop in center...in order for me to get out of the drop in center they wanted me to say that I do drugs and then you get into an apartment...I wasn't not going to say I was doing drugs, I was not going to say it either.

Perspectives on Support Services

Of the seven focus group participants, four reported attending the adult day program offered in the building. It is important to note that not all participants are able to access this program, due to insurance barriers. The participants articulated that Medicare does not cover this program, so they must have their own insurance that is not Medicaid or Medicare. Several participants noted that they would like to attend the program, but they are unable to do so:

I have Medicare/Medicaid and I'm not under the other insurance programs...Medicare doesn't pay for those programs. Let's be real, if they aren't getting paid, I can't be a part of the program...I used to have regular insurance but once I had the disability they took me off.

Those who attend the program described helpful aspects, in that they have an opportunity to meet new people and socialize; interact with friendly staff; and attend shopping trips, educational workshops, and other activities. They also noted that healthy lunches are sometimes provided. They articulated that the program could benefit from more attendees and more staff members. Other than the adult day center that eligible participants can attend, the participants described some support services they receive outside of MRT (not funded with MRT dollars). The services include engagement with social workers or case managers, home care services, and nursing visits. The services used varied based on each individual's needs.

Changes Experienced Since Entering the Program

The participants indicated that their daily activities have changed since entering the program. Most changes centered on increased independence realized since entering housing, which comes with the ability to make choices:

You have your key. You can come and go any hour at night.

You don't have to wait for someone to wait to use bathroom or use kitchen.

Overall, most participants described improvements in their health since entering the building. Changes included recovery from depression, initiating more exercise (e.g., getting out and walking), improved sleep, and improvement in their overall physical condition. One participant indicated that her health has not improved, but it is now easier to see

primary care doctors who can help her. As the participants reported:

Yes [my health] improved! I suffer from depression but since I moved in here, everything is different.

I continue to go to therapy...now I walk much better and sleep much better.

I had a mini stroke before moving here and herniated disk and a stent in my heart too...where I was before, I was always wheezing and coughing...from time I move here my doctor and specialist said 'there is some changes in your walk and bulging in your disk.' I say, 'Yeah I'm comfortable, I am happy. That makes a difference.' I don't need a counselor about how I find myself crying anymore. I used to be hurting and since I came into the building, I get to share my life with people. I feel proud and happy.

In terms of changes in use of health services, the participants discussed how access to health care providers is now easier. Some described needing to see health professionals less, due to improvements in their health condition and stress reduction:

Mine are stretched out a little longer...don't have to see the doctor as often. Has to do with the stress factor and health wise.

I see my primary doctor every 4 months instead of every month or 6 weeks. So that is great! I don't wheeze anymore.

Perspectives on Program Strengths and Weaknesses

When reflecting on their experiences in the building, the participants were grateful to have clean accommodations. Central weaknesses include perspectives on a lack of safety in the building, and lack of access to the day program. As two participants reported:

To me the greatest strength is that they keep the building very clean. What they could improve is security because what could happen during day time is different than on weekend. I thought there was supposed to be 24/7 day security.

With the cameras on the weekend, if something happens to one of us here, by the time the police get here, they are gone.

Norwood Terrace (Concern for Independent Living)

Administrative and Staff Perspectives

Program Context and Key Program Components

Norwood Terrace (Concern for Independent Living), a capital project in the Bronx, serves a population of individuals who are classified as "Population A", meaning those who are chronically homeless single adults with a serious mental illness. The building is mixed-use; fifty-eight of the one hundred fifteen units are designated for supportive housing.¹⁰

The program includes a small clinical team that provides comprehensive case management. Specifically, three service coordinators, a supervisor, an administrative assistant, and a medication manager are employed by the program. Clients must be seen a minimum of 1-2 times per month. Upon move-in, staff typically engage with participants more frequently, though this depends on client needs. Staff are available 24 hours per day.

¹⁰ Per a personal communication with NYSDOH, Norwood Terrace was the first building where DOH required that eligible applicants be prioritized on the basis of Medicaid spending. NYC HRA determined applicant eligibility.

A key program goal is to link clients to services that will enable a reduction in the utilization of high cost Medicaid services. Staff noted that a unique component of their program includes the work of a medication manager, who provides education on medication regimens and supervises clients on taking their medications. Further, staff work as a team to ensure clients' needs are met. Staff strive to maintain client engagement while upholding client independence. Contact with clients is typically more frequent upon move-in, but is reduced after clients are connected to support services.

Regional Factors

In general, program staff described positive aspects of the program location, in that there are many providers in New York City who can respond to participants' needs. They noted difficulties when the program initially opened, as the Montefiore health system had a two-month waitlist to see clients. More recently, Bright Point (for Health Home coordination) has become an asset to the program in terms of the provision of support services.

Targeting and Eligibility Determinations

All referrals to the program come from the Department of Homeless Services (DHS). Eligibility determination and prioritization is completed by DHS, and Norwood staff let DHS know of vacancies in the program. Program staff noted that since Norwood is a mixed use building that houses children, it is important to ensure that applicants to the program are safe and appropriate for the environment. According to the program managers, participants must be in a shelter for over a year to be eligible, and must reach Medicaid costs of a particular amount (a usage tier). A program manager explained the following:

All of our referrals come directly from DHS – Department of Homeless Services – and they actually look for people who have...been designated through the PAC system as and MRT consumer/recipient. So, they have to be Population A – that means they have to be in a shelter for over a year...and then you have to be in a certain decile of Medicaid spending. They send us those referrals and we see who is appropriate for this level of housing. We interview them and decide if they'd be a great candidate.

What will happen is: let's say, I identify a vacancy. I'll reach out to DHS and be like, "I have one vacancy." I'll ask them to schedule five candidates for me to interview to see who is the best participant to fit within our community and to fill the vacancy, because one of the things about Norwood is we have 54 children in the building...So one thing when we identify clients, we want to make sure it's a safe, kid-friendly atmosphere as well.

To determine an individual's eligibility for the program, the candidate must complete a screening process, which includes an interview. Staff noted that it is common for individuals to prepare for their interviews and modify their narratives in order to be accepted into the program. In light of this, staff feel they are not receiving enough information to make well-informed admissions decisions. Recommendations for improving the eligibility confirmation process included establishing a panel to conduct screening interviews, as well as requirements to ensure that clients are well-prepared to enter a more independent setting.

Due to requirements¹¹ for documentation of homelessness, staff reported that a large piece of the overall homeless population is being missed. The only applicants who are able to provide the required documentation are those who have stayed in a shelter, which neglects high-need homeless individuals who have not utilized the shelter system. As a program manager reported:

I think that in New York City, you always run the risk of the fact that you have to be Pop A to reside in this building, so you have to have been documented homeless for over a year. And the issue with the documentation of homelessness – you have to be in a shelter. This is not street homeless, this is not couch counting – you live on your mama's couch or you live on your friend's couch – or you're living in the hospital ER or the train station. I think that we're missing a huge piece. I think they're picking up people that want to be housed, that are currently in the shelter. I just think that the population of homelessness is so much bigger than what we have access to.

¹¹ Refers to NY/NY III requirements.

Regarding shelter-users, staff stated that they do think the program is capturing a population with the greatest health needs. However, not every eligible individual is willing to engage in the support service component of the program. As program staff explained, some clients refuse services, and service acceptance is not required to reside in the building. Some clients are more interested in stable housing than accessing support services.

Program Changes and Innovations from MRT-SH Funding or Other Funding Streams

According to a program manager, recent innovations enabled the program to employ a medication manager, who works with clients to understand and manage their medication regimens. The manager supervises the client's medication administration as well. However, funding for this program innovation was not provided through MRT dollars, as the MRT investment was capital only.

Perspectives on Housing: Reflections on Housing First

According to the program manager, the program did not intentionally adopt a Housing First model, but several components of the program are playing out that way. The program holds a no-tolerance policy regarding substance abuse (not a Housing First principle), but lacks a treatment mandate; thus, staff feel limited in their ability to prevent clients from using. Staff noted that a challenge with this situation is the potential for the whole building community to be impacted if a client is not yet ready to work towards sobriety. As the supervisor reported:

The one big issue that I think is driving most of our problems is the alcohol and the substance use. Because then they don't pay their rent, they take their rent and they go drink it, use drugs with it, disturbing other people...And then there isn't any mandated alcohol or substance abuse treatment so you can only keep trying to send them into treatment and they have to agree to go – it's such a tough combination that I'm not sure where the answers will come from for that...We have zero tolerance, but we can't do anything about it. Eviction process is almost non-existent in New York City because the process takes forever and it costs too much. And so, we continue to try to intervene as best as we can and it's very difficult.

Perspectives on Housing: The Congregate Model

According to program staff, utilizing a congregate housing model enables staff to work on site and manage incidents immediately, so clients are not left to face challenges on their own. With congregate housing, staff are better able to meet with clients and immediately address problems as they arise. Additionally, clients can easily find staff when needed. As a staff member explained:

I think one of the benefits of our building is the staff on site 24 hours so no one has to deal with an incident by themselves. All they have to do is – we have phones in each of the units so they can call down to security, which we also have 24 hour security, and they can be like, "Oh, there's something going on this floor," and staff will go to address the issue.

Some program staff have previous experience working in scattered-site housing and contrasted the approaches. They noted that it is easier to find and access clients when needed in congregate housing. Congregate housing also eliminates the need to interact with landlords over challenging client behaviors, which happens frequently in scattered-site housing.

Perspectives on Housing: Early Adjustment Issues

When describing the process of transitioning participants to the building, staff described challenges associated with early adjustment. Participants often struggle to adjust to independent living, and may lack the resources needed at an early stage. Additionally, alcohol and substance abuse create a number of difficulties. Participants may not pay their rent on time or may disturb their neighbors. As the program supervisor described:

There was no – not enough, in my opinion – resources put in place to deal with the lack of readiness of the type of people that we got in here. For example, you have people coming from the shelter, some with no recent independent living skills – some with none at all – street homeless, and then

normally you would think that there should be a transition period where you go somewhere and learn some of these independent living skills but it's not. They come straight into their own apartment and this is supposed to be independent living. But how do you take somebody who has no independence and put them into independent living? It makes it very, very difficult, and that's one of our biggest challenges here, because now we're doing extra just to maintain these clients in their apartment.

The staff emphasized that referrals are critical at an early stage, when many participants struggle to adapt to living independently. A staff member described how the program managed difficulties that a client was experiencing at an early stage:

We have one client, when he came here he used to just stay in the room with the door closed, the window closed, no air. Wasn't cleaning, wasn't doing laundry, wasn't doing much of anything. So, we got him into a day program. Started going to his appointments, started going to the psychiatrist, started taking his meds again, and he's fine. One of the best clients we've ever had.

In contrast, a staff member described a client who is having continued difficulty with adjustment:

He's very challenging. There's a lot of intervention and a lot of plans that have been put in place. He has no daily living skills at all. He's very limited as far as keeping his apartment clean, taking his medication, reporting to appointments. Even I would consider hand holding, it still seems like it doesn't work...I think it's a combination of his mental health and the fact that, I think, he's been institutionalized. He's been homeless for as long as he could ever remember. I think it's a combination of both. So being in supportive housing and being asked to structure – when you're homeless and live on the street there is no structure. All of this is like foreign for him, so it becomes a challenge.

Overview of Service Delivery

Staff view service coordination as paramount to client engagement and success. However, staff identified active substance use as a barrier to benefitting from the program, as it detracts from engagement in medical psychiatric health care. Staff support clients in improving both their mental health and their physical health by providing referrals and transportation, as well as by encouraging substance use treatment. Staff indicated that mental health and primary care referrals are both critical to the participants, as well as substance use treatment services. Participants often have chronic conditions, which are linked with or exacerbated by substance use. The staff work with participants to ensure that they schedule and attend their appointments and refill their medications, which also helps to prevent unnecessary hospitalization.

As stated above, program staff are in contact with participants at least once or twice per month. As the program manager explained, staff maintain open communication with clients, and clients often approach them as they need support:

What we've noticed is a lot of our clients, they'll come to us. And they come, even though we have a scheduled appointment Monday, we might see them on Wednesday and Thursday with a follow up question or follow up assistance. So, one of our other things is we don't want to limit their access to us.

Staff noted that some clients refuse to engage in support services while in the program, as this is not a requirement for participation. Service coordinators play a significant role in establishing linkages to services for those who are willing to engage. Staff described how they also go beyond the scope of their position to ensure clients are being appropriately supported and assisted.

Reducing Medicaid Costs

A key goal of the program is reducing participants' use of high cost Medicaid services. Program staff approach this goal by providing case management to support, linkages with services, and facilitation with care coordinators. As a program manager described:

Even though we're using the MRT population – the high utilizers of the Medicaid system – all of our 58

participants come from the shelter...So one of our things was a lot of them weren't linked to services. So, one of the things that my team did was to make sure we're linking everybody to services, and that was our goal to help reduce the Medicaid utilization. Another thing is, when a lot of our clients were sick, instead of making an appointment with the doctor, they'd automatically go to the emergency room because they didn't have a doctor. So, I want to say one of the biggest things that we've done is link them to a case manager. Some of them had care coordinators but they didn't know who their care coordinator was. And so, one of the things we've tried to do is be that bridge between the client and the care coordinator.

Staff highlighted their collaboration with Bright Point as being particularly useful in coordinating care and arranging transportation for clients. The program's approach to reducing Medicaid costs is linking clients to primary care physicians and psychiatrists, and teaching clients how to discuss questions and concerns with these providers. Staff often interface with the psychiatrists, which they described as helpful. The 24-hour availability of staff also helps facilitate early intervention for client needs. The program manager described how staff work with participants on self-advocacy, particularly around psychiatric medications:

And, you know, one of the things we talk to our consumers about – having that open dialogue with the psychiatrist about what your concerns are. Don't just stop taking the medication because you don't like the side effects; talk to the doctor and maybe he can give you something to counter the side effects or change the medication, that way you don't have to worry about decompensating.

Perceptions on Participants' Progress

In discussing exits from the program, staff noted that most exits have been unplanned. Reasons for leaving include lack of readiness for independent living and not wanting to be in supportive housing. Housing is designed to be permanent for participants. Those who leave may move on to a more independent setting (a successful discharge), while others return to the homeless shelter (an unsuccessful discharge). In general, however, there is little turnover in the program. A staff member described an unexpected discharge as follows:

We've had one person move to...more independent housing. He ended up going into the shelter because of a domestic dispute between him and his wife and our apartment program automatically went to her side – agreed with her. So, he got evicted and he had to go to the shelter system, but he was able to fight it legally and basically...the incident was unfounded. So, they had to provide him a Section 8 apartment and they had to place him on top of the priority list and he was able to get independent housing. Since he's been discharged, we've followed up with him, we've still provided support, and he's doing really well. But he's also still is linked to providers and he still has a care coordinator so he still has that extra safety net there.

Some staff members noted that participants who are benefitting most are those who are motivated and who are open to help from providers. These participants meet regularly with staff and attend their appointments. Staff indicated that participants who have a history of independent living tend to fare better than those who have never lived independently. The program managers noted that clients who are actively using substances who are not willing to engage in health care are experiencing the most significant challenges:

I've noticed that people that are actively using substances aren't ready to be part of – I don't know – they're not interested in engaging in their medical or psychiatric health. I think one of the biggest barriers is the treatment of substance use.

The program manager further described the role participants play in their own success. Even those with significant challenges can do well in the program, if they are willing to engage:

I think some people have more barriers, but I think it depends on where they're at. Even the client with the most barriers, if they're interested in treatment and following through and meeting with their service coordinator, and going to their appointments, we work with. I think an example of the client that utilized K2, he's someone that we realized early on that he really needed a higher level of care. But we were able to – instead of the service coordinator meeting with him weekly – we scheduled all his appointments, we scheduled all his transportation.

Program Strengths, Weaknesses, and Future Directions

Stable housing was identified as the foundation for reducing clients' healthcare problems. In addition, connection to services and different support systems has made a positive impact on clients. The team of staff was considered the greatest strength of the program, as they are able to incorporate their range of experiences in the field into their work with clients. As the program supervisor explained:

We have a collective group of people with a lot of experience and how to get these problems solved. It's like, you hear a bang – everybody gets up and goes. And that's that instinct and that teamwork mentality, I think is what's been very, very successful with us.

Staff are constantly working with clients to address various barriers to engaging in treatment and support services, so increasing the number of staff, particularly on weekend and evening shifts, would be greatly beneficial. Staff highlighted several areas for improvement to the program, including establishing mandates and consequences (approaches that are not compatible with Housing First), amending eligibility criteria, and obtaining additional resources. As the supervisor explained:

I think one of the main things that [the state agencies] can improve is first to perhaps amend the requirements so that the organization, our organization should have the ability to say a person must have a certain amount of independent living skills training in order to come to this level. And if not, then they should be coming with certain particular services in place to help the transition.

Participant Perspectives

Housing Status and Lived Experience Prior to MRT-SH Enrollment

Most participants of the Norwood Terrace program described experiencing homelessness prior to entering the program. Some were unstably housed in temporary accommodations, while others resided in shelters or on the streets. The participants generally reported a smooth process for entering the program. Most were referred to the program from outside agencies. As the participants described:

My counselor from BronxWorks brought me here. They have counselors at BronxWorks that deal with homeless people, people in shelter, and out of housing like that. There was no word of mouth.

Where I was at, my anxiety level was off the chart; I mean off the chart. So, when they sent me the interview, the first thing that came to mind was I ain't moving to Brooklyn. But when I went to the interview they explained to me that it was just an interview and at the bottom of the interview paper it said that I was going to be living here. So, I was shown the apartment, I had to go back to where I was living, and when I got back I dropped on my knees and I thanked the lord because without [inaudible] I would probably still be living in the streets.

One participant indicated a perceived program requirement, stating that he needed to reside in a shelter for a full year prior to becoming eligible:

With me it was a little different, because I was coming from a shelter and I had to be there a year before being seen by anybody. When it did come, it was a shock to me. It was different.

Perspectives Regarding MRT-SH Housing Accommodations

When describing their housing accommodations, the participants provided positive feedback regarding their ability to live autonomously (without roommates) and to have personal privacy. The participants described living in studio apartments, with many indicating that they like their apartments and neighborhood. The participants indicated that without housing through Norwood Terrace, they would likely still be unstably housed in temporary accommodations, or living on the streets. Housing provided a sense of stability and pride:

The best feeling in the world is putting a key in the door, you understand? And seeing what you accomplished. This was a big accomplishment for me.

Perspectives on Housing First

When discussing the harm reduction approach associated with Housing First, the participants offered mixed reactions. Some indicated that harm reduction is practical, as individuals who wish to use will do so regardless of program rules. For these participants, if individuals are using substances, it does not personally impact them and thus doesn't concern them. As one participant reported:

Everybody's not going to listen to the rules, so they're going to do what they want to do. And that's anywhere – a program, or whatever. The society, period, is nothing but drugs. So, wherever you go, brand new building or whatever, if that's what you do that's what you going to do. But have some kind of respect with it...do it incognito, not letting everybody all into your business.

Others, however, indicated that there should be consequences for using substances while housed through the program. These participants endorsed a no-tolerance policy, in contrast to Housing First principles.

Perspectives on Support Services

The participants did not highlight specific support services as especially helpful, but rather indicated that a caring and supportive staff is especially important. The participants indicated that program staff do the best that they can to help the participants and show concern for their well-being.

Changes Experienced Since Entering the Program

When describing any changes in daily activities, the participants contrasted their lives since entering the program with their experiences in shelters or other unstable housing environments. The participants commonly described a sense of independence and peace since entering the program. They appreciated having a place of their own, which was a first for several individuals. They also indicated a sense of relief at no longer having to follow homeless shelter rules. As one participant relayed:

First of all, I ain't got nobody to turn that light on, talking about its time to wake up. I wake up when...I want to get up. That's number one. Talk about breakfast, I eat when I want to eat, I cook what I want to cook.

Similarly, the participants stated that since entering the program, they feel more relaxed, better able to manage anxiety, and more in control of their health. Those who resided in homeless shelters prior to the program reported that it was impossible to address their health in that environment. One participant [speaking through a translator] indicated:

He said he's able to control his health now. Before, when he was in the shelter, he sleeps in a chair so he was having all these medical conditions. But he says now he's able to lay down and actually have control.

The participants noted a decreased reliance on emergency services. Some participants indicated that while homeless, the hospital felt safer than living on the streets:

I used to lock myself in the hospital because there were times that I just felt safe there. Because I've been in the street, you understand? And just being homeless, period. I have not seen a hospital since I moved in here. And that's real. And I have my primary doctor and I get my medication, and I'm good.

The participants also reported using primary care services since entering the program. Some indicated that they continue to see the same doctor on a more regular basis.

The participants indicate that in general, they have been maintaining positive relationships with family members since entering the program. Housing provides stability to engage or re-engaged with loved ones.

Perspectives on Program Strengths and Weaknesses

When providing feedback on the program, the participants most frequently commented positively about program staff, indicating that staff treat them with respect and dignity. The participants indicated that staff get to know each of them

as individuals. No significant weaknesses were noted. As one participant described:

The strengths are obvious. You have staff – they all know your name. I've never met a staff that didn't know who I was and that's so important because...they treat you like a human being. You're not a number to them, you're not "oh that poor washed up old maid." It's just anyone who takes the time to learn who you are, the whole way the building is tinted with it is so important and that's what the staff does here.

CAMBA Gardens II (Camba, Inc.)

Administrative and Staff Perspectives

Program Context and Key Program Components

CAMBA Gardens II is a mixed congregate building in Brooklyn with three hundred units, including one hundred eight units that are designated for MRT. The remaining units are HASA and low-income community units. The program serves individuals with serious mental illnesses who were experiencing homelessness prior to entering the program. Staff are located in the building, which is where case management and other services are provided.

CAMBA Gardens II employs a program manager, clinical supervisor, and several case managers. CAMBA Gardens II staff indicated that they serve clients with serious mental health issues and complex needs. The staff indicated that the complexity and acuity of the clients is of particular note, as it impacts the ways in which the program is run; particularly, case management and other services are designed to be more intensive, and they endeavor to be responsive to participants, both proactively and in response to times of crisis.

Regional Factors

CAMBA Gardens II staff indicated that regional factors impact the program. Specifically, the building shares grounds with Kings County Hospital. The staff indicated that this helps when getting individuals to their appointments and also facilitates communication between program staff and health care staff. They also noted that the concentration of shelters and permanent supportive housing in the neighborhood, coupled with significant drug use in the area, can increase the risk of relapse for participants struggling with addiction. Regarding the program's location in Brooklyn, a staff member described:

I think [the location impacts the program] definitely in good and bad ways. We're right next to Kings County, which is amazing. We can literally walk people to the Psych-ER. In the neighborhood, there are a lot of drugs. Our clients, most of them, have comorbidity with substance abuse. So, it is just so prevalent and with the shelter being right across the street and two other housing facilities near, a lot of our clients know people. So it is easier to relapse.

Targeting and Eligibility Determinations

According to CAMBA Gardens II staff, some of the program participants have extremely high levels of need. Eligibility is determined by DHS using the 2010E (a housing application) and a psychiatric evaluation. Packets describing eligible potential participants are provided to CAMBA Gardens II when they have vacancies in the program. Staff then conduct interviews with eligible clients.¹²

When reflecting on eligibility criteria provided by DHS, the staff noted that a lot of potential participants "aren't ready" for independent living. For instance, some individuals may require a very intensive form of case management in order to stabilize. Some staff indicated that such individuals might benefit from having a housing option "in the middle" (between a shelter and supportive housing), before moving into a program like CAMBA Gardens II. As the staff described:

¹² Per a personal communication with NYSDOH, CAMBA Gardens II is the second building where DOH required applicants to be prioritized based on Medicaid spending. For CAMBA Gardens II, the criteria by which a person could be deemed eligible were expanded to include Health Home enrollment or eligibility.

Uhm...I was part of interviewing for the majority of the people that moved in and I think that that are a lot of people who are not ready for independent living who are sent to us and I know it is difficult to make that decision but I think the amount of intensive case management services that we have been giving them, they aren't able to function.

There needs to be housing in between...not the shelter, not the independent living, but one that has more support 7 days/week.

The staff indicated that many of their cases are psychiatrically complex. The staff noted that some participants have psychiatric illnesses so severe or complex that even with treatment given by injection, the client still is not stabilized and may end up requiring involuntary hospitalization. Additionally, some participants struggle with basic skills, such as money management. These individuals struggle to pay bills, rent, and utilities on time. The staff further noted that the daily living skills of clients coming directly from shelters can be quite low. The clients need assistance with basic skills, such as laundry and keeping the apartment from becoming “unlivable”.

While the staff reported challenges faced when serving participants with psychiatrically complex conditions, they did not believe that their caseloads were too high or that these challenges were associated with under-staffing. Rather, they indicated that the setting itself may not be a good fit for some clients. Those who struggle significantly with independent living sometimes return to a shelter.

Perspectives on Housing: Reflections on Housing First

CAMBA Gardens II is considered a “sober building”, which is not consistent with Housing First. However, staff indicated that judges typically do not approve evictions from the building based on drug use. Rather, the judge “puts it back on the case managers” to offer supports to participants to promote sobriety. Thus, while harm reduction is not the chosen approach, it becomes the standard due to logistical constraints. In practice, the staff indicated that the strategy is to limit the damage and impact of relapse, which they view as a better alternative to eviction. Staff indicated that they can ban known drug dealers from the building.

In general, staff were in favor of the sober building. In their views, substance use can easily cause clients to decompensate, due to their underlying psychiatric needs. However, the staff also indicated that it is better to have the client remain in the program where they can access supports and be encouraged to seek assistance and treatment.

Perspectives on Housing: The Congregate Model

The program staff indicated that a primary benefit of the congregate nature of CAMBA Gardens II is that significant support is offered to participants right in the building. Each case manager has a caseload of sixteen to seventeen participants, and they get to know each participant very well. Staff reported that because they work on site, some clients proactively seek out their assistance; for those who are less comfortable requesting help, staff contact them to check in about their needs and how they are doing. By co-locating services within the building, staff indicated that they are able to monitor participants and to intervene before decompensation occurs. Congregate settings also eliminate some of the safety concerns staff experience when seeing clients in scattered-site apartments.

The staff also described some negative aspects of the congregate setting. While a building that serves mixed populations can allow individuals to flourish, there is also the chance that when some individuals relapse, it can destabilize others. Some non-MRT residents complain about living with the MRT clients. As a staff member suggested:

We want to build a community here and want them to have each other but it is a double-edged sword because they can trigger each other in negative ways. So, there are positive clients who come to group and are very engaged. But if one person, relapses you can see how this trickles to other clients.

Staff indicated that when participants first enter the program, they may struggle to adjust to program rules and regulations, such as regular meetings with a case manager and not using substances on the premises.

Reducing Medicaid Costs

CAMBA Gardens II staff described services that are designed to stabilize health, with the goal of reducing Medicaid costs. Several groups have been created for participants, such as yoga, cooking classes, nutritional classes, and budgeting workshops. Staff frequently make referrals to services in the community.

Overview of Support Services

The staff described that once a participant moves into the building, the program provides them with a “starter kit”, which includes household items. Staff also conduct an interview to learn about the individual’s needs and existing linkages to services. They described how this interview can be an opportunity to highlight social activities in the building and encourage the participant to take advantage of these opportunities, with the goal of preventing social isolation.

Case management¹³ is a critical component of the services offered by CAMBA Gardens II. Additionally, program managers are on call around the clock; security calls them should a crisis occur after hours. Staff indicated that the security staff are experienced in determining when they should call a program manager, versus calling 911.

As the staff described, participants have various needs, and staff use a client-centered approach to address these needs. Staff conduct regular wellness checks; while OMH requires that these checks take place twice per month, the program performs the check a minimum of once per week, and as often as daily for some participants. The staff also provide assessments, work with participants to schedule and maintain medical and other service appointments, accompany participants to their appointments, and work closely with them on daily living skills. Additionally, staff provide psychoeducation to assist the participants in understanding their conditions. They work with participants to determine what resources might be required, particularly if clients are in crisis or decompensating. Staff described the importance of case managers working in the building:

Uhm...I just think the presence of your case manager being in the building is a significant major factor in their supportive housing because whether they want to see us or not, we are able to see their progression and make sure they are still walking on a straight and narrow. If they're not, we are able to seek help for them.

The program manager works with staff to follow up on any incident reports that may have been filed the day or night before, and coordinates with them to determine next steps. All staff indicated that they collaborate very closely and work well as a team. While each case manager has their own caseload, the staff work together to problem solve, identify resources that participants might need, and to share information about the best ways to help the participants. The staff meet with OMH once per month to discuss difficult cases; the staff also frequently meet internally to touch base and regroup more informally. Staff also described how helpful it is to have a clinical supervisor on site, as she can provide ongoing support and explain the symptoms and conditions to their participants.

Perceptions on Participants’ Progress

According to CAMBA Gardens II staff, participants who understand everything that is available to them through the program are more likely to utilize the services, and thus, to benefit. In general, the staff found that intellectually or developmentally delayed individuals have been especially receptive to the assistance. Two staff members described clients who are doing well or struggling in the program:

I think I have a client who is benefitting a lot. I think because she understands exactly what we provide, she utilizes everything that she can. She fully understands why we're here, what we're here to do and just how much she can use social services.

I also have a client who doesn't understand. He just looks at it as we're just being intrusive, so he is not benefitting from it at all. He doesn't really see the benefits of independent living and supportive housing.

¹³ MRT funding for CAMBA Gardens II is capital only. Thus, case management and other support services are funded through different funding sources.

Program Strengths, Weaknesses, and Future Directions

Staff perceive the greatest strengths of the program to be the on-site services that are offered to participants. Services are delivered by a closely-coordinated team. They also highlighted the congregate setting and community building as significant strengths.

The staff also indicated that the program could benefit from an on-site nurse practitioner, who could assist with medication management or prescription injections. They perceive that such a service would help significantly with medication compliance. They also noted that a nurse practitioner would be able to help deescalate clients who are paranoid about their health (e.g., providing blood pressure readings if a person is concerned about having a heart attack). As a staff member reported:

I think it would be very important to have a nurse on-site. But I think we are lacking in that piece. We have a lot of clients who have medical issues...one of them, if someone could just take his blood pressure and tell him he's okay, he will call ambulance a lot less.

When asked to if there is any information they wished to share with the state agencies, the staff indicated that the agencies should know that they are working with clients with very complex needs. While the program is meeting the needs of these clients, it is a unique and often challenging environment.

I think it has been a hard year but incredibly interesting. Probably the most interesting experience I have had in supportive housing. Our clients are very unique, and all have a lot of issues that we can help them with...but they have a lot. There's always something to do.

I never worked with an entire caseload diagnosed with schizophrenia, so it has been difficult to manage all seventeen. Seventeen is not a lot but when they are all schizophrenic, it is a lot. Each person is never the same.

Participant Perspectives

Housing Status and Lived Experience Prior to MRT-SH Enrollment

Most focus group participants reported that they were residing in a homeless shelter prior to entering the program. Most participants resided in the shelter for long periods (up to three years), or reported experiencing multiple shelter stays. Some described relationship problems that led to unstable housing or homelessness, and a few indicated that they spent time in jail prior to entering the shelter. One participant described entering the shelter after the loss of a relationship, and an inability to afford rent:

I was not used to the shelter system. I was working full-time, so I had a little bit of income but then it kind of went sideways with me and my ex and I couldn't afford to keep paying 600 a month for just a room when I was only getting 800 dollars a month.

The participants learned about CAMBA Gardens II through the shelter system. About half described the process of enrolling in the program as very burdensome, while others found the process easier. A participant who found the process difficult reported:

The process was a pain...and that's putting it nicely. They need your this, your that, you need to prove this, you need to prove that, you need statements going back 3 and a half years. And you have to be careful how you answer a lot of these questionnaires and how you fill out the housing packet.

Another participant who experienced a more seamless process described:

See, they did mine so quick. I showed up and did not expect to move in and they had my lease ready to go.

One participant wondered if timing may have factored into the different experiences, with the process being easier when the building first opened versus when the building was mostly full. Participant experiences varied in terms of

help received prior to enrollment through the shelter system; some described helpful workers, while others did not feel supported in the process.

Perspectives Regarding MRT-SH Housing Accommodations

The participants provided mostly positive feedback about their apartments and about the building. Most participants described the building as quiet, peaceful, and much nicer than most buildings that would cost a similar amount, with reasonable rent. The participants also contrasted life in the building with the shelter, and described appreciating their personal privacy, living on a nice floor with kind neighbors, and not having to hide their food as they would in the shelter. The participants appreciated the ability to cook their own food and engage in healthy behavior. As one participant noted, "CAMBA keeps me away from bad habits." Other participants reported:

It's not too rowdy...it's not like I can't go somewhere and worry about if my stuff will be there when I get back.

For me, it was a blessing to come here.

It's a beautiful building...aside from the little inconveniences, I don't really see...this is better than most buildings I've been to or seen.

The participant indicated a few factors of the building that were less desirable. Some wished that they could own a pet, which is not currently allowed. Several noted that the building is not centrally located near amenities:

I feel like I have to walk at least 2 and a half blocks to do anything...there's nothing here, it's all mom & pop shops, 99-cent stores...

Most participants indicated that they would likely still be living in the shelter if they had not enrolled in CAMBA Gardens II. One participant wondered if he might have ended up in jail, due to conflicts that were arising for him while in the shelter:

I'd either be in the shelter or in jail. In the shelter, if someone was bothering me, I'd just snap [others agreed].

Perspectives on Housing First

When asked to reflect on program rules regarding substance abuse, the participants perceived there to be a "zero tolerance" policy, but noted that substance use does occur:

Oh, there's a zero tolerance policy...especially in common areas, you're not supposed to be doing it at all. With that, I have definitely smelled weed before and I'm on the 9th floor. So, if I smelled that, it's definitely coming out of somewhere.

Reactions to this policy were mixed; some believe that people in the building need to be "weeded out" for drug use, while others indicated that this policy is not helpful to individuals with addictions, and argued that substance use is fine as long as tenants are not impacting their neighbors. As one participant reported:

It doesn't really bother me. There're people that live next door to me and I smell weed. I even smell crack sometimes. But it doesn't bother me because I am inside my apartment. To each its own. People want to live their life. I moved out of the shelter to do what I had to do for me.

Perspectives on Support Services

In regard to support services, the participants indicated that it is especially helpful to have support staff on the premises to assist them as needed. Some participants indicated that support groups are helpful, and appreciated the food pantry. Several participants expressed positive feedback regarding staff, noting that their caseworkers are "awesome and helpful". As two participant reported:

Of the services that are available, I do think they're great and I like that they are there. I like that

there's somebody there to make sense of everything.

I like that we have the food pantry when you're running out of food, it's a big help.

Changes Experienced Since Entering the Program

The participants described changes in their daily lives since entering the program. In general, a sense of independence emerged as an important change. The participants described how their children are now able to visit them and how they can cook on their own. As the participants explained:

I get to bring my daughter and two boys over here...I wasn't really able to do that in the shelter.

I feel great, I'm eating good, I'm cooking good.

Overall, the participants reported improvements in their health, which they often attributed to housing and to positive changes in their daily routines (e.g., eating "real food"). Several participants reported having easy access to health services. Also, the participants discussed having better eating and sleeping patterns, losing weight, and requiring less medication for sleep or blood pressure. As several participants explained:

I sleep and I eat better...because I have blood pressure issues.

I have been eating healthier because I have been able to cook food that is readily available.

I lost pretty much 50-pound by living here and got off my blood pressure medication.

As participants discussed changes to their relationships since entering the program, experiences were mixed. Some participants appreciated strengthened connections with their children, who are now able to visit. However, others reported that their family relationships continue to be strained.

Some participants noted that the privacy and resources provided by the program allow them to pursue their goals. Several described a sense of hope that has emerged for them since leaving the shelter and entering CAMBA Gardens II. As one participant explained:

I think goal-setting depends on the person...the only difference now is you have the privacy, the space, and the resources available to be able to move closer towards those goals...it was just about when I was about to give up that CAMBA thankfully came through and it all worked out.

Perspectives on Program Strengths and Weaknesses

The participants' overall feedback on the program was very positive, in terms of both housing and support services. A few offered suggestions for improvements, noting that it would be nice to have an area for children to play while visiting. Others desired a gym or fitness center on-site, and well as a recreation space (e.g., a place to congregate to play board games and other activities).

HHAP PROGRAMS

86 Carroll St. (Opportunities for Broome)

Administrative and Staff Perspectives

Program Context and Key Program Components

86 Carroll Street/Opportunities for Broome is a capital project in Binghamton serving single individuals struggling with addiction, severe mental illness, and physical disabilities. The program offers congregate housing with on-site case management services, which are individualized to meet the needs of the specific participants. There are twenty-two apartments in the building for MRT clients, and the program employs case managers, a family advocate, an intake coordinator/housing manager, and the Deputy Director.

The 86 Carroll Street program is designed to work with participants to achieve goals that they define for themselves. However, an overarching goal of the program is to work with participants to become as independent as possible, with the goal of fostering skills needed to graduate from the program and live independently. According to program administrators, there is little turnover in the program, with an average stay of approximately a year.

Regional Factors

According to program administrators, Broome County consists of both urban and rural areas; housing is located in a building within the downtown area of Binghamton. In the downtown area, public transportation is more seamless compared to rural parts of the county, though the administrators noted that it difficult for participants to access bus passes. In terms of the broader housing context, the administrators described how housing in the area is impacted by gentrification, with students renting apartments and low income individuals having few affordable options. This impacts the participants who are ready to move on from the program, according to staff:

Very much so the appropriate, affordable housing once they've done well in our program and are ready to move on. Due to a lot of factors within the city, whether it be student housing dominating the downtown area now, jobs that are not accessible through public transportation, anything outside the actual city of Binghamton itself is very hard to access for people that are low income. So that is a huge barrier moving on and outward into the program itself when it comes to the region, just something that's safe, affordable, low income housing.

In this area, administrators described difficulties individuals with criminal backgrounds face when seeking employment. The program holds job fairs with employers who are willing to consider applicants with past criminal histories. Staff noted that transportation possibilities impact the jobs that participants can accept, as the jobs must be accessible via public transportation. Further, staff indicated that community resources (e.g., grocery stores) are scarce.

Targeting and Eligibility Determinations

According to the administrators, the program eligibility criteria were determined by the HHAP RFP. They suggested that some of the criteria tend to overlap. The program serves low income individuals with disabilities, who were homeless or

unstably housed, with frequent hospitalizations¹⁴. The administrators agreed that this criteria allows them to serve the neediest populations and to prioritize the most vulnerable. However, it is challenging to meet definitions that tend to be inconsistent, such as definitions of homelessness versus chronic homelessness. As an administrator described:

I think at times it's difficult to meet certain definitions because of actual guidelines. If you were going to stay 91 days in an institution facility, that no longer counts as an instance homelessness. Little definition quirks are difficult to prove but I think in terms of the most vulnerable population it's a good program...

An administrator also highlighted how the focus on chronic homelessness allows the program to serve a hard to house population with unmet health needs:

I think we are getting a population that has burned a lot of bridges. That has had trouble accessing services and has accessed them in the wrong way and is now having difficulty getting those services. A lot of the clientele that we serve have significant health needs that has either been to their own refusal to participate in services or a lack of knowledge of how to access the services. A lot of individuals have transferred from institutions and haven't had the ability to live on their own, haven't had the services in the community. Just figuring out to how to navigate services. So, with having stable housing, its one less thing to worry about.

Referrals typically reach the program due to outreach, as well as from referrals from institutional facilities and homeless shelters. Health Homes, DSS, community agencies, and self-referrals are also made. Upon entering the program, staff administer a family well-being scale to determine the most critical needs of each participant. A key duty of the housing manager is to determine participant eligibility:

The eligibility for this building specifically, you have to be homeless at point of intake and a high Medicaid user. So, we do house our Shelter Plus Care primarily out of this building. So, Shelter Plus Care you have to be chronically homeless, which would be at least four times in the past three years that accumulate up to 12 months with a documented disability. So, the intake process is really trying to obtain all that documentation as quickly as possible to provide safe, affordable housing as soon as possible for that most vulnerable population.

According to the program manager, need for the program is high, so there is no lack of referrals to the program. However, eligibility determinations are more burdensome.

Program Changes and Innovations from MRT-SH Funding

According to the program administrators, MRT funds were largely used to renovate the building. They also noted that NYSSHP funding is used for program services¹⁵. Program innovations also included adding apartments, as only eight were useable prior to the renovations. The program also added an elevator, which allows them to serve participants with chronic health needs.

Housing Specifications and Placing Participants into Housing

As participants are initially placed into housing, staff work with them to ensure that they have what they need, including food, bedding, and personal care products. The apartments are furnished for the participants. Staff described the importance of establishing trust with participants, noting that this is a prolonged process. However, they also made clear that housing is their focus, and that the rest lies with the participants:

What we provide is safe, affordable housing. So, anything that you want to accomplish or achieve outside of that is exactly on our tenants. Some tenants, the relationship builds very quickly. Other tenants, it's taken well over a year to have them feel comfortable to be somewhat honest with us. And that's okay, that's what we preach to them – that even if you're dishonest with us, that's okay;

¹⁴ Per a personal communication with NYSDOH, "frequent hospitalizations" were not specifically required by the HHAP RFP.

¹⁵ Per a personal communication with NYSDOH, MRT provides funding to NYSSHP.

the fact that you're willing to sit with us, communicate, and you're not breaking the law, you're not breaking the lease, you're maintaining a safe environment, you're remaining stably housed.

Perspectives on Housing: Reflections on Housing First

The program administrators described how the program has changed since adopting the Housing First model:

Things have changed since we adopted the Housing First model about 2 and half, 3 years ago. It became basically a requirement from HUD that regardless of the person's situation, regardless if they are using, whatever the circumstance may be. That changed our approach a bit...we had to be more flexible, more willing to think outside the box. It's a different atmosphere now. We still advocate for a clean program but if someone uses or relapses...outside of severe criminal activity. We really look into getting them into assistance versus removing them from the program. Our program is unique in that these individuals sign a year lease...we have safeguards in place. Clients are no longer required to participate in services, we obviously encourage and want them to, a lot of times they are willing to do that because they are in our program...

The program administrators and staff highlighted advantages and disadvantages associated with Housing First. In terms of advantages, staff meet participants "where they are at", with minimal barriers to accessing housing. Practice is geared toward what is best for the client, and it promotes stable housing as a key to success in other life domains. It also gives clients greater agency in decision making. Disadvantages include difficulties ascertaining if the model is being implemented properly. Further, since clients are not required to engage in services, the administrators find that there are difficulties with retention, especially among those with addictions. They also noted that when individuals are using in the building, it can present a challenge to the long-term sobriety of the other tenants. Staff noted that the model can bring frustrations to their job, particularly around substance use, but that they appreciate its benefits for clients as well. As the housing manager described:

The disadvantages are the frustrations it can bring for staff. When we don't act immediately, finitely, about drug use, about breaking laws; it's a case by case basis. And again, it really promotes the house – the home is the key to success in outside areas. Again, the deterrent is, I think, strictly on professionals when it comes to the Housing First model. I think it's very frustrating for the change. It gives the tenant so much more power when it comes to their abilities to make decisions. And I think that's a good thing overall and the right way to gear people towards success.

Perspectives on Housing: The Congregate Model

The administrators and staff provided feedback regarding the congregate model, since all apartments are located within their agency-owned building. They noted that the building becomes its own community, and that having staff in the building allows participants continuous access to their case managers. There is a community room in the building where on-site support groups are held, and staff are able to identify issues at an early stage. In terms of disadvantages, participants sometimes "can't escape each other" due to living in the building. As the administrators reported:

I would say the positives outweigh the negatives. We've been able to bring in AA meetings, peer support group...having access to those things has been really positive.

It's been extremely beneficial to catch some of the issues early. In one case, it saved an individual's life. We would not have known about if staff weren't on site. To specifically know your tenants and know what is going on, on an on-going basis, especially when you are talking about the high Medicaid users with some of the high mental health issues, I think that right on staff is very beneficial to know how soon to intervene...it is really, really beneficial.

To address early adjustment issues, the staff noted that it is important to ensure that participants' benefits (e.g. Medicaid, SNAP benefits) are active. They also focus on education, which includes helping participants with basic life skills and relationship building.

Overview of Service Delivery

In addition to case management, staff identified mental health and addiction services as particularly crucial to the participants. However, they noted that accessibility is often an issue, and that it takes a long time to access these services.

Reducing Medicaid Costs

86 Carroll Street has a goal of reducing Medicaid costs. They approach this goal by connecting participants with primary care and community services. According to program administrators, at intake and throughout the process, workers identify the needs of each participant and link them with relevant services that are preventative in nature, or that are helpful for stabilizing their medical or other conditions.

Perceptions on Participants' Progress

The staff indicated that as the program has a high retention rate, discharges are relatively uncommon. They noted that they would describe the last six discharges as unsuccessful. However, one individual left the program to live in the community and has not returned to homelessness. In general, the administrators indicated that the most vulnerable are benefitting most, along with NYSSHP families:

I would say the people who benefit the most who are the most need. Our NYSSHP families, anyone in our HHAP programs. I think they quote-unquote benefit the most because their situations were so dire when they came in. Establishing the stable housing and providing the case management, they have been able to quote-unquote achieve the most. Those benefitting least include those who do not communicate and those who are unwilling to coordinate with a case manager.

Staff indicated that participants who are the most open to the program and willing to communicate seem to especially benefit:

Ultimately, whether it's mental health, drug addiction, if people communicate effectively and are open about changing the plan as it needs to change and just being open and honest, that's really where we see our success stories.

The program administrators highlighted how their perspectives of participants' success in the program depends on each person's situation and baseline characteristics:

When they come into the door, we do a housing/family wellbeing scales, which shows the most vulnerable aspects whether it be employment or budgeting, health, anything like that. Really successful outcomes would depend on really fall where they score on that assessment. So, say someone comes in chronically homeless, really hasn't had stable housing in over a year. One successful story would be that they are able to maintain and stabilize housing, and not put themselves at risk. So, someone comes in the door and after 6 months they have been able to maintain that housing, we kind to refocus on those other vulnerable areas, say employment. If they have been dependent on DSS services, our goal would be to get them off of DSS services to be as independent as possible. A success story really depends on the individual when they come in the door. You know if they struggle with addiction and they are sober for 6 months that would be a success story. But again, it depends on the individual and where they are assessed at intake and track them quarterly.

The program relies on assessments to track participants' progress, such as a well-being scale. This scale is used to inform and updated the individualized service plan.

Program Strengths, Weaknesses, and Future Directions

The most important program activities, according to the program managers, are working with participants to set and achieve goals; providing safe and affordable housing; and facilitating access to services. Staff indicated that case conferencing is particularly strong, and brings varying perspectives to the process. They also noted that participants

come first, and that they all aim for flexibility in their schedules to meet the participants' needs.

The administrators suggested that continued funding is critical, and expressed optimism regarding NYSSHP. They also wished for the state agencies to know that when individuals' MRT status changes, they should not have a change to their housing, as this often deters people from working full time.¹⁶

Staff noted that the state agencies can assist through the provision of further funding. They also suggested that the supportive housing model is very important for this population. However, they would like certain barriers to be addressed, such as the need for documentation to show breaks in homelessness. As the Housing Manager noted:

I would think the barriers to get some people qualified in the past to qualify currently would be the documentation requirements. With the new requirements now in 2017 you actually have to show breaks in homelessness, they can be self-declarations. But when you're talking with the limitations people have cognitively when it comes to being chronically homeless, having someone recall where they had spent a month three years ago can be extremely difficult. When it comes to the population with the high Medicaid use, with the homelessness, tracking somehow, where they've been, how to get there, it does create some sort of a gap in ability to provide services because if I can't obtain the documentation needed to at least justify homelessness I can't enroll them into the program. Even though on paper it looks right, it's just I can't obtain the documentation from the right sources. It's extremely limiting on who we can actually admit to the program.

Participant Perspectives

Housing Status and Lived Experience Prior to MRT-SH Enrollment

Participants from the 86 Carroll Street focus group described experiencing unstable housing conditions prior to program enrollment. Participants reported living in shelters, halfway houses, or with family in precarious situations. Though less common, some noted that they experienced housing instability following the illness of a family member or housing loss due to a flood. Others noted coming to the program from drug treatment programs:

Before entering the program, I was on the verge of graduating from a drug treatment center...I was in recovery, I didn't have anything, so I needed something to help me get on my feet. This place was like perfect after coming out of drug treatment. It is a good program. No NYSEG (electric), low rent. It is really good for people like he said coming out the YMCA or out of recovery. Situations and places like that to get on your feet. The counselors are good here.

The participants commonly learned about the program through others who "graduated" or are currently enrolled. Others learned about the program from the YMCA. Most described a generally easy process to become enrolled, though participants differentiated between "old" and "new" processes for entering the program. They noted that originally, participants needed to prove their homeless status, and then were admitted same-day. Currently, they describe meeting with staff and submitting paperwork from various agencies that they may have been in contact with, which can create a lengthier process. As one participant explained:

Because there was an open apartment, it was a couple of weeks. I went to the office, met [the case manager], and I told him my situation. They faxed the letters saying I had successfully graduated from there (recovery) and the paperwork. It was pretty easy for me. If you weren't lying about anything. I had mental health already, it was just faxing everything from the different places.

Perspectives Regarding MRT-SH Housing Accommodations

The participants reported a high degree of satisfaction with their housing accommodations through the program. Many described living in newly remodeled studio apartments of a reasonable size, and find their housing affordable. Several

¹⁶ Per a personal communication with NYSDOH, DOH does not require programs to evict participants if their Medicaid status changes. However, they may move programs or experience a change in the source of a subsidy.

appreciated having elevators and secure doors. As one participant noted:

[In my apartment] the floors are good, no chipped walls. It's really good...elevator in the building. Laundry right down stairs. Secure doors. So, people that visit can't believe, (laughs), are you serious? Apartments are pretty nice.

All but one participant remarked that they did not have an opportunity to choose their apartment. However, they noted that the staff and counselors are very supportive and helpful regarding their housing accommodations. For instance, repairs are facilitated by staff, and staff provide social support to the participants:

We just put a ticket in and then fix it. It's a pretty good program. They are good counselors.

When asked where they might be living if not for the program, most participants articulated that they would be unstably housed (e.g., in an apartment, but struggling to pay rent and avoid eviction), homeless (e.g., "under a bridge"), and for a couple of participants, possibly dead.

Perspectives on Housing First

The participants expressed mixed views on the harm reduction approach related to Housing First. Some participants reported that Housing First is an important approach, due to the belief that someone does not deserve to be homeless because they may be using drugs. As one participant described:

I think it's a good thing. Just because someone is on drugs doesn't mean you should be kicked down or turned their back on. They were once good people, they just need help. And making them homeless, just because they are drugs, making them homeless doesn't help them.

However, other participants noted that it is difficult to live near others who are using drugs when one is grappling with one's own recovery. One participant described the experience of being around drug use, including people overdosing around her, stating her perspective that this is not helpful or acceptable:

I don't think this is a place for people who want to come to get recovery. There has been overdoses in here. Nothing was done. I had someone across the hall who was shooting dope on a daily basis. I was in my bathroom crying. He went down and stole the TV. There is nothing done about it. They can have you go to rehab but you can sign yourself out two days out and come back and overdose again. It's just basically...you know...I took it to the higher ups.

Some participants expressed that harm reduction, particularly following overdoses, may be akin to enabling dangerous behavior. Other disagreed, arguing that individuals are in different stages of their recovery, which may be difficult to understand from the outside.

Perspectives on Support Services

The participants reported that all support services currently offered by the program are helpful. This includes rental subsidies, transportation, and non-judgmental staff who are available to help. For instance, the participants noted:

They take us shopping. They make sure we have food. Clothing, whatever we need, they are there.

You've got people to talk to, meaning the counselors.

They noted that some staff are especially easy to relate to and feel comfortable with. However, some participants articulated that there should be more workers with lived experience, who can relate personally with their experiences.

I like that no matter what happens, they are here for you. I know she sat in the hospital with me for hours and didn't have to. She goes out of her way. I don't have to sit there and be judged. She's not...I don't care for book smart people for recovery. I like people who have been where I have been and the struggle. I think there should be more workers that have the background to work here. Book smart people don't understand what you have done for drugs.

Some participants recommended that the conference room be made available to them for socialization and activities:

We have this conference room that we aren't allowed in after a certain amount of time. I wonder if we could have some arts and crafts or maybe watch a movie. This is our community room and it gets locked which is understandable because there has been some theft in here. But during the day if we could have a gathering to get together to say, 'hi how was your day,' type thing. Or watch an educational movie or have a dinner. It's to bringing people together. There are people in here going through a lot. Anything positive is a good thing.

Changes Experienced Since Entering the Program

Overall, the participants articulated that a daily change experienced since being housed through the program is feeling less alone and isolated, and beginning a path to recovery. Staff and peers allow some participants to experience a sense of support that they were lacking previously; as one participant explained, "we have a community in the building". One participant described how support offered through the program helps her to move past suicidal feelings she was experiencing previously:

I think you are never alone anymore. That's what it is, you are never alone... my typical day before I moved into a place like this, was always thinking of ways to end my life. When I moved in here, I got into some drugs moving here. I asked for help and they were good at sending me away to get help. Now I can't really get away with isolating because this one here and a few other people check up on me.

The participants articulated that housing provides them with a sense of security and personal space that allows them to address mental health and physical health needs. Most participants indicated that they now see a primary care physician, noting that this has been a change that occurred since entering the program. Housing also allows participants to develop healthier behaviors for coping with stress and difficult life experiences:

When I'm feeling overwhelmed. I think let me go drink coffee and get my thoughts together. A sense of mental stability on your own.

Oh yes [my health has changed]! I can look on years back and when I was on drugs, running the streets, this and that and the third, you gonna be with someone so have somewhere to sleep or just tolerating them so you have somewhere to sleep. So, this is a blessing for me. I can live the way I want to live in my apartment. No one can control that environment. I pay for that.

The majority of participants described improvements in their relationships since entering the program, due in part to having more time to visit and connect with family members. Some indicated that their families visit them in their apartments, noting that they have the opportunity to connect with grandchildren. Other participants, however, continued to experience strained relationships, stating that children or grandchildren are not currently in their lives:

My grandkids can't come because of drugs and stuff. So yes, it has changed. My children won't let them come.

Several participants described how staff are supporting them as they work toward personal goals. For instance, those who are interested in education noted that staff help with paperwork and provide information about programs. They also noted a long term goal of continued recovery.

Perspectives on Program Strengths and Weaknesses

The participants mostly described positive aspects of the program, underscoring how the program is helping them to gain independence, strengthen relationships, and help themselves. The participants noted that the help provided by the program is appreciated, but highlighted the importance of accepting responsibility for one's recovery:

It's something with the name, Opportunities for Broome. Its opportunities to set you up for life.

I really feel like the rest is up to us, everything is here. The rest is up to us.

Some participants described how a positive aspect of the program is the ability to volunteer, which allows him to feel a part of his community:

Well, this program is about giving a lot. We go down with the case managers to help give away food to people, which I never did before. I am getting out doing something and not staying in my apartment like I normally do. We have a great time.

HEALTH HOMES SUPPORTIVE HOUSING PILOT

Living Opportunities of DePaul

Administrative and Staff Perspectives

Program Context and Key Program Components

The Living Opportunities for DePaul program provides supportive housing to participants with the goal of reducing Medicaid costs. The target population includes a wide variety of demographics, including veterans, people living with HIV/AIDS, elderly individuals, formerly incarcerated persons, LGBTQ individuals, families, singles, individuals with serious mental illness, individuals with substance use disorders, homeless or unstably housed individuals, people with developmental disabilities, and individuals who are more appropriate for a less restrictive level of care than their current setting. The program houses individuals in Niagara County who are enrolled in Health Homes. Participants typically enter the program from a hospital or homeless shelter (of note, a Health Home is located within the hospital). Staff view successful outcomes as participants moving on to Section 8, gaining employment, or working toward an agreed upon discharge date.

The program employs supportive housing specialists, a housing coordinator, and a program manager. These staff members maintain contact with participants throughout their participation in the program and are responsible for enrolling participants into the program, supervising the team, and managing fiscal responsibilities.

Participants tend to reside in the program long-term, as housing is designed to be permanent. According to staff, participants who exit the program sometimes move on when support is no longer needed. Others begin to require a higher level of care, and some have passed away.

Regional Factors

DePaul serves both rural and urban areas. Staff noted that housing stock is more limited and the transportation tends to be a challenge in the rural areas. Support services also tend to be more sparse. As the program manager described:

The problem when you get to out in the country is it becomes difficult for individuals to access their supports, their linkages to their behavioral health or whatever other. So, we do transport, we do have a couple people out there just because they grew up in certain areas but the majority of individuals are living in the city of Niagara Falls proper. They want to be right near the hospital, they want to be right where all the services are.

Staff explained that a lack of public transportation creates obstacles for participants:

So, we service Niagara County. I would definitely have to say that in certain parts of Niagara County something that is a real big challenge is public transportation for our folks. The folks that live in Niagara Falls or the LaSalle area of Niagara Falls, there is transportation, when you move out to the Lockport area, transportation is horrible for our folks...And I think that that's a real hardship for our folks...it limits people's independence or their ability to access services. Sure, they get Medicaid transportation, but that's simply to doctor's appointments, treatment, those kind of things. I would say the number one hardship for our folks is access to transportation.

Targeting and Eligibility Determinations

According to the program manager, the eligibility criteria are successfully capturing individuals with the greatest health needs. The FACT-GP acuity score is calculated by the Health Home every six months, which allows the program to determine the level of need. All referrals to the program come from the participants' Health Home. As such, the program serves a range of populations.

The program maintains a shared system with the Health Home care coordinators. Staff check the shared file system to see if there are updates on referrals. As program staff explained, there is an intake office that screens potential participants for eligibility (e.g., verifying benefits and finances). If there is an opening in the program, the referral proceeds to the housing coordinator. It is a shared responsibility between staff and clients to assess needs for housing and services. It typically takes approximately thirty days to place a participant. The housing coordinator described the information they obtain from participants in order to secure housing that best meets their needs:

Then we reach out to that individual, hopefully within a day of getting the referral, we introduce ourselves, then we start working with that individual...What are you looking for? Where would you like to move? What's your ideal situation? What are some things that you don't like? Are you a smoker? Do you have pets? All of those kind of things, we like to have that initial conversation then we start working to find that apartment for the individual.

Program Changes and Innovations from MRT-SH Funding

The program manager reported that through MRT-SH funding, the program was able to add an additional ten program slots during their second year. The program continues to try to add more clients, given the unmet needs in the area.

Placing Participants into Housing

While housing through the DePaul program is designed to be permanent, the goal is for participants to become independent. According to the program manager, a stay of approximately 3-5 years is typical. As the program manager reported:

This is permanent housing; however, all the goals are always to be more independent – meaning that at some point if you're able to work, if you're able to have enough funds, or if you're able to get a Section 8 voucher – for you to open up the slot for other individuals coming through our program.

As described above, participants move in following a referral and intake process. Staff work with participants to develop a support plan and meet with them to look at apartments, which the client gets to select. When an apartment is chosen, a housing inspection is then conducted. The client's name is on the lease, so they are able to maintain the apartment for as long as they wish. Furniture is provided by the program and belongs to DePaul for one year, and then it is turned over the client, as long as apartment maintenance has been good.

Perspectives on Housing: Reflections on Housing First

Program staff described advantages and disadvantages of Housing First principles. Notable advantages, according to staff, are that participants secure apartments that they likely could not rent on their own. The program manager also noted that expectations of abstinence from drugs and alcohol can hinder participant engagement in the program; thus, the harm reduction modality associated with Housing First can be beneficial:

I think that obviously for the population we're trying to serve, the Housing First model seems to have more flexibility. To have total abstinence, have those expectations...you're not really engaging, you're not gonna engage in treatment. The person might not be ready for that so that's why we use the Housing First model...I think that there's a lot of models where the abstinence is expected. And unfortunately, with the population we're working with, this is probably one of the last resources for them to have...in terms of housing.

However, staff reported that issues with landlords can be problematic, noting that landlords are less tolerant of the harm reduction component of Housing First. The program manager described how staff manage the issue of matching

participants to apartments and landlords:

We serve some of the most challenging individuals. For HUD [a different program with a funding source other than MRT], we serve individuals who are chronically homeless. And for someone to become chronically homeless, there's a lot of reasons they go into that. Unfortunately, it's not an issue of poverty like a lot of people that don't do this really think that it's because of the income. A lot of folks, unfortunately, it's because of the mental health and the substance abuse they become homeless. What we try to do is, again, the Housing First model. We try to make sure that we find the right apartment for the individual, we try to work with the landlords. Some landlords are not going to be as tolerant so we don't waste our time by setting somebody up to fail by bringing them to this particular landlord. So, it's really having that experience, that knowledge of the community and where we can house these individuals properly...And usually the landlord will work because they know us, they know that we're good for whatever supports. So, individuals get an apartment they normally, they probably, wouldn't get on their own when they work with us.

One staff member questioned Housing First principles, describing problems that arise when participants are using substances:

I think maybe like a required sobriety time, maybe. I've taken someone who was in rehab while we were trying to find him an apartment, where all he had was the 20 days of sobriety. And the day that he moved out of his apartment he just went right back to using again. I don't know if a really required sobriety time would work because once someone's in their own individual environment it could completely change, but maybe at least a six month sobriety date or something like that with substance abuse or something might be a little helpful just because I know that's a problem we have sometimes, or all the time.

Perspectives on Housing: The Scattered-site Model

Program staff reflected on the scattered-site approach to supportive housing. The described benefits of this approach, in that participants have agency in choosing the environment they wish to live in. Within their apartments, they can create a home environment and exercise autonomy and independence, as well as social opportunities in the community, as the housing coordinator explained:

Definitely one huge advantage, I can say, is that hopefully we are placing individuals in the environment that they want to be in, in the neighborhoods that they want to be in. And I think that there tends to be, when you're living in the lower part of a house, more of a feeling of a homey environment or things like that.

From a programmatic perspective, however, a disadvantage is that staff have to travel quite a bit to meet with clients. Staff also have frequent interactions with landlords to manage issues that arise. The program maintains close relationships with landlords and act as the primary point of contact, and landlords call them frequently to manage situations. As the housing coordinator described:

A client had her grandchildren over, they were being a little bit loud, the landlord called to say the next time they visit could they...so we're managing situations like that. Or a landlord might sell the building and we're working to get a new W-9 and a new lease from the new landlord and coordinating all that. Maybe they increased the rent and we've got to put a new budget sheet together for the individual and we're coordinating those pieces.

Staff described how they attempt to mediate conflicts and salvage the situation for participants whenever possible. When participants lose their housing due to eviction, they work with the individual to identify barriers and to strategize about a situation that might be a better fit. As the housing coordinator explained:

[After an eviction, we discuss] What are the barriers? What are the problems? Let's figure this out so the next placement we have is more successful. And we're just going to work with that person, show them a bunch of apartments, we're gonna work with them, we're gonna get them movers, we're gonna move them to the next apartment.

Staff noted that it is important for participants to perceive their housing situation as both stable and safe. It is also critical for participants to know who to access for which supports. According to program staff, challenges that arise as individuals enter the program differ based on that person's needs and circumstances. As a staff member described:

It depends on who the individual is...It depends on what the challenge is. Sometimes people don't follow through with recertification for Medicaid, for food stamps, for public assistance. Sometimes people are on public assistance and we're working to help them get Social Security. Sometimes people struggle with budgeting. And so, it is making sure that they are utilizing the community supports that they need. Some folks struggle maintaining linkages, some folks struggle maintaining their relationship with us and calling us back.

Overview of Service Delivery

According to the program manager, in addition to using the rental subsidy, the participants use the following support services most frequently: transportation, community linkages, group outings, and intensive case management. She perceives case management to be the most critical supportive service for participants. The program manager described how many of these activities are designed to decrease social isolation:

Well obviously the subsidy is the biggest thing. But all the support services that we provide them, whether it's transportation, whether it's linkages to community resources...We also have a component that does outings. So, we'll do some work outings for individuals. We'll do little things like next week we're gonna take them all out for a holiday luncheon. For the holidays, for individuals that have a lot of depression, if I was to say one thing that really works for individuals – really intensive case management services. The more you see an individual, the better they're gonna be. Isolation is the worst thing that could happen to folks with mental health history. We've had an individual that committed suicide last Thanksgiving. So, I'm always cognizant of that, so we do all kinds of little things...we offer them that kind of activity so they don't isolate. So that's a huge thing, especially for the holidays. A lot of folks don't have family or do have family that might not be exactly the relationship that they should have.

Program staff also emphasized how activities designed to prevent social isolation are important to the participants:

And then I think that there really is a social rec[reation] piece to all of this that is really helpful. Some of our folks are very social and they can have meaningful downtime...and some of our folks struggle with that. And so, providing them with access to social rec things is very helpful, would be very helpful. Sometimes that is missing overall in the community and for the population that we serve – how do I utilize my downtime in a positive, constructive manner? Sometimes folks struggle with those skills and sometimes it's just not out there for folks. And we go back to transportation issues, and how do I get to these places? And we go back to the fact that I'm on public assistance and I don't have money for the movies or for a cup of coffee or things like that. So, when we can provide those things, or at the holidays when we can say "Happy holidays, here's a tray of cookies. Happy New Year, here's something sweet for the New Year. Here's a pie at Thanksgiving."

Program staff concurred that case management to ensure proper linkages to services is especially critical. They reiterated that participants have a Health Home care manager who also works to establish linkages to mental health and substance use services, as well as health appointments. Staff follow up with referrals and provide transportation. They also meet with care managers at the hospital in the event that a participant is hospitalized, to review the case and discuss next steps:

We meet with the case managers at the hospital...And they'll discuss, basically a case review. So, John Smith is having problems, he's falling, or whatever it is. And they'll discuss those cases, what other supports can we put in place? So, try to think outside the box. So, we'll review all the different concerning cases. If people are doing well, we can just skip through it and say, 'Hey she's doing fine, she's continued to be linked at this program and getting all the services so no major concerns there.' But the other ones who are a concern, it's kind of like a mini risk assessment so we'll discuss those cases in further detail.

Relationships with Health Home care managers were described as collaborative. Since the care managers have significant caseloads, DePaul staff “pick up where they leave off”. Some staff perceive that joint visits with participants might be helpful, but the care managers are not always available. Some articulated that better role definitions would be helpful.

Reducing Medicaid Costs

Reducing Medicaid costs is a key goal of the program. To approach this goal, staff teach participants about coping mechanisms, coordinate with Health Home care managers, and work with participants on symptom management. As a staff member explained:

A lot of the folks, for instance, that we have going into the emergency department would be someone with anxiety disorder – they’re out of their Ativan, they’re out of their Klonopin, so they get a little edgy. If they don’t have the prescription they’ll just show up at the emergency room. So, we try to work in other things. Sometimes we’ll just kind of treat them, talk to them, bring them sandwich or whatever works, just to kind of relieve some of those anxieties until they’re actually able to meet their primary instead of going to the emergency department. So, we try to focus on other ways that they could deal with that symptom management instead of just running to the emergency department.

To reduce unnecessary hospitalization, the program provides crisis services, which are available around the clock. They also coordinate with the clinic to provide reminders about appointments and medications.

Perceptions on Participants’ Progress

The program manager described participants who are doing well or less well in the program. The program manager noted that single males with substance abuse issues do well in the program, due to the Housing First model. Older females with more significant medical needs have a number of ongoing struggles, so staff engage more frequently with them. Program staff perceived that all participants benefit, as the team individualizes services as much as possible. They also described some unexpected benefits for participants, such as responsiveness to therapy pets, as well as a more significant decrease in hospitalization than expected. Staff noted that they endeavor to creatively address client needs:

I was hoping that we would see a decrease in hospitalizations, but I think that there’s a huge decrease for a lot of our folks in hospitalizations...I think it’s because of the creative approaches we’ve been able to have for some people. For one of our women, we realized, she doesn’t want to sleep in a bed; she wants to sleep in a mattress on the floor. And making that home environment kind of what worked for her...Being creative and coming up with these things, and I’m always amazed at the different solutions that team members come up with and just the creative ideas that people have. And it’s like, wow that really is out of the box, but that’s working. And I think that that’s the neat part about this program, is that you can do a lot of out of the box stuff. And really, we’re seeing results and so something that I’d love to have the flexibility to do even more.

However, those who are not engaging in support services tend to struggle the most:

I think that the people that benefit the least are probably those people that are not engaging...It could be a multitude of factors...When they’re not engaging in the supportive services. They’re not engaging in treatment, they’re not engaging in substance, they’re not engaging in what’s out there for them and then that makes it tricky...You put the supports in place and I think people get out of them what they put into them. And it makes working with this program a little more difficult when those pieces aren’t in place.

Program Strengths, Weaknesses, and Future Directions

Program staff perceive the staffing team as the greatest strength of the program, in that they truly care for the participants. They work to individualize services as much as possible, and “meet people where they’re at”. Staff perceive that participants are benefiting from increased stability, learning alternative responses and problem solving skills, and enjoying a new environment of their own. They are prevented from re-entering the street, experience

improvements in self-esteem, and are able to engage with the community.

In terms of program improvements, they would like to be able to provide more social and recreational activities for the participants, including creating opportunities for them to tap into past talents, interests, and passions. The staff noted that the budgets are very limited in this regard. As a staff member explained:

We do have a professional relationship, we do have a working relationship, but we are working with people who have been through quite a bit. And I think that being able to go to the movies or something, when you're working with these budgets that are very limiting, or that they're working on making sure I have toilet paper and paper towels and personal hygiene supplies and they don't have ten dollars for a movie. And I think being able to do that is nice every once in a while. It breaks up the monotony, it gives you something to look forward to.

In terms of feedback to the State, program staff would appreciate greater flexibility, as they perceive bureaucratic requirements to impede flexibility that is required when working with participants who have complex needs:

On the ground level when you do direct care, I think flexibility and having the ability to say I could do this a little different, I could tailor that program to meet this person's needs – I think all care managers and case managers, we all need that flexibility. I think if you give them that and the person is dedicated, they could do miracles with some of the work that they do...I just don't want to ever come to where we're spending more time collecting data and doing paperwork than we're actually spending with the actual residents.

Program staff also noted that agency vehicles would be helpful to their work, as would the ability to provide participants with items to make them comfortable at home, such as a television, landline, or DVD player.

Participant Perspectives

Housing Status and Lived Experience Prior to MRT-SH Enrollment

Participants of the Living Opportunities of DePaul program indicated that prior to program enrollment, they were experiencing precarious housing arrangements or homelessness. For many, housing instability was associated with difficult life events, such as family illnesses, personal illnesses or accidents, or domestic violence. As one participant reported:

[Prior to MRT housing] I was living with my son, in and out of the hospital for mental health issues. They got me hooked up to DePaul.

[Prior to MRT housing] Then my sister passed away from cancer, two years ago my other sister passed away from cancer, my father died from cancer and my brother took his own life. So, it's like, just one after another.

Most participants indicated that the process to enter the program was relatively easy. While most were unable to articulate clear steps leading to their enrollment, most indicated that housing “fell into place”, often noting that they were referred from a hospital:

It just all fell into place [others in the room agree]. Everything just seemed like, 'Wow'. There no confrontations. It just all fell into place. It was a godsend for sure... it was like you just sat back everything seemed to be coming at you.

Heaven sent for me [indicating a sense of good fortune for housing].

Perspectives Regarding MRT-SH Housing Accommodations

Several participants described aspects of their housing accommodations that they appreciate, including living in a furnished space. Some participants described how their place feels like home, and were especially appreciative that

their apartments included items such as pots and pans. A couple of participants reported living in apartments, while others indicate residing in a mobile home within a mobile home park. As one participant reported:

Everyone who comes to my apartment, says they don't want to leave. Most of the things I got through DePaul was all nice stuff.

Several participants also reported housing challenges, however. Challenges most often focused on residing in unsafe neighborhoods with crime or drug activity. One participant noted that his case manager is trying to help him to move to a new area:

I live one street over from a lot of drug activity, which I am not comfortable with. As soon as I told my case manager, we went around looking at apartment. Still haven't found nothing yet but still keeping an eye out.

Most participants had the opportunity to choose where they lived from a couple of options. They noted a preference for clean and safe accommodations with pleasant neighbors. Even participants who did not have an opportunity to choose from several options indicated gratitude, given the improvement over the previous living situations:

We looked at a lot of apartments before we picked this one.

I was just happy to get a roof over my head....sure beats the bridges. I go to the church and do my volunteer work.

The participants indicated that if it were not for the program, it is likely that they would continue to be homeless or precariously housed. They reported that they would be living "day by day." One participant indicated that she would likely still be in a violent domestic relationship.

Perspectives on Housing First

It appeared that the participants were uncertain about program rules regarding substance use. Like participants in several other program, participants of Living Opportunities of DePaul reflected on natural consequences of substance use that occur in the context of relationships with landlords.

Perspectives on Support Services

The participants indicated that strong personal relationships with staff members are particularly helpful, along with the quick responses from staff when participants are in need. The participants further noted that transportation is a helpful service. As the participants reported:

[The staff] always seem to be there when you need them or when you need to talk to them.

They always give you somewhere to reach out to when you talk to them.

Changes Experienced Since Entering the Program

As the participants reflected on changes in their typical day or daily activities, many referenced mental health. Some reported struggling with mental health issues at present. Others indicated that they have obtained mental health services since enrolling in the program. Participants who are currently struggling with mental health issues explained:

See now I am the total opposite [from a participant who explained improved mental health]. My anxiety is so bad, I don't even leave my house half the time. It took everything I had to be able to come here today.

The participants noted that since enrolling in supportive housing, they have been eating better and adhering to medication regimens. Some described improved nutrition due to having more resources, since they are now receiving rental stipends.

While the participants expressed continued mental health difficulties, some reported reduced hospitalizations. Most indicated receiving mental health services in the community, but noted that frequent turnover in community providers can be difficult for recovery (e.g., losing a therapist and starting over with a new provider):

I had therapist at [a community organization] and they would stay however so long and then leave. I had a great doctor but then she got a promotion. It's just hard starting over all of the time.

The participants provided mixed feedback in terms of relationship changes since entering supportive housing. Some indicated that family relationships have strengthened since entering the program. Others, however, noted that relationships continue to be a significant source of stress and anxiety. One participant described anxiety associated with a feeling that she is inconveniencing her family, and that her family doesn't fully understand mental health issues:

My family will be there for me but it is just like feeling (pause) I've never been in this situation before so I'm feeling like imposing on people and I don't like that at all. I don't like to have to have someone take me to the store and fly around that store and forget half of the things I need. I have to go back around to get the things I forgot. They are out in their vehicle. They don't understand. And then you come out, just the comments. I figure out something. I got to start riding a bike or start hitchhiking. I'm pressured. That makes my anxiety worse and then makes my depression worse. How am I ever going to get better?

The participants indicated other goals that have been impacted by the program. Several individuals described developing a sense of hope. Others indicated that simple goals have been achieved, including the ability to be independent by getting one's own groceries. Some are cultivating new hobbies, such as baking or arts and crafts. Multiple participants noted that staff have been helpful and supportive as they have worked on increasing their daily living skills.

Perspectives on Program Strengths and Weaknesses

The participants generally indicated that staff members are the greatest strength of the program. They further described stable housing as a relief that they are deeply grateful for:

I was battling bipolar depression and that just took so much from me. Then DePaul came along and took all of that off my shoulders. I just felt [exhaled deeply] relief.

Yeah relief. You wake up, in your own apartment. It's a big difference then living in a trailer in a driveway.

In terms of program weaknesses, some participants indicated that it would be helpful to have more staff, referencing a recent reduction in staff members.

BronxWorks

Administrative and Staff Perspectives

Program Context and Key Program Components

BronxWorks serves single, high Medicaid users with chronic medical conditions. The program offers rental subsidies as well as case management and care coordination. According to the program managers, the goal of the program is to work with participants to increase their independence and quality of life, and to decrease their reliance on emergency services. Twenty clients are currently served in apartments, where they contribute 30% of their income toward rent, with the program paying the balance. BronxWorks acts as both a housing provider and (through separate funding sources) a Health Home care manager to program participants.

BronxWorks employs housing specialists/social workers, a clinical coordinator, and a program director. BronxWorks staff work closely with participants through the provision of routine home visits, by accompanying clients to medical appointments, communicating with the clients' providers, and generally advocating for their needs, as well as crisis

management. Program staff described working closely with one another and consulting on various cases as needed.

Regional Factors

With the program's location in the Bronx, the program managers and staff highlighted challenges in finding housing that is affordable and/or handicap accessible. As the program manager explained:

Finding units is a huge challenge, at fair market rent. So obviously apartments, the cost of housing is going up and then finding apartments that are first floor or in elevator buildings, which is what our medically fragile clients need, is very challenging...And in a couple cases we need handicap accessible apartments for folks in wheelchairs and that has often also proven to be extremely challenging.

Staff described limited availability of affordable housing, also noting that affordable apartments are often located in unsafe neighborhoods. They further noted that it is difficult to find landlords in the Bronx who are open to renting to program participants. As a staff member reported:

It's illegal for landlords to say they won't work with programs. But it was very easy for somebody, once they gave us that answer, especially if we made them aware of that – you can't say that – they'd be like, "Oh, we have nothing available." So, then it just became – we just got euphemisms for "We don't want to work with programs."

Targeting and Eligibility Determinations

The program targets single individuals who are homeless or unstably housed, as well as individuals with physical disabilities or chronic conditions, and those more appropriate for a less restrictive level of care. According to the program managers, the program especially targets the "medically homeless", meaning those who cycle in and out of the hospital due to their homelessness:

We work with the Bronx Health and Housing Consortium as one of our consultants, who has helped us in creating referrals streams for our program. They work a lot in terms of health and housing and that's a term that they use. It's just individuals that often cycle in and out of the hospital due to their homeless status...and the frequent medical issues that are perpetuated as a result of lack of stable housing.

The program consulted with the Bronx Housing and Health Consortium to create the program criteria. Staff initially found that their method of determining the highest need populations was not as effective, as they were not capturing individuals utilizing high cost Medicaid services. The program then brought together providers, ER staff and Health Home providers to modify the criteria based on a Medicaid spending report provided by DOH. The program subsequently modified its eligibility criteria to focus on Medicaid dollars spent (specifically, \$60,000 or more of Medicaid spending over the past year) rather than a focus on a number of ER visits and inpatient stays, and has since been able to target individuals who are missed by other supportive housing programs. The program managers and staff now view the criteria as very appropriate for reaching the target population. As the program manager reported:

At first we were just doing four emergency room visits within the past 12 months or two emergency room visits and two inpatient stays. And through talking with the hospital staff, we realized that an emergency room visit is like, tops \$1,000. So that really does not determine high utilization. So, through those conversations we met for, I want to say four to five months – we created an MRT toolkit for other providers to be able to use, and kind of just like a rough policy and procedures just for some baseline ways of identifying, targeting, the referral process. So, it was through that process that we came up with our ongoing eligibility criteria.

Referrals are typically provided by hospitals and care management agencies, who identify clients who may not qualify for other housing programs or shelters. The housing specialist requests a Medicaid spending report to determine if applicants meet the eligibility requirements. The referral source completes a referral form, including psychosocial information, and the communications with staff in advance of the applicant interview. The interview includes a comprehensive assessment, leading to a determination regarding the applicant's appropriateness for the program. As a staff member explained:

We're asking the referral source if they are eligible for other types of housing because we're really trying to capture the subset of people who aren't eligible for other types of housing, have no other option, kind of fall through the cracks.

Program Changes and Innovations from MRT-SH Funding

The program managers described how BronxWorks used MRT funding to improve the overall program structure and targeting procedures. This funding is also used to create opportunities for the clients through a peer program¹⁷, in which participants receive training for stipend work. A program manager described the program as follows:

The roles are designed and created based on the participants we interview. So, they're tailored to the interests and skills of the folks who are interested to become peers. If they're accepted, then they get to decide what kind of site they want to work at through BronxWorks, what population they feel passionate about, and what their skill level is – like if they want to work with food and they want to work in the kitchen...or if they want to help run group, it depends on the interests and the skills of the person. So that's why we were saying we're waiting to see exactly what [one applicant's] position will look like, but she does want to do outreach, specifically with homeless women. So that's something that that peer position will be created and tailored to her.

MRT funding is also used to pay for monthly case consultation with a psychiatrist for behavioral health support, and supported employment opportunities .

Placing Participants into Housing

Staff are heavily and consistently involved throughout clients' housing placement and retention/discharge, acting as liaisons between clients and landlords. Staff advocate for client needs and resolve housing-related issues with landlords. Transitioning into independent living was noted as a common challenge for clients, who often struggle with the responsibility of having an apartment. However, staff strive to assist with this transition and equip clients with the skillset to retain safe housing, as well as their sense of independence.

According to staff, housing provides participants with a sense of dignity and allows them to integrate into the community. Staff reported that they work as quickly as they can to get clients connected with services and facilitate participants' transition into housing by providing household items.

Housing through BronxWorks is intended to be permanent, as long as the client wants and needs it. According to the administrators, no one has graduated to date; one participant has moved to a higher level of care, and three participants have passed away. When participants transition to a different setting, staff work with them to facilitate the transition (e.g., making the referral, accompanying the client to appointments, etc.).

Perspectives on Housing: Reflections on Housing First

The program utilizes a Housing First model. According to staff, advantages with Housing First include the ability to "meet clients where they're at". The staff agreed that it is important to care for basic needs first (e.g., housing), before clients can focus on other issues, such as health and well-being.

Staff agreed that housing is crucial for recovery, consistent with the low barrier emphasis of the model. Staff did note, however, that during intake, they attempt to assess if participants can be successfully housed, which may not prioritize the most vulnerable:

Since we do quite a vetting process with the interview, like with talking to the referral source and the interview, that's what we're really trying to do – trying to make sure that somebody's appropriate for scattered-site with limited oversight and is not going to move into an apartment and decompensate. So, we try to reduce the risk a little bit that way. And then I think having someone in recovery, I think having housing is really crucial to their recovery. And if you want them to stay stable, psychosocially,

¹⁷ The peer program may not be MRT funded.

then having the stability of stable housing is gonna really help with that...When you don't have housing, housing is the main stressor and the main focus. So, by removing that and giving them that stable place, then we can actually work on any kind of substance use going on, versus that taking a backburner to there being a housing need.

Staff also describe challenges associated with the Housing First approach. Staff viewed participant readiness as important to success. Individuals with substance abuse disorders challenge staff, in that a significant amount of support is needed for participants to maintain their health and housing.

Perspectives on Housing: The Scattered-site Model

The program administrators and staff described several advantages to the scattered-site model. Clients are more independent, have a lease in their own name, and are not stigmatized by living in a building for individuals with complex needs. By promoting independence, this model can allow participants to restore their previous level of functioning and restore their self-esteem and identity. As a program manager described:

I think an advantage for a lot of our folks is a lot of our people, as [staff member] was describing, are used to living independently. And then they lost that ability to maintain their independent housing, whether it's because they got sick and they couldn't work anymore and then couldn't afford rent, which is the case in a lot of cases, or they were always living with a partner and the relationship ended and now they're sick and they can't afford housing on their own, etc. So, I think a lot of it is preserving that independence and what folks are used to, or being able to restore them back to the level of functioning that they had, which does a lot for their self-esteem and their self-identity, because they were used to living in their own apartment

However, administrators and staff also described challenges associated with the scattered-site model, such as the adjustment period that is required for participants to become comfortable in independent housing. Transportation is time-consuming for staff, who have to travel across the borough to visit participants. The scattered-site model can also be challenging to the program in terms of the ability to secure units for participants. While some landlords are accepting of working with programs to house clients, staff noted that many are not as accepting and will deny the availability of open units.

Perspectives on Housing: Early Adjustment Issues

The staff described issues that often occur with participants, following the "honeymoon phase" of entering the program. Some assume that housing will automatically fix a number of their other needs, which is not often the case. Participants are also sometimes overwhelmed by the responsibility of having their own place. Others struggle with social isolation and the lack of a support network. As the staff members described:

One of our interview questions is like, "What's contributing most to your stress right now?" and like, "What kind of coping skills do you have?" And at the interview the answer is always housing – "I'm stressed because I don't have housing." And then as soon as they move in it's like, "I'm stressed because of all of the other things going on in my life." Like the actual medical condition, family stress, lack of social support. Those things that were there now come more to the forefront.

For a few of our clients, after they've moved into the apartment, and realizing their lack of social support. Like thinking, "Oh when I get my apartment I'm gonna have my family and friends come visit and be able to have them come over" and then after they move into their apartment, the estrangement having to do with their family or their family coming over and they just feel ill and are not able to be as independent as they wanted to be, I think can be a challenge.

BronxWorks staff viewed staff support to be the most critical service required by participants when they first enter the program. Staff work with participants to transition to independent living:

It's a lot of responsibility and I think it's us lowering our expectations in understanding that our clients are gonna need a lot of support in the transition...Trying to set them up with direct payments...or making sure that they're sending out their money orders or helping them in terms of healthy eating

and buying things that are appropriate to their diet from the grocery store. Really trying to get them integrated into their new communities so they know where the laundromat is, and they know where the post office is, and where to get groceries.

Overview of Service Delivery

The program provides wraparound services (e.g., intensive person-centered case management) to clients that are individualized depending on the clients' needs. Staff offer education and psychoeducation regarding services and benefits, as well as clients' medical conditions and how to manage them. Staff described home visits provided by case workers as particularly critical, and also highly appreciated by participants. A staff member reported:

We do get a lot of feedback from them and they are very vocal about their gratitude for the program and for our support, which a) indicates, I think, that we're doing a good job, and b) reinforces the need for a program like this. Like they constantly talk about how for so long they didn't qualify for anything. And so, they know that this is a unique program and they're like, "Oh, this needs to happen for more people" or like, "I'm sad that this wasn't available earlier."

BronxWorks staff described wraparound services as the service most critical to housing stability. As part of this service, staff facilitate communication between clients and healthcare providers:

I feel like that's one of our main goals. We accompany clients to doctor's visits, but that's only one step. We're talking to the doctors about what treatments are recommended, and helping the clients make decisions about what treatments they want to engage with, helping them get educated about their conditions, and how to take care of themselves at home, and the best way to really engage with their overall care, whether that be physical or mental health.

Reducing Medicaid Costs

BronxWorks has a goal of reducing participants' use of high-cost Medicaid services. They educate participants about using proactive and preventative health services. As an administrator reported:

We talk to folks about going to primary care or going to their specialist instead of the emergency room, which is a culture shift because the emergency room is seen as somewhere where I don't need an appointment, I don't have to wait days. I can just go in there and get urgent care. So, we've been trying to do a lot of psychoeducation around the quality of care that you get in an emergency room versus if you were to see your actual doctor who knows your history. And that's something that folks have started to realize. Another thing is checking on medication refills because that's another thing that folks go to the emergency room for. So, we try to be proactive with our clients, asking them if they need medication refills, getting them in the habit of checking ahead of time before they take their last pill, and getting their information so that can get called in and refilled.

While BronxWorks is teaching clients to use alternative resources to high cost emergency services through psychoeducation (e.g., seeing a primary care doctor rather than using the ER; learning how to manage medication), staff are still encountering larger systematic challenges in connecting participants to quality care services and in collecting and tracking data on Medicaid service use. Direct access to real time Medicaid data (e.g., better linkages with MCOs to get real-time claims data) was highlighted as a method to relieve some of these challenges.

As described earlier, a unique aspect of the BronxWorks program is that it directly provides Health Home care management. The program administrators noted, however, they could benefit from better contact with hospitals and clinics. They also relayed that even with support, there are systemic challenges that the participants face, such as lack of availability of medical appointments, limited access to high quality medical providers, and lengthy referral processes.

Perceptions on Participants' Progress

The program administrators reported that participants who are at both ends of the age spectrum (youngest participants and those at the end of life) seem to benefit the most. Younger clients are learning life skills for the first time and benefit from them; older clients experience a sense of dignity that comes with housing. However, the administrators

also noted that all clients benefit in their own way. Similarly, staff perceived that all participants benefit, but noted that those who truly cannot sustain independent housing without supports in place benefit most. They also described some unexpected benefits of the program, such as participants reunifying with their families.

According to staff, the program struggles to meet the needs of participants with cognitive or intellectual disabilities. These participants have a difficult time remembering appointments and retaining the information they receive.

Program Strengths, Weaknesses, and Future Directions

According to program staff, the most important strength of the program is the ability of staff to meet the participants' needs due to their availability and flexibility in their roles. The wraparound approach allows staff to successfully meet these needs. The program has seen successes that have exceeded staff expectations, including clients reunifying with family, maintaining apartments well, and obtaining citizenship. Staff believe that their low caseloads enable them to remain flexible in their work, to the benefit of the program.

In terms of improvement, staff perceive the need for more housing, further help with moving participants into their apartments, and assistance with apartment maintenance. Some would like the program to expand to include families, as it currently serves only single individuals. Staff also described how the program struggles to support clients with mobility issues. They would like to establish more contacts and relationships with health care providers and MCOs:

We've seen the importance of having contacts at hospitals and at medical providers...at certain places where we have more familiar faces, right off the bat it's that much more helpful and comfortable for both ourselves and the client to get in touch with people, to advocate for them. So, I'm thinking from a systems point of view, just having more established relationships and established contacts could be helpful.

When reflecting on how the state agencies can assist in the program's mission, staff expressed that help with landlord advocacy¹⁸ would be particularly welcome. They would also like help from the state agencies to provide education and work incentives to participants. They also discussed the need to think about "graduation plans" for participants:

I think another thing that the state was talking about is graduation plans for our clients. Like what does graduation look like? And for the majority of our clients, they will be in our program through end of life. I'd say out of the 19 we have now, there's probably one that could sustain scattered-site housing but doesn't have the financial means. Like he's trying to find a job, he's on public assistance, he's not eligible for SSI, so he's not able to sustain housing outside of our subsidy. So, if there was another way that vouchers for Section 8 or something could be had, then we could potentially graduate some people out of our program to make space for other individuals that need a higher level of care if they were provided a voucher that they could then sustain whatever their fair market rent is.

Participant Perspectives

Housing Status and Lived Experience Prior to MRT-SH Enrollment

Participants of the BronxWorks program indicated that they were homeless prior to their enrollment in the program, with many describing the experience of being very ill and using the hospital frequently, sometimes to have a place to stay:

I was living with family, house to house. But mostly I was using the hospital for shelter. I also was diabetic and had ulcers. So, I knew...the hospital would take me in.

Most reported transient lifestyles where they moved from one precarious living situation to another. For some, housing instability was a long term experience:

¹⁸ The nature of help needed for landlord advocacy was not explicitly stated.

I was in the system my whole life, being in the group home and everything...When I got 18 I got myself out the system, started staying with my moms and...she just kept kicking me out. And then I was working, I had jobs – numerous amounts of jobs – and I end up getting sick. My kidney started failing on me. I got a transplant, thank God. I told the hospital I was homeless during the transplant and they set everything up to where they got me into community life.

The participants indicated that the enrollment process was relatively seamless, particularly due to the help of staff members throughout the process. Referrals were typically made from a shelter or from the hospital:

The social worker at the hospital connected me with Safe Haven, community life...You go through the process there with them, they give you a whole bunch of options, whatever. But as I was about to leave, because I left so many times, they introduced me to this program.

Perspectives Regarding MRT-SH Housing Accommodations

The participants described their housing accommodations through the program in positive terms, indicating their gratitude for having their own living space. Most participants reported having the opportunity to select an apartment with the help of the staff. One participant indicated that only one apartment was offered. They described their apartments as spacious, comfortable, quiet, and private:

It's lovely. It's quiet, peaceful. I'm just blessed, you know, things could be worse. Last year this time I was going to sleep in my car, I was on the streets.

Mine is very comfortable, apartment is very nice. It's a privately owned building and it's very nice. There's good heat, it's very roomy...I like it.

The participants frequently indicated that without being housed through BronxWorks, they would likely be living in a shelter, experiencing homelessness, or living precariously with friends or family:

I don't know where I would've been. Probably would have been with another friend or family member.

I don't know, to be honest. Most of my family is far away from me. The closest relative I have lives in Atlanta. Most of my other family is out west, mid-west. So, I don't know. But that's something I don't have to worry about due to the MRT.

Perspectives on Housing First

When reflecting on harm reduction approaches specific to Housing First, most participants described natural consequences of using from the perspective of issues it might create with landlords and other tenants. They indicated that housing through BronxWorks is just like "regular living", in that one needs to be respectful of the lease and of one's neighbors:

It's just like regular living. You just got to respect the guidelines of the lease and the tenants.

Perspectives on Support Services

When reflecting on the support services offered by BronxWorks, the participants indicated that the support of social workers and staff is paramount. They reported that staff are there for them whenever support is needed, and that staff advocate for their needs and help them to interface with health professionals:

I like the support that my social worker has given to me. She is there all around the board. Anything that I need, insist on, she will advocate for me. That's a great support, all around the board, can't get better.

Even physically, if you want her to come with you to your appointment – she's not busy that day, she'll come with you. Most of the time she will come with you anyway if you ask her. But she'll be there for you. She'll talk to you. I see a psychiatrist so she keeps in contact with my psychiatrist, keep up with my appointments.

Changes Experienced Since Entering the Program

The participants commonly reported that the most significant changes in their daily lives center on the independence and stability they have achieved due to housing. They indicated that housing provides a place to go and feel safe and relaxed, in contrast to shelter life:

Now you have a home. You have a place to go to and relax...Before you had to probably be waiting time to go if you were living with somebody or whatever. You'd have to wait the same time to go home or in the shelter.

In terms of overall health and quality of life, the participants indicated that their mental health and physical health has generally improved. They attribute this improvement to the stability provided by having a place of their own, as well as the ability to regularly schedule and keep appointments with a primary care provider. As one participant explained:

[BronxWorks] keeps me out the hospital. My health is better now. Before I got into the program, it was worse. It's better now.

The participants perceived that greater use of primary care services has allowed them to experience fewer hospitalizations. They noted that transportation services are especially helpful to them, as they are able to keep primary care appointments:

By me being diabetic and my other illness – amputations on my toes, on my feet – it was kind of hard on me. So, every now and then I would get kind of sick and I would have to stay in the hospital. For March sometimes, Christmas, New Years, Thanksgiving, Halloween, my birthday, all of that – hospital. But now that I've got a stable place I'm able to take care of it more better, and manage it more better, and make my appointments – they help me with that too, help me make my appointments, keep my appointments up – and I'm much better now.

Most participants reported improvements in family relationships since entering the program, noting that they are now able to be both physically and emotionally closer to their loved ones:

My daughters come over, spending nights...Got a little bit more closer to them, 'cause before I wasn't able to do that either. So it brought us a little closer, I got a better understanding of them.

Other participants, however, described continued family conflict that has not improved with housing. Though less common, one participant described a lack of close relationships, but reported that he is happy to have his home to relax in.

The participants noted that the program has been helpful in allowing them to achieve goals of maintaining their housing, improving their health, and keeping busy. Several noted that they are generally feeling well, and described that it is helpful to have the stability needed to plan one's day more productively:

I'm beginning to feel good when I wake up, feel better. I can plan my day. Before it was a little different. It was more difficult for me to plan my day because it's like, okay where I'm gonna eat? Where I'm gonna do this? Everything was just a question mark before you actually jump into something. Being that I have my own apartment, it's much more convenient and it's much more relaxing for us, we can all relate to that.

Perspectives on Program Strengths and Weaknesses

The participants expressed positive perspectives regarding the program, especially as it pertains to staff, as well as the stability that comes with being housed. Staff were characterized as flexible and readily available to help the participants to stay on track. They widely described the staff as BronxWorks' greatest asset:

I think they have a good support team together. Why I say that is because sometimes my social worker might not be available, but there's always her coworker that I can call as well.

While no weaknesses were reported by participants, some indicated that the program should be expanded to help more people in need.

Ithaca Housing Authority

Program Context and Key Program Components

The program run by the Ithaca Housing Authority was designed to serve a low income elderly population, with the goal of assisting these individuals to live independently. In addition to providing housing through a building run by the housing authority¹⁹, on-site nurses provide case management services to the participants. Most participants were already residing in the building when the program was implemented. Others were residing in a nursing home, but transitioned back to the building. According to the staff, typical trajectories included entering the building from a nursing home, from independent living (often within the building), from a family residence, or from a homeless shelter.

According to the director, the program sought to reduce participants' use of high cost Medicaid services, including emergency department visits. The program also sought to improve participants' ability to manage their medications and overall health, and to facilitate an improved understanding of their medical conditions. As the program director described:

The basic concept behind the nurse case manager program was to help a low income elderly population live independently for a longer period of time. The Ithaca Housing Authority is a public housing authority and the residents live here based on income eligibility and HUD guidelines that have absolutely nothing to do with whether or not they need a nurse case manager program. But in 2008, 2009, we were witnessing a large population of residents that were prematurely going into nursing homes because there was a missing link. And the missing link was simple, basic nursing services that provided some education and help so that they could live independently for a longer period of time.

A nurse associated with the program described her work with clients, noting that much of the assistance provided varied based on each participant's needs at a given time:

Well that's the best part about that was there was no typical day. Each day could be anything different, especially later on in the grant period when residents really knew who I was and that we were here. They started coming to us so much more and it would be something simple like, "My doctor just changed my blood pressure medication and wants me to keep track of it for two weeks, can you help me?" or, "I just got this folder full of papers from the hospital and I have no idea what any of it means." It was really different every single day.

Using grant funds, the housing authority modernized a building where residents were currently living. The program was able to perform home modifications to prevent falls (e.g., grab bars in bathrooms). Additionally, two full-time nurses were available in the building to assist residents with their medical needs, which included helping them to better understand self-care and manage medication. The nurses also helped ease the transition to independent living for participants entering from a nursing home.

The program included an executive secretary, two nurses, a case manager, and the Executive Director. The program staff provided hands-on assistance to the participants, and also completed reporting requirements, data collection

¹⁹ Per a personal communication with NYSDOH, MRT funded the support services, but not housing for this program.

activities, and other required duties. The executive secretary and nurses met monthly to compile required reports. The nurses provided recommendations to the executive secretary regarding necessary apartment modifications, which were then provided to contractors hired to complete the work. The full program staff met periodically to review the work plan, while the case manager and nurses worked together daily to review each participant's needs and progress.

According to staff, participants who exited the program had typically moved on to a long-term care facility, left the area, or passed away. Others required program services for only a short time. Staff indicated that they worked with each individual to plan for discharge, including coordinating necessary supports.

Regional Factors

According to the program managers, there are a lack of programs and services appropriate for the population served in the Ithaca area. Other regional considerations impacting service delivery include transportation challenges, in that it is difficult to find urgent transportation besides ambulances. The area lacks Medicaid-eligible assisted living facilities. The program managers noted that this gap forces individuals to enter into a nursing home when they may be more suitable for assisted living. Finally, the program managers described a shortage of home health aides to serve the target population. As the program managers reported:

We have a lack of Medicaid assisted living. So, there is absolutely no assisted living facility near us in our county, and I don't even know of our adjoining counties, that accepts Medicaid for payment for assisted living. When our residents can no longer live independently, they're forced into nursing homes when they would probably, in some situations, be suitable for an assisted living facility if it were available.

The other thing I would say is there's a shortage of aides for in-home care. So that is a huge barrier. If somebody could live at home with an aide versus going to assisted living or a nursing home, it would definitely save money that way.

In addition, program staff described a general shortage of affordable housing stock in the catchment area. This challenge is compounded by a lack of resources and services, particularly for participants who are socially isolated:

I think it really all comes back to that, is that the struggles and the challenges of the residents who are served by this grant face is a lack of housing, lack of resources, lack of transportation, lack of advocacy – a lot of residents are living here, they have few family members who can truly assist them or are willing to assist them. Or they have no family members and they're not connected to human service agencies such as APS or mental health and that makes it very difficult.

Targeting and Eligibility Determinations

The target population for the program was elderly residents (age 65 and above) from low-income backgrounds. Individuals residing in the building were initially placed based on income eligibility and HUD guidelines, but these criteria did not indicate whether participants required a nurse case manager program.

According to the program managers, the eligibility criteria was provided by the grant requirements. They noted that it would be helpful if non-Medicaid participants, such as those receiving Medicare, could also receive services, as some of these individuals are eligible for Medicaid, but cannot afford the spenddown amount:

It would be, I think, helpful if folks that were non-Medicaid eligible could get these services as well, including Medicare individuals...They're eligible for Medicaid but can't afford the spenddown...So they're going to have to have a serious event before Medicaid is going to kick in because they're never going to meet their spenddown in those situations.

The program managers also indicated that there are individuals younger than age 65 who have significant health needs– some of which are greater than other individuals served by the program. However, they are ineligible based on the age restriction. As a staff member explained:

The population only gets older. So over time, if you were able to share the wealth of that education, that knowledge, with the younger population, they're going to groom and become your next population of targeted individuals that you're going to be helping. And most likely, when you are able to help them, their health is going to be worse. So there needs to be intervention and prevention at all ages, and not just at 65 and older.

Participants of the program were current residents of the building, so most referrals were in-house. According to program staff, all residents were told about the program through a memo. Additionally, the case manager attended meetings for local service providers and presented information about the program to obtain additional referrals. As the program director explained:

We're a public housing authority where we have two high-rises, side by side. And in that, we have 235 apartments for seniors. So, our captive audience is already here on-site. We tried to go outside and seek for other referrals to live here but we only got one from the outside. We had plenty right here under our roof already.

The director described the process of placing participants into housing. The case manager makes a referral, which one of the nurses then assesses to determine eligibility. Once housed, the participant can be linked to necessary services beyond what the program can provide.

When program staff worked with referring agencies and hospitals, there were difficulties conveying the nature of the program. As a staff member explained:

We also had communication issues with making the service providers understand what the program here was that was available to our residents. We had issues with discharge planners at hospitals not communicating with staff here. So sometimes residents were being discharged on late Friday afternoon with no services in place and nobody here to kind of catch that softball that was coming to the pitcher's mitt. And two or three days of a resident coming back home with no family involved, unable to get the prescriptions at the store, or even food in their cupboards. That, by Monday morning when the nurse came in, a lot of times that resident had already gone back to that front door of the hospital.

Program Changes and Innovations from MRT-SH Funding

Using the MRT-SH funding stream, the program was able to add an additional nurse to the program. Additionally, the program was able to perform more apartment modifications and to facilitate educational sessions. Specially, the staff worked with outside agencies to bring information sessions to participants on relevant topics:

We were able to work with other agencies and bring in informational sessions on diabetes and healthy cooking and COPD, signs of a stroke. There was an educational component that went along with it.

There was a group that came in from Cornell University and worked with a population of residents that were interested in participating...So they basically explained to the residents what happens when you go see your doctor and how to be prepared for that visit and how to make the best of your 10 minutes. Because at best, that's all you have with your doctor. And how to prepare a notebook and they even provided the notebook.

Perspectives on Housing: Early Adjustment Issues

According to program staff, medication management, follow-up contact upon hospital discharge, and educational services about health were especially critical to the program participants. Staff indicated that initially, all participants in the program had challenges that they were attempting to resolve. However, some were reluctant to engage with staff at first, due to fears about being removed from the program:

Some residents were reluctant to work with us because they felt that we would just realize that they weren't suitable for independent living and then go and try to kick them out, send them to a nursing

home. And when they realized that we were here to help them and keep them here, try to live here longer, with the supports in place then they were really receptive to getting the services and seeing how we could help them.

Overview of Service Delivery

According to program staff, assistance regarding the participants' medical care is the service that is most critical to the participants' well-being. Program staff work with clients to obtain needed medical testing, to ensure appropriate medication management, and to provide education about disease processes and warning signs for more acute medical symptoms. Some staff indicated that an element of the program's effectiveness is the sense of security participants experience due to having a point person on-site to assist them with their medical concerns. As the staff members explained:

Helping people to understand exactly why they were at the hospital, what the instructions are for them to prevent a readmission [is effective]. And then follow through. We actually have a specific type of admission, it's called care transition. What that is it's a 180 day admission. So somebody that was released from the hospital, we'll follow them for 180 days to help keep them on track with their medical regimens and keep them from being hospitalized again.

There's a level of security in having a point person on-site for them to go to. And if your goal is to help people live independently for a longer period of time, it's a huge component, it's a successful component. In terms of the doctors' offices, as I said, you're lucky if you get five minutes, let alone 10 minutes with your doctor for them to understand whatever they think is going on with you.

Perceptions on Participants' Progress

According to the program managers, participants who benefitted most from the program included those who had most significant medical needs and lacked family support. These individuals required the services of the program most, and benefitted significantly from developing a stronger understanding of their health conditions and how to manage their overall health and wellness. Individual who were more independent and medically stable showed less dramatic benefits, given their lower level of needs.

Program Strengths, Weaknesses, and Future Directions

The program managers and staff at the Ithaca Housing Authority indicated that participants experienced improved quality of life while in the program, due in part to their ability to live independently for a longer period of time with their conditions stabilized. They further reported that the participants benefitted from the peace of mind and sense of security they experienced through stable housing with support staff, including nurses, on the premises.

The program managers perceive that the State can continue these efforts by targeting housing authorities and replicating the model, indicating that the program is poised to save both Medicaid and Medicare dollars. Regulatory restrictions and barriers need to be addressed in order to replicate the model. As a program manager reported:

If there's interest in reducing the Medicaid costs, then I feel like when we were in Albany and reported out to the Department of Health in June, we provided them specifics and data to show 1.6 million dollars in Medicaid savings over an 18-month period. I feel that that data spoke to the success of this program and also provided them a model that could be easily replicated. The problems in replicating that model are the regulatory barriers at the Department of Health. So I firmly believe that the ability to reduce Medicaid savings is going to be contingent on the changes to regulatory barriers. Because you can't implement innovation if there's not a slot to stick it in. And there's only so many slots at the Department of Health in terms of what meets the regulatory and licensing requirements.

The program managers wondered if the Department of Health might be able to work with the Department of Transportation and HUD to provide a funding mechanism for replicating the model:

If the Department of Health somehow got on the same page with the Department of Transportation and the Department of Housing and Urban Development and were able to fund or provide the

funding mechanism needed to provide grants to housing authorities that wish to adopt or replicate the model that we've created. And you can take this model and make some adjustments to it as necessary and pretty much layer it at public housing authorities. And the benefits, the savings that would come from that, I can't even imagine what that number would be. Because we just talked about 1.6 million dollars in 18 months. So it's beyond bigger than what we could even imagine. Not to mention improving the lives of an underserved population of individuals. We've got barriers with the Department of Transportation, we've got barriers with the Department of Housing and Urban Development, and we've got regulatory barriers with the Department of Health. Those are three huge departments and if they were able to brainstorm, put a think tank together, take the individuals who have done this and succeeded at this, then there is the ability to have huge savings in Medicaid spending.

NURSING HOME TO INDEPENDENT LIVING

Federation of Organizations

Program Administrators and Staff

Program Context and Key Program Components

The Federation of Organizations program serves a population of elderly individuals with medical needs. The program supports participants' ability to live independently, in contrast to residing in a nursing home. The program also serves individuals who had been homeless prior to program entry. The program provides a subsidy for shared, scattered-site apartments in the Long Island area (Nassau and Suffolk counties), and served just under one hundred clients at the time of the interview. The overall goal of the Federation of Organizations program is to promote independent living, decrease participants' reliance on hospitals and other high cost Medicaid services, and create relationships with primary care providers. As the program manager explained:

The whole mission statement of the program is to reduce hospitalizations and reduce the reliance for high Medicaid users, to try to provide them these services at home and connect them to medical providers in the community so that they are not going to the ER...and then our case management staff, they work closely with the participants to make sure that they're successful in the community with either their entitlements, they have food, they have medication, they're following through with their doctor appointments.

The Federation of Organizations is unique in that it is comprised of both a housing team and a medical team. The two teams work together to provide wraparound services to program participants, including home visits and linkages to healthcare providers. A program assistant, case manager, intake coordinator, nurse, program coordinator, physician assistant, program director, program manager, community health worker, and administrative assistant are employed through the program. The roles of staff within the MRT-SH program necessitate flexibility and constant team communication, as responsibilities and priorities may vary depending on crises and emergencies that may arise. Staff described constant communication and positive relationships with one another, which facilitate participant success.

Given that most program participants have progressive diseases, they are expected to remain in the program through end of life or until they are in need of a higher level of care. However, some clients have been able to improve their health and independence such that they were able to move into housing that does not have the intensive structure of the MRT-SH program. Throughout each discharge process, staff work closely with clients and their families to assist in their transition to the next step. According to the program manager, the program defines success through independent living with reduced reliance on high cost Medicaid services:

As far as success, we look at overall the ability to remain in the community as independently as possible and decrease hospitalization. So if we can identify, we do a lot of preventative care. Any time we get into a home and be able to teach somebody how to check their blood sugar more frequently, or learn about what to choose as far as dietary options when utilizing their food stamps or identifying why they take their medications when they're resistant to and understanding the risks versus the benefits. Any time that we can do preventative care, smoke cessation, I feel that overall it is a success for us because it prevents long term admissions and more sequelae of their disease state.

Regional Factors

The catchment area served by Federation of Organizations is quite large, necessitating a great deal of travel for both program staff and participants. As the program manager described:

Geographically, it's large and there is a challenge as well with transportation in that there have been a lot of cuts in budgets at the local level in both counties to transportation for the disabled...but all of our participants are eligible for Medicaid transportation through a vendor called Logisticare. Some of the issues have been that because it's such a large geographic area, there have been long wait times for participants to be picked up or dropped off and that can be frustrating. And it's really difficult to get around Long Island unless you have a car, and almost none of our participants have cars...

Further, the cost of living in the area is high, which creates difficulties for staff as they seek affordable apartments for the participants. In addition to affordability challenges, providing accommodative housing and services to accepted applicants in the Long Island region poses a challenge. According to program staff, sanctions regarding county borders impact participants' access to transportation and certain healthcare providers, and can disrupt the continuum of care.

Staff noted that their agency as a whole struggles with community acceptance of their clients, as they have often experienced being denied leases and lease renewals due to discrimination. As the program director explained:

Prior to this program, we're really a mental health agency, so there's a little bit of a target on our back...We can only afford to be in certain areas, we can only be in certain areas, and a lot of people just don't want our folks around, they just don't understand what we're trying to do and it's difficult. Complexes don't want to work with us, we've lost leases, not specifically because of our people but we share it with our mental health program.

Staff also described the challenges of individuals in need of a home health aide who do not meet the stringent requirements for the service, also indicating an overall shortage of home health aides in the area. At present, there is not enough funding to incorporate home health aide services into the MRT-SH program. As the program staff explained, without access to a home health aide, some individuals have to move into higher level of care facilities that are inappropriate for the level of care they actually need. To address this challenge, staff endeavor to be constantly available to program participants to meet their needs.

Targeting and Eligibility Determinations

The Federation of Organization program follows eligibility criteria provided by the State. Program staff conduct outreach efforts to engage current referral sources and to establish new connections with community resources. As a staff member described:

We conduct outreach to different community resources, either through referrals we've already had, or sometimes we hear of different programs or nursing homes that we'd like to come and spread the word about our program. We are still pretty new, so we do a lot of outreach and discussing with referral sources and making relationships with them and maintaining them.

Applicants are required to provide documentation for proof of eligibility, and to undergo an intake and assessment process, using the Uniform Assessment System. Staff collaborate and work with applicants to identify client needs and determine their appropriateness for the program. Copies of insurance, SSI, Medicaid, proof of income, and proof of homelessness are obtained as part of the process. If participants are under the age of 55, they must also furnish proof of chronic disability. The program manager indicated the significant needs of the population served:

There's a lot of funding for mental health beds but there's no real funding other than this project and the NHTD waiver to provide people who are medically compromised. It's a relatively small group, but the aging population on Long Island is exploding. And homelessness is, of course, an issue on the island because of the high cost of rents and high cost of living. So serving the homeless population is really appropriate, especially those who are about to lose their housing, who are medically vulnerable.

Staff highlighted issues with the computerized system used to evaluate program participants, including response bias and the inability to capture those with progressive diseases who would benefit from the program. As the program manager indicated, there are participants who would be appropriate for the program, but who don't "pass" the UAS requirements. She perceives that this tool does not capture progressive diseases:

There are some times that there are patients that we would feel are appropriate that sometimes don't pass the UAS. And they do have certain medical conditions that I feel would benefit from our subsidized housing. But the UAS is a computerized system that determines a number based on questions, and sometimes it's more because of the deficiency in their activities of daily living over a number of only three days. And sometimes if somebody has a progressive disease, it may not catch our patients that are predicted to decline. And if they're not acutely and currently in a declining state, sometimes it doesn't capture a high enough number for us to be able to serve them.

Program Changes and Innovations from MRT-SH Funding

MRT-SH funding allowed the agency, which primarily functions to serve mental health needs, to incorporate a medical team into this program:

The grant implemented from the beginning that we were going to attempt to have the medical as part of the actual team, rather than to sublet it out and refer out. So out of other programs...they don't have medical staff on their team. And we find it actually very helpful also because of the HIPAA barriers; we're able to obtain more continuity from hospitals and doctors, from provider to provider, than non-medical staff may have.

As the program staff indicated, having the medical component enhances staff's ability to address participants' needs more quickly and easily. Participants are also able to access services provided by other programs within the agency, particularly for mental health needs.

Placing Participants into Housing

Prior to placing participants into housing, staff engage and develop relationships with landlords. Landlords who agree to work with the program must allow subleases; as program staff explained, some landlords are hesitant to sublet to the program, while others are comforted in knowing that they will receive rental payments consistently through the program. Staff assist clients throughout the lease process and set up their new units with furniture upon move in.

Staff members work together to assess where participants can be most comfortable and successful. A number of components are taken into account, as the program director explained:

We'll look at open beds, we'll figure out who's living there, would this be a good match? Are there stairs going up? Is this person in a wheelchair? Basically trying to put a puzzle piece together and seeing where we can fit people appropriately.

Perspectives on Housing: Reflections on Housing First

According to program staff, the Housing First model creates a supportive environment that is free of judgment from staff and demonstrates their willingness to work with clients through their addiction and recovery. As the intake coordinator described:

I think one thing is that it shows our clients that there's not a lot of judgment coming from us, that we're really here to work with them, we're here to help them through these obstacles that they're facing and that they don't have to be scared of being homeless if they're really struggling with addiction. That we really meet them where they're at and help them, to link them in the community but maybe they're not quite ready to do that. And because we have the mix of the medical and the housing staff, we have social workers and medical team. We have a lot of people that can really provide, looking at the health component of it and we can also help them with developing some of those coping skills to manage some of the urges or the triggers that they're dealing with. And really show them that they're not going to be reprimanded for this use, that we understand the level of addiction.

The program manager noted, however, that it is important to have the right supports in place for a participant prior to the move-in date to facilitate success:

The Housing First model is an approach that offers the quickest possible way to get housing and avoid homelessness. But as [a] medical [program], I like to make sure certain services and supports are placed first so they could be safe and avoid re-hospitalization and return to homelessness. And even though Housing First is great, I think sometimes if you do it too quickly, you don't necessarily prepare appropriately and they end up not being successful.

Perspectives on Housing: The Scattered-site Model

According to program staff, shared, scattered-site housing offers participants opportunities for companionship and reduced isolation, as well as a stable and secure living space. Scattered-site housing was described as closer to “real life”, and was noted as being less stigmatizing for participants. According to program staff, scattered-site housing offers participants an opportunity to thrive in their own environments and uphold personal freedom.

As noted earlier, program staff described challenges engaging landlords, due to stigma and in some cases, concerns about the sublease. The program has a maintenance team, so they are able to offer landlords the opportunity to bring in their own staff to address issues around apartment upkeep as needed:

One of the things we have is a maintenance team. So if it's not an apartment complex that has their own maintenance staff, we are able to sweeten the pot that we can address maintenance issues pretty quickly if it's our clients doing damage or any issues that come up we can send our maintenance team in pretty quickly, we don't have to call outside vendors all the time. I think that helps.

While staff endeavor to provide participants with a choice in their housing, the limited affordable housing stock in the area makes this challenging. It is sometimes infeasible to find an apartment for a participant in a desired area. Staff indicated that apartments in Nassau are especially difficult to locate due to affordability challenges.

However, staff noted that participants are sometimes placed into apartments before they are fully prepared to live more independently; if they are used to being in someone else's care, they often need to learn the necessary skills to support their health and adaptive living skills. As the program manager indicated:

The advantage is that we try to put people in their community where they may have family members or support systems, closer to their doctors. The disadvantage is we have a very small staff that have to travel around and sometimes in an emergency they're not all in one close area... These are older individuals who want to just live their life. They've been cooped up in nursing homes for so long. There is a flip side to that – there's less travel, you don't have to go into certain neighborhoods, everybody's there, maintenance issues would be less, we don't have to deal with the NIMBYism and all of the other issues. I don't think this program would be successful if it was a congregate level.

Several challenges that clients experience once they are housed were highlighted by program staff, including adjusting to living with a housemate, integrating into the community, and developing awareness of their capacity for independence. As the program assistant explained:

Many times, our patients that we're getting from a nursing home were rehab initially...And a lot of times they have an issue with their own self-awareness – what they used to be able to do before they broke their hip and they feel they are independent. And we find out that, really, nobody's been checking their blood sugar, the nurse has been checking their sugar, they don't take their own medications, a nursing assistant will help bathe them. So, a lot of what they feel that they can do independently and once they become independent are different. We have to figure out and putting on them what they really can do and what they need assistance with, additional linkages. I think both populations, homeless, especially, definitely need linkages because they utilize the emergency room a lot more. And the nursing home staff – they were just not going to the doctor – the doctor just would come to the bedside. They wouldn't actually have to actively go into the community and find anything. We have the same barrier with both populations with providing linkages.

Additionally, individuals who had been unstably housed prior to entering the program experience early adjustment issues integrating into the community. As the program assistant described:

A lot of our clients come from either a homeless shelter or somebody's couch, or whatever the case might be. And they find it difficult to get around in the community because they're out of their element – they don't know where the store is, they don't know any of that stuff. So, they feel like they have to stay in the house for a little while until they get acclimated into the community.

Staff work with clients in attempts to resolve such issues by linking them with community resources, teaching daily living skills, and ensuring that services are in place before move in.

Overview of Service Delivery

Case management was noted by program staff as an important and heavily used support service for participants. Staff highlighted the importance of home health aides, whose services are crucial for client success in the community, but are difficult to obtain and to coordinate in tandem with a client's move into new housing. As the physician assistant described:

Home health aides are so crucial for clients in order to be successful in the community. We have a client right now who has been decreasing her chemo because she doesn't have an aide that is consistent to actually shower her and help her in the morning to get her on the bus. So that is the biggest barrier. Another part of the aides is that earlier in the program, when we were trying to get clients that were from a nursing home to the home, they had to be assessed within the home. And in order to evaluate, through Maximus, the UAS and how many hours the aide would be able to come once the client was in the home. So it was hard to actually project – they wouldn't even come because they were in the nursing home. So the patient would have to be discharged, without an aide, unsafely, because they really needed an aide, in order for an aide to actually come and get the assessment to see how many hours the client would need.

Staff noted that services designed to improve participants' health were also discussed and included smoking cessation groups, in-home primary care linkages, transportation to Alcoholics or Narcotics Anonymous meetings, and intensive discharge planning.

Reducing Medicaid Costs

A key goal of the Federation of Organizations program is to reduce Medicaid costs. As the program manager indicated, preventative care is critical to approaching this goal:

As far as the medical component, we decrease Medicaid costs by preventative care. I am a prescriber so, for instance, I had a patient last week that was complaining about flu-like symptoms. Instead of her going to her doctor's office, in a snow storm because it was snowing here, I was able to examine the patient in their home, collaborate with their doctor, agree with the plan, prescribe medication. And if this patient, who is a chronic oxygen user, would have progressed without medicine, could have been in a hospital.

Program staff collaborate with the agency's own Health Home, as well as other outpatient providers, to serve medical needs that cannot be addressed within the MRT-SH program. Having a medical team within the program enables staff to objectively monitor and track participants' healthcare needs.

Perceptions on Participants' Progress

Overall, participants have provided positive feedback on the program, according to program staff. Staff reported that individuals with a comorbid psychiatric condition, those less comfortable with self-advocacy, and those who have a history of substance use may face more challenges in benefiting from the program. As the program manager explained:

I find that some patients who do have comorbid psychiatric illness are less likely to be as successful because of their depression or their just overall psychiatric illness – either with their medication

effects, their medical well-being, their compliance, their willingness to trust us, their willingness to be compliant with medicine.

Program Strengths, Weaknesses, and Future Directions

According to the program managers, supporting participants' abilities to live independently enables them to age with dignity and consistent support, as well as to gain independent living skills and self-awareness:

I think it's wonderful for patients to be able to age with dignity in their own home. Many of these patients would never have had that opportunity. To die in a homeless shelter or on the streets is always going to be much worse than being in your own bed peacefully with support around you, with people who care and assist you.

However, non-compliance and withholding information may obstruct certain participants from benefiting from the program. The high cost of living with limited funding and public assistance was highlighted as a major challenge in serving individuals on Long Island. Moreover, the program managers identified challenges in obtaining home health aides as a significant issue for the program. This situation can be especially problematic when participants are first transitioning to the program from a more restrictive setting:

I think if there were more service dollars, that we would have the ability to hire a home healthcare aide or agency privately until the MLTC or aide agency picks up. We would be able to service patients quicker and safer. Because in the first day of moving somebody out of a hospital, especially, they have to go 24 hours before an aide shows up, so that's something that gives us a lot of anxiety...Or what if the aide doesn't show up? For a lot of the aides, they're paid so little they don't even own cars, they depend on public transportation. So, if there's a snow storm or traffic, they're late or can't get there.

Regarding issues surrounding home health aides, the program director went on to explain how agencies often require a family member to act as a "back up" if an aide cannot show up on a given day. This condition prohibits the staff from serving clients without a family member or support person, who might otherwise be eligible:

People who don't have family members – for example, a lot of MLTCs and aide agencies require there to be an alternate if an aide doesn't show up, and that back up really can't be us. So we have a member, for example, that does not have any family. We've been trying to sign him up for an MLTC for quite some time and they tell us that his needs are too high or he does not have a backup so they can't place an aide. And he's somebody who's been living independently for many years and can still live independently even with an aide only a couple of hours a day, but he will probably go into a higher level of care much earlier than he really needs to because he doesn't have a secondary support.

According to program staff, the extent to which clients benefit from the program is based on the individual. Some participants are more engaged in their independent living environments than others. The program's success in reducing hospital recidivism was also noted by program staff and was attributed to the medical team's intensive work on discharge planning and follow up. Overall, staff teamwork was acknowledged as one of the program's greatest strengths, due to their reliance on one another to effectively serve clients.

Rigidity in budget spending and staff roles were discussed at length as areas that could be improved in order to serve clients in a more timely and appropriate manner and save Medicaid dollars. As one staff member indicated:

To be able to help people with petty cash when they have no food and the pantries are closed, somebody who needed a commode, people who need a cane or a ramp – yes, we understand that Medicaid may cover them, but they may not have active Medicaid or they may be in transfer from one county to the next. It's really hard...It's not asking for more money, it's just being able to use the money that we have been granted in how we see fit that would benefit the clients.

Participants

Housing Status and Lived Experience Prior to MRT-SH Enrollment

Participants of the Federation of Organizations program typically experienced a trajectory of moving to supportive housing from a nursing home or from an unstable housing situation. Two participant who experienced housing instability prior to program enrollment explained:

I was in a shelter before I came here. I had been staying, renting a room, at a friend's house but it was only a temporary situation. And unfortunately, because I was diagnosed with end-stage renal failure and put on dialysis three days a week, I had to stop working. So I went down to Social Security which is not survivable. So that was pretty much how it started.

I was married with my second wife...we moved to Carolina, her father died so we moved in with her mother – bad, that was the beginning of the end. Her mother was self-needy so I got thrown to the curb. Then she had her own health issues and between me and her mother she couldn't take it anymore. Although, my biggest problem is I can't see, which, you know, stops you from doing a lot of things. So I was no good and she left, wasn't coming home. So her mother kicked me out this past summer; I had no place to go to. I had to live in a box almost, in my brother's apartment – that was hostile enough. But at least he took me in. My friend took me to Federation of Organizations, filled out an application with me, and I got a call three months later and that's where I am. And I'm very grateful; I don't know where I would be.

Many participants described experiencing serious chronic health conditions that impacted their ability to live independently. These conditions included renal failure, blindness, cirrhosis of the liver, and chronic knee or back problems.

Most participants described a relatively easy process to gain entry into the program. The enrollment process consisted of paperwork and an interview, along with a psychiatric evaluation. The participants were most frequently referred by social workers and in some cases, by a family member. Though less common, one participant described a more cumbersome process to access the program; she advocated for herself to gain entry:

I contacted the head of the program via email. They had supposedly put in an application for me through the shelter, but the social workers there are useless...so I said to them, "Do I have to be in an MLTC program, or qualified?" "Oh we don't know, we have to ask, we have to email them." And a month went past...So I went upstairs and I googled Federation, got [staff member's] name, sent him an email, I get an email back two hours later that said can you call me at 9 o'clock tomorrow morning...Called him at 9am. He said to me, "Listen, I am so sorry," he said, "We've got your file right here." He said, "We've been asking them for documentation for a month now...Would it be okay if I had our PA contact you because you have to have an intake done – medical and psychiatric"...I went from upstairs to downstairs outside to have a cigarette and my phone rang and it was [staff member], the PA and she's like, "Can I set you up?"

Perspectives Regarding MRT-SH Housing Accommodations

In terms of their housing accommodations through the program, most participants reported a high degree of satisfaction. Several reported living in new units, or units that had been renovated. However, participants are often required to live with a roommate, which created some difficulties for the participants.

Most participants were given a choice of housing accommodations, having seen a couple of potential units. As a participant explained:

They gave me the option of Central Islip or Amityville and, like I said, I know the Amityville area and I knew when they told me what the name of the complex was where it was. So I knew I was in walking distance of like CVS, 7/11, and whatever. CI I don't know that well. I really didn't want any part of it. I also have kids so they're closer to Amityville.

When asked where they might be residing if they were not enrolled into the program, the participants articulated that

they would likely be in a homeless shelter. They noted that they likely would not have been able to live independently. Additionally, some participants noted that they likely would not have been able to stay in New York State due to the cost.

Perspectives on Housing First

The Federation of Organizations program adopts a harm reduction approach, drawing from the Housing First model. The participants reflected on this policy and reported mixed reactions. They perceived harm reduction and housing without sobriety preconditions as positive for those struggling with addiction. However, they noted that it is a “fine line”, as residents without addictions do not wish to be near drugs and alcohol, particularly if they have past issues with substances or have family members who have struggled with addiction.

Perspectives on Support Services

When discussing the support services offered by the Federation of Organizations program, the participants were especially grateful for the services provided by the staff nurse. The participants appreciated visits from the nurse, which were especially helpful to those coming out of a hospital. As one participant described:

For myself, when I first signed the papers was the day I got out of the hospital. Then I had the nurse that came every week and checked me. And it was very nice in that I felt like they were taking good care of me.

In addition to the appreciation for nursing services, the participants had positive feedback on all program staff, who they find helpful and caring. The participants noted that it would be helpful to have conflict resolution assistance in place during the adjustment period of settling in with a roommate.

Changes Experienced Since Entering the Program

Overall, participants described an improved quality of life since enrolling in supportive housing through the program. They recounted waking up feeling happy and at peace. There was an appreciation for small conveniences, such as having hot water. They also appreciated the ability to have their children visit them.

The participants most frequently reported mental health improvements since enrolling in the program. They noted that the relief that comes from stable housing allows them to reduce stress, which also improves their physical health. The participants frequently reported decreases in their use of the emergency department and inpatient hospitalization.

Other participants described improvements in their physical health conditions since moving from unsanitary and unstable environments into supportive housing. As one participant reported:

I had been hospitalized, I was in the hospital for two weeks in really bad shape with sepsis at one point and I have a lowered immune system because of the end-stage renal failure. So to go from a situation where you've got all these other women...who doesn't bathe, who doesn't wash their hands before they cook or when they use the bathroom...So to come out of that and to kind of come into a situation where, first of all, everything is nice and shiny and brand new. But not even that. Just to be able to sit back and relax, I mean, it has a wonderful, positive effect on the psyche which, in turn, has a positive effect on your physical health too. Because when you start getting depressed and whatever else, it definitely, definitely takes a toll physically.

In terms of relationship changes, the participants most frequently reported increased contact and connections in the community, as well as improved family relationships. As the participants explained:

For myself, I was just thinking that since I was always moving around, that now I'm making those connections with the church and different organizations.

My family I had been totally disconnected from. Because I was wandering, I was using drugs, I was self-medicating...My family, they come visit me now, they help me with things; where in the past they were done with me, just washed their hands with me. So my family – I have five children, I have a

relationship with them again. I'm closer with my ex-wife right now than I was when we were married. She helps me a real lot.

Perspectives on Program Strengths and Weaknesses

According to the participants, the greatest strength of the Federation of Organizations program is its staff. The participants noted that they wouldn't change anything about the staff, as they are caring and "give 110%". The participants further noted that they are treated as people and not as numbers. Staff members spend as much time with them as they want and need, and are very responsive. The participants recounted the following situations, in which they felt very supported by staff:

I had an issue with my secondary insurance and it was more than one of the girls, were so worried that I was going to lose my transportation to dialysis. And I get picked up at 4:15 in the morning; I'm an early bird. So I go Tuesday, Thursday, Saturday, 4:15am to 9:15am. They were like, "Okay, you know what, don't worry about it because if the transportation isn't in place because of this issue that's going on, we'll come pick you up." I'm like, "You can't do this, that's 4 o'clock in the morning when I go up there." "No, don't worry about it"...That's a lot to ask of somebody. And, knock wood, it didn't come to play – the transportation stayed intact – but just the fact that they said, it was a load off my mind.

In the winter, I go through this mode where it's dark too much. I'm an outdoor person, I like to walk. I call [staff member], it was February some time but I was going through a rough period. She was at my house half an hour later. She took me out to the park to get out – it was a nice day to get out and walk around. She knows me good enough to know I just needed some company, to get the hell out of the house.

In terms of program weaknesses, the most frequent feedback is that it is difficult to live with a roommate. The participants suggested introducing potential housemates to one another to see if there is compatibility.

OASAS RENTAL SUBSIDIES

Bridging Access to Care

Administrative and Staff Perspectives

Program Context and Key Program Components

Bridging Access to Care is an OASAS-RS provider site in Brooklyn, New York, which offers rental subsidies and support services, including case management, to single individuals struggling with addiction. This provider offers scattered-site housing to participants, along with support services in home and within the community. Participants receive weekly home visits from case managers and vocational assistance, and groups are offered to foster life skills.

Bridging Access to Care employs a Housing Counselor, who visits participants twice a month and provides referrals, performs vocational and independent living assessments, develops a service plan, computes income and rent calculations, and offers supportive counseling. A Recovery Coach also visits with participants twice a month, assists with service plans, provides recovery support, and helps participants address any barriers to achieving their goals. A Program Manager/Supportive Housing Manager supervises the Housing Counselor and Recovery Coach and oversees the program. Additionally, a Property Manager oversees the leases, supervises two maintenance workers who are employed through the program, and manages relationships with landlords.

According to the Bridging Access to Care administrators, most clients access the program directly from a homeless shelter, while only three clients accessed the program directly from substance abuse treatment. Clients are at various stages of recovery, with some actively using substances while housed. The program adopts a harm reduction program for addressing participant needs. Some clients are engaged in outpatient or harm reduction programs, based on their particular needs.

Regional Factors

Located in Brooklyn, New York, administrators of Bridging Access to Care described several regional factors that influence program implementation and contribute to housing challenges. The administrators noted that the community in Brooklyn is racially and ethnically diverse, and reported that program staff reflect the diversity of the community. The greatest regional challenge described was the lack of affordable housing stock. The rental market in Brooklyn was described as extremely challenging, given high rental costs that continue to climb. As an administrator described:

The biggest thing in terms of being in New York City, and particularly in Brooklyn right now, has to do with the rental market. It's just exploding and it gets really difficult to find and maintain housing that's within our budget.

Program staff also described the challenging rental market in Brooklyn, and went on to describe the additional challenge of finding landlords who are willing to accept their clients:

As far as being in this region is the market, the housing market. With the rent being increased. We do follow the HUD guideline for rent so we only pay so much for one bedroom and studio. And as you know – Brooklyn – the rent now is going sky high...And because we can only stay in this region it's difficult to find apartments. And sometimes it's very difficult to find landlords who, even if we're able to

pay the rent, that's willing to accept the program because of past experiences with other programs.

Additional challenges within Brooklyn include transportation. The administrators noted that it is difficult for staff to easily travel to all clients given the distance between where the scattered-site apartments are located; however, they noted that clients can typically access public transportation easily. As an administrator reported:

The access to public transportation, I think, is a really big positive for our clients. Because pretty much everywhere we do place them, almost everywhere where we could place them, as really easy access to buses and subways. And that's a great thing in terms of dealing with folks who are on a limited income. Having public transportation is really inexpensive and accessible for them.

Targeting and Eligibility Determinations

The target population served by Bridging Access to Care is single individuals struggling with addiction who are homeless or unstably housed. Specifically, the program uses OASAS-provided criteria²⁰, which define high Medicaid utilization. Program staff verify emergency department and inpatient use through a data system, and then meet with participants to complete paperwork. If there is a vacancy available, the participant is contacted and the program entry process begins. As the program administrators noted, the OASAS-provided criteria prioritize medically unstable individuals for supportive housing. Once participants are deemed appropriate per the eligibility criteria, housing is provided on a first come, first served basis. Staff reported that slots are typically filled through referrals (e.g., through Health Homes, the mental health department, shelters, outpatient OASAS programs, or other human service agencies), though they occasionally meet participants who walk in to the program offices to inquire about housing.

The Bridging Access to Care administrators reported aspects of the participant targeting process that are working well. They noted that it is easy to fill vacancies, particularly given the strong network between OASAS providers in New York City. A Health Home is also located within the agency, which assists with locating and placing participants. Within Bridging Access to Care, there is a Housing Placement Assistance Program, an outpatient substance use disorder clinic, and a mental health clinic; the program receives a constant stream of referrals from these entities. Bridging Access to Care staff believe that the emergency department requirement does indeed allow the program to capture the highest need population. The administrators reported that they always have more referrals than available slots in the program. As one administrator described:

We always have way more referrals than we have room for. I think that there's a good network in the city, typically within the other OASAS providers. So people know that we have MRT supportive housing and so we get referrals all the time. When we have a vacancy it's very easy for us to fill that vacancy.

Program Changes and Innovations from MRT-SH Funding

According to the administrators, program changes and innovations abounded due to MRT-SH funding. MRT-SH funding allowed the program to increase client-centered services, as well as client contact. More specifically, the funding allowed the program to begin using vocational assessments. Also, the program now provides more frequent in-home visits, which the administrators believe is helpful for promoting greater connections between participants and their primary care providers, as well as for addressing client needs throughout the recovery process. As an administrator reported:

The MRT requires more frequent in-home visits than any of the other programs. So I think that that has kind of promoted a more...frequent monitoring of the clients. With the folks that we get in MRT having higher medical needs, I think that that's kind of promoted more connection, more case conferencing with the primary care doctors and making sure that clients get connected with primary care, which helps them to stay stable and stay out of the hospital.

The funding also supports a Recovery Coach, which is a peer-certified position; this individual is a person with lived experience who is in recovery. The Recovery Coach works closely with the participants and conducts home visits.

²⁰ OASAS criteria for program entry specify that participants must have experienced five emergency department visits and two inpatient hospitalizations, or four emergency department visits and one inpatient hospitalization.

Placing Participants into Housing

As noted previously, the Bridging Access to Homes program offers scattered-site apartments in Brooklyn. This housing is considered permanent, and the administrators noted that there is no ideal length of stay. Since each client is different, with varying needs, some are capable of moving into independent housing after a time, while others are not, due to continued mental health concerns and chronic physical conditions. As an administrator reported:

I would say most of our participants have been here since the beginning of MRT. I don't think that there's an ideal length of time, just because our clients are all so different. Some of them are capable of moving forward with independent housing, in which case we'll help them to do that. But some of them are just not and they're – in terms of their mental illness, or their medical conditions, or their substance use disorders – they're disabled and they aren't really able to generate income that's required or achieve stability, at least in the short term, that's required for independent housing. So I wouldn't say that there's an ideal length of stay...We don't want to keep somebody in supportive housing who's able to be independent, but we don't want to push them out either because if they're not able to be independent it just creates more homelessness.

The administrators noted that participants tend to stay in the program for a long duration, with most current clients having been in the program since the start.

Of note, the administrators explained that participants do not have to leave their apartment if their Medicaid status changes. In the event of a Medicaid status change, part of the service plan would center around helping them to become more independent.

The administrators also described the process of placing participants into housing. Staff are actively involved throughout the process of enrolling participants, showing them available housing units, and helping them to move in. As the administrators described, participants initially complete an intake with the Housing Counselor, which consists of a needs assessment; during this process, they verify the individual's income and calculate their rent payment. Staff then review the documentation and then meet with the client for an orientation and review of program expectations.

Bridging Access to Care staff describe providing significant support to clients during the move-in process in particular. Specifically, maintenance workers pick up the client and his or her belongings and transport them to the apartment. The apartment is already set up for the client prior to their arrival. As a staff member explained:

When they go in it's already set up with a bed, a dresser, pots and pans, and stuff like that. And we move them in...We never allow them to just go in by themselves. We take them in.

The case managers provide a "Welcome Home" flyer which lists resources in the area, and visit with each client about a week after the move-in date.

Staff reported that their goal is to move the participants into housing immediately. The client is shown an open unit/s to choose from. The administrators noted, however, that participants often do not have a choice of multiple rental units, given the scarcity of affordable housing units in Brooklyn. When the program first began, there were far more units to choose from than there are at present. As an administrator explained:

When the program first started there was more of a selection. Now we usually only have one vacancy at a time. So they can take it or leave it, and it's up to them – there's no penalty. But if they decide not to take it, it's unlikely that we'll have another one to show them anytime soon.

Perspectives on Housing: Reflections on Housing First

The administrators highlighted several key perspectives on the housing associated with the program, including reflections on Housing First. The administrators viewed the Housing First principle of providing access to housing without pre-conditions, such as sobriety requirements, as vital to supporting the needs of this population. Additionally, the administrators noted that individuals who abuse substances often slip through the cracks or are otherwise not prioritized for housing. As one administrator described:

I think that, in terms of advantages, the best thing is that people who really are in need don't have

the barriers to accessing services. I think that it's very hard for somebody to get clean and sober if they're in a shelter or if they're living on the street. That's not something that can be prioritized for most people in their life when they're just living to survive. So having access to housing allows them to consider that maybe treatment might be beneficial or to consider that there's more to life because they have the stability.

Similarly, program staff emphasized that housing stability is critical to a client's stability and recovery. As a staff member explained:

First and foremost, everything starts at home. Once the cloud is lifted and they develop that hope, that's where we come in – to kind of monitor them and put them on the right path and be consistent with it so they get used to it.

Stabilizing housing allows participants to focus on addressing other issues they are facing in their lives and to pinpoint what they most need to work on. Participants may then be able to focus on education or work.

In contrast to the positive aspects of Housing First, however, the administrators and staff identified aspects that they find disadvantageous. Specifically, they noted that behavior associated with substance abuse can create challenges to keeping participants housed in the community. For instance, landlords are troubled by units that are being poorly maintained or damaged by some tenants. Staff also need to address participants who have many individuals coming and going from the apartment, which is often associated with substance use. As a staff member reported:

One disadvantage is – 'cause whether the clients are active or not, if they meet the criteria we will still take them – sometimes when the clients are still using and we still house them, it poses some difficulties because they may not be ready. We try to encourage them. We can't mandate anyone to treatment but we definitely encourage them. If you want to be able to maintain this housing, this is what you need to do. So a disadvantage could be that they're actively using and it may pose risks to their housing. Because they may be getting into activities and bringing it into the home; that would pose problems for us with the landlord.

Perspectives on Housing: The Scattered-site Model

Scattered-site apartments have particular advantages to participants, according to program administrators. This model is often less stigmatizing to participants, as they do not reside in a building known to be designated for individuals with substance abuse issues or complex needs. As one administrator explained:

As opposed to congregate, I think scattered-site is much less stigmatizing. Our folks don't live in a building that the neighborhood knows is full of people in supportive housing, or is program housing. They experience much less stigma; they're just people who live in buildings like every other person in the city.

Program staff view scattered-site housing as important for easing the transition to stable housing. For instance, living in the community allows participants to separate from old behaviors and empower clients to make positive choices. As a staff member explained:

When you're trying to get people to transition into independence and being responsible, and you have 5 people on one floor that are still getting high and 10 people over there that's collecting bottles, and you just cannot get away from the crazy. It's hard to help that person make the transition...This way they're in their own space. You now have a choice. You do not have to open the door for nobody. This way it helps them make the transition a little easier.

A key aspect of the scattered-site model is forming and maintaining relationships with landlords. Within the Bridging Access to Care program, the Housing Counselor is charged with negotiating with landlords. Staff reported facing significant resistance from landlords regarding accepting program participants. Landlords are often reluctant to accept clients due to past negative experiences with similar programs. It is challenging to convince landlords that a particular client is different from a previous one who presented problems. To address landlord resistance, staff emphasize that the landlord can call staff rather than the client to resolve it. Home visits are another way to ease the concerns of landlords, as the landlord knows that staff will be checking in on both the client and the apartment.

Staff find scattered-site housing to be challenging, given the need to visit all participants who are living far apart from one another. Program administrators noted that it is more difficult for staff to monitor participants who are not all residing in the same place. As one administrator reported:

In terms of the disadvantage, or the struggle, or challenge, I think it's harder to manage when people are not all in one place and you can't keep your eyes on them every single day.

Perspectives on Housing: Early Adjustment Issues

In addition to reflections on housing and housing-related policies, staff offered feedback about particular challenges participants face after receiving housing. For many participants, living independently is a challenge, as they are not used to being settled in a stable housing situation. Some participants are accustomed to living on the streets, and struggle to feel comfortable in a home. As a staff member explained:

Sometimes putting them into an apartment that they've never had is like a shock to them. Like, "Oh my god, how do I deal with this? What do I do next?" So sometimes they'll ask us.

Staff noted that they work with participants to get them into the "right mindset" for independent housing. A staff member described a client who struggled to settle in to her new apartment:

We've had another client that I'd moved in and it took her weeks to unpack. I kept telling her, "You got to unpack, you got to unpack." Because she's so used to get up and go, get up and go every day...You got to get them in the mindset to let them know this is your home, this is you. No one is going to put you out. The only way you get put out here is if you do something to mess up your housing, you walk away from it. But this is you.

Overview of Service Delivery

MRT-funded support services offered by Bridging Access to Care include supportive counseling services via home visits, which are provided by peer counselors or case managers, as well as referrals to mental health and substance abuse treatment services. Services provided by the program through non-MRT funding sources include Health Home medical case management. In regard to substance use treatment, the administrators noted that the program holds units for ninety days when a client requires inpatient treatment. As the Housing Counselor described:

My responsibilities entail me visiting the client at their home, just to monitor to make sure everything is okay...But another part of what I do is provide support and guidance. Housing is just one part of what the person needs. And so as the counselor I sit with them, talk about what their barriers are. How can I help you? Do you need a referral to go somewhere? Are you engaged in services that you need? If not, how can I get you engaged?

The administrators perceive Health Home and behavioral health services as most critical to meeting participant needs. They noted that providers communicate easily and well together, and that it is seamless to collaborate with Health Homes and substance use treatment providers. As the administrators described, a Health Home is located one floor above the program. Program staff hold a case conference every month with the Health Home, and at least every six months with the mental health and substance use treatment providers. The administrators perceive that coordination with Health Home managers is strong. To illustrate the benefits of this collaboration, an administrator explained:

There is a little concern that [a client] might have some dementia and initially he was having a hard time getting to the doctor. So we arranged with Health Homes and we escorted him to the doctor and made sure he got to the doctor and got his family involved, made sure they knew what was going on in his care and that they can be involved in his care.

Overall, Bridging Access to Care staff concurred that Health Home collaboration is critical. They also asserted that mental health services are essential, especially since substance use problems are often associated with past experience of trauma. As a staff member explained:

I will say mental health services. To me, I think some of the substance abuse is because of past

traumas or other issues that the client had dealt with. And so using substances is a way of self-medicating. But I think there's always an underlying issue and I feel if they engage in mental health services it can kind of bring out some of those underlying issues. So if you address that, you can address the substances.

Staff described some services that they implement with the goal of improving participants' overall health. Nutrition, cooking, and wellness are discussed and emphasized with participants to identify how to create a healthy lifestyle. A harm reduction model is in place to address risk factors that participants face if they are actively using. As a staff member reported:

Nutrition is one. And just wellness – that whole concept. It can be holistic, it can be spiritual, it can be whatever floats their boat. But the key of it – that they become aware of it. After using 20, 30 years, trust me – something's not going to be kind of functional to a degree. So you need to address it and be aware of the risk factors. After you use, what's going to happen?

Additionally, staff described the importance of motivating participants and encouraging them to promote health through positive activities and community integration. As a staff member described:

I always encourage them to do something. I say sitting at home, taking your medication, playing with the remote, is not a good place. You're not using now, you're not collecting cans no more or whatever you were doing. But you have to replace that with something positive. And in that positive activity you'll meet some new people and develop a new kind of support network and social network which will open the mind to some new possibilities.

Bridging Access to Care staff were asked which housing services they view as most important when participants are initially housed. They pinpointed social support as the most critical component during this time— specifically, building trust with participants. They perceived the home visits to be especially helpful in this regard to address any anxiety participants may experience, as well as socializing participants to live successfully in housing.

Reducing Medicaid Costs

According to Bridging Access to Homes administrators, reducing Medicaid costs is a key goal. The primary way the program approaches this goal is by diverting participants from the hospital by emphasizing preventative care. Participants are connected with primary care physicians, and are encouraged to adhere to medication regimens and to schedule and attend medical appointments. Program staff teach participants about alternatives to using the emergency room. Additionally, as participants first enter the program, they are given a "Welcome Home" flyer, which lists the name and location of various community resources. As one administrator explained:

And one of the things that we do whenever anybody moves in is we give them – it's called a "Welcome Home" flyer. And it tells them where everything in their community is located, and that includes urgent care and where their nearest medical clinic is, their pharmacy. So those are things that can be utilized other than going to the emergency room and before maybe the emergency room is necessary.

When reflecting on these protocols, administrators noted that the process is working well, but noted that perhaps more incentives can be offered to participants for engaging with primary care physicians.

The administrators identified particular support services as helpful to the goal of reducing high-cost Medicaid service utilization. These services included help with transportation to medical appointments (Metro cards are provided) and the utilization of treatment-adherence services. They noted that to divert participants from unnecessary emergency department visits, maintenance staff are able to reach clients quickly and assist them, as appropriate. The program also provides a 24-hour emergency hotline that participants can access. As an administrator explained:

Sometimes if somebody's having a panic attack or something, sometimes they might call 911 and get in an ambulance to go to the emergency room. But if they get on the phone with us – we have an emergency hotline – if they get on the phone with us, sometimes we can talk with them and provide them support, and go to them, and see them, and help them to manage whatever's causing that anxiety or whatever it may be

Perceptions on Participants' Progress

Overall, administrators and staff of Bridging Access to Care emphasize their mission as supporting clients in achieving and sustaining independent living. Administrators and staff at Bridging Access to Care perceive successful program outcomes to include the ability of participants to remain housed and to manage their addiction recovery. Additional successes include the ability of participants to manage their finances to sustain independent housing, and to achieve the highest degree of independence possible within their lives. As an administrator reported:

As long as they're remaining housed, I think that's successful. We hope that in time, our clients will be able to move on to completely independent housing- that they'll be able to manage their recovery.

When asked if certain participants tend to benefit from the program more than others, the administrators reported that overall, all participants tend to be relatively successful in the program. Staff described unsuccessful discharges as individuals who cannot remain housed through the program (e.g., those who are evicted) or if an individual becomes incarcerated. In the event that participants lose their housing through eviction, staff noted that the work with clients on next steps. They will refer the client to other programs and work to prevent that individual from going back to the shelter or returning to an unstable housing situation.

Staff reported that they encourage small steps toward recovery and overall progress. While there was no clear consensus on participants who tend to benefit the least, the staff noted that in some cases, illiteracy acted as an obstacle to a client's continued progress. However, overall, they reported positive outcomes. As the administrators and staff described:

I think overall our clients tend to be really pretty successful. It's not very often that we have somebody that's not successful.

We've had a few success, we've had one just move upstate to his family. And we've had two downfalls. And what we recommend for them before they leave is to go into long-term residential treatment facility.

We've had clients where there's a positive outcome, where they'll get jobs, get connection back with their family, gone back to school. And we have clients who are trying to do more with their life, all they needed was that little break, which was the housing.

Program Strengths, Weaknesses, and Future Directions

Program administrators articulated that the opportunity for stability and improved quality of life is the most important strength of the program. As one administrator described:

People have the opportunity to become stable in their life. When people are able to achieve that stability with their housing then a lot of things that were not possible for them before become possible. So becoming clean and sober, or getting healthy, or developing relationships with family that they haven't seen in years and years and years. All of that stuff becomes possible.

According to program staff, the team approach used by the program is one of its greatest strengths. They also view the client-centered approach as key to their success, as clients are able to define their own goals and work toward them. As a staff member explained:

It's the individual client. And just being able to meet them where they're at. And even with the treatment plan, making it their goals, not our goals. This is your goal – you tell us what is it that you want to work on? And let me help you with the steps.

Overall, administrators noted that more funding is needed for the program, especially given the challenging and expensive rental market. As one administrator reported:

The only thing I would say is just more funding. And I would say the funding has to be tied to the rental market. Because it just increases and if the funding doesn't increase then we end up in the hole. And that's where we are with MRT and with all of our housing currently – we're in the hole because the funding doesn't increase.

Staff concurred the funding is a significant obstacle, noting that it is important to consider the expense of the Brooklyn rental market. They described how landlords will give units to programs who can offer more money. They also noted that it would be helpful to provide more transportation assistance to clients through Metro cards, so they can make their appointments consistently. As a staff member explained:

Some of the times they will tell you that we weren't able to go to the doctor, we weren't able to go to an appointment because they don't have a Metro card. We're not funded to give them Metro cards to go to their appointments, we're only funded to give them Metro cards when they come here.

The administrators viewed OASAS as a great resource, as agency personnel have been approachable and available; networking opportunities with other providers are encouraged. The administrators suggest that the State Department of Health encourage all agencies to take this approach. Similarly, program staff noted that additional outreach activities would be helpful, as well as stronger collaboration with Health and Hospitals Corp, the hospitals, and communication with other MRT programs.

Participant Perspectives

Housing Status and Lived Experience Prior to MRT-SH Enrollment

Participants of the Bridging Access to Care program described being homeless prior to entering the program, with most entering the program directly from a homeless shelter. Participants described losing a loved one or "overstaying" their welcome when residing with family members prior to entering a shelter. As a participant described:

I was in two shelters. In 2011, I lost my job, started living with some family. Then I said, "You can't live with somebody for so long, you got to have your own." So I went into the shelter system, I got into the shelter system and they housed me with four other guys in an apartment, which was illegal...so we lost the apartment there. Then I had to go back into the shelter again, and then this is where I met with MRT.

Most participants reported learning about the Bridging Access to Care program from shelter staff. They described a generally smooth process for entering the program. Most participants remained in the shelter while their waiting for an apartment. While this perspective was not universal, one participant perceived that he had to wait longer to enter the program because he was not consistently staying in the shelter prior to entering the program:

In my case, I had to wait for a little while because I was staying with friends. And if you don't be persistent at living in a shelter, they take advantage that you don't really need no housing because you got somewhere else to stay. So if you're running back and forth to your friend's house...and you can't hold a bed in the shelter, that puts you at the end of the list. They say, "What is he here for? He don't need us, really," but I really did need them. But I just found it hard living in the shelter because it reminded me of the prison, the penitentiary housing I was in before.

When the participants were asked where they might be living if they were not in the program, most replied that they would still be in a shelter. They reflected on how continuing to reside in a shelter would have worsened their chronic health conditions:

When you're in the shelter system...you have to get up and get out. So no matter how you feel, you have to be on your feet. It's no hanging out there all day long; you have to stay in the street until about 4:30, 5 o'clock.

Several participants reflected on how living in a shelter would cause them to require hospitalization, often contrasting their hospital utilization while homeless to their current utilization:

I definitely know I'd be in a shelter, Because of my condition, I've been in the hospital a lot...Let's say I've been in the shelter for a year, I've been in the hospital at least, out of that year, five to six times. Since I've been in my apartment, I've gone like once a year.

You've been in an environment where you got to go out on the streets... so you would feel safer saying, "I'm sick already, I'm going to go to the hospital." Instead of being on the streets and getting

in trouble or something like that, end up in the hospital. But now, I have an apartment. You learn to adjust and deal with certain things that normally you might not do in a shelter.

Though it was a less common response, a couple of participants wondered if they might have eventually ended up incarcerated if they continued to be homeless:

I've never been to jail, but I know I might have been in jail. Because I was getting really desperate.

Perspectives Regarding MRT-SH Housing Accommodations

The participants described several positive aspects of being housed through the program, which included easy access to public transportation, residing in housing that is affordable, and the relief that comes from not having to worry about eviction. They emphasized the importance of having independence, as well as the sense of security and peace of mind that results from having a place of their own. As the participants explained:

I like being independent...I got new friends, a girlfriend, people who I can hang out with, but at least I can say, "See you all later." I ain't going to worry about them kicking me out, because I can say "I'm going home."

You have peace of mind when you have your own [place].

Having your own apartment, you got your own place and you make the law.

The participants overwhelmingly described their housing accommodations (studios or one bedroom apartments) through the program in positive terms, while noting that their neighborhoods are acceptable. For instance, two participants reported:

It's nice. I got a one bedroom, living room, kitchen, and a bath. It's nice, it's quiet, neighborhood's okay.

I have a studio but it's nice and quiet, peaceful. My own kitchen, my own toilet, my own bathroom.

Perspectives on Housing First

The participants were asked to provide opinions regarding the harm reduction approach associated with Housing First, which Bridging Access to Homes staff reported adhering to. The participants articulated that this is a good policy, as housing often facilitates recovery. As one participant noted, "This program saves a lot of lives." They often reflected on their own substance use when reflecting on the policy:

At one time I would light a joint and take two puffs and put it down. When I saw I got to the stage where I would be burning my fingers and my lips, that was it for me...I want to say thank God for this facility right here.

Perspectives on Support Services

The participants described continuous psychosocial support as most crucial to their recovery and well-being. The participants reported using outpatient mental health services and addiction services most frequently²¹. As one participant reported:

Outpatient...they have groups, one-on-one counseling, you can talk to a counselor about your depression. They helped me a lot with my addiction.

They found home visits to be especially helpful, as they appreciated someone checking in with them. Some participants find workshops offered through the program helpful, and they were also grateful to have a hotline to call. As a participant explained:

[About home visits] It's best that somebody come and check on you...They kind of keep you in check too.

²¹Per a personal communication with NYSDOH, these services are not funded by MRT dollars.

Changes Experienced Since Entering the Program

The participants reported a sense of increased autonomy, which they believe provides opportunities to address other life needs and goals. As the participants explained, stable housing allows them to plan for more successful days, and removes worries about making shelter curfews:

If you're in the shelter, you got to get up in the morning and you got to get out. Now, you can plan your day. I'm going to do this, I'm going to exercise, I'm going to the gym, I'm going to do that, take a walk.

You're not stuck to a curfew. You can actually go out and enjoy yourself...If you go out you ain't got to worry about, "Oh, I got to get there, I got to get back."

Similarly, the ability to plan and access to a kitchen allows the participants to follow a healthier diet and lifestyle:

Because of my dialysis I'm on a renal diet. In the shelter you got what they served you, which was not good for me at all. And then to just keep ordering out every day, I don't have the funds to do that. So now I got the refrigerator, I can plan my diet, I can store my food.

Overall, the participants described the most significant change to health and quality of life as a reduction in stress that abounded from receiving stable housing through the program. They noted that this reduction in stress is associated with both mental and physical health improvements:

Your mental health changes because you don't have to deal with a lot of the environment that's around you.

My blood pressure went way down.

I have hypertension and I take medicine every day for high blood pressure but – the stress – you're stress free, basically.

With the reduction in stress associated with placement in stable housing, the participants reported using the hospital less and preventative services more (e.g., primary care visits, visits with a psychiatrist or therapist). As the participants explained:

Having to go to the hospital for certain little things, it's been a whole lot less.

I go to the doctors' right down the street from my house – my psychiatrist, my therapist, and my GP.

Several participants reported that they have been able to strengthen positive relationships in their lives since entering the program. The participants reported that their families are relieved to know they are stably housed through the program. Stable housing has also strengthened positive relationships and reduced relationships that centered around substance use and negative behaviors:

Family feels happier because they knew I was in the shelter system and that worried them a lot. I was always an independent person, no matter what's my condition. They do feel happier and I know that they can sleep better at night.

I live alone but I've got my six daughters and they're proud of me. I don't smoke, I don't drink no more. They're everything I need.

Since I've quit smoking and drinking I've seen who my real friends are. Nobody ever comes visit me besides my son and my daughters, but I'm okay with that.

Several participants reported developing goals related to education and employment. As the participants reported:

I was wondering if there's some kind of program that I could get into after I graduate from this program; what's next for me? This is what I'd like to do. Right now I'm in stage two, after that I get to stage three and I graduate. I would like to know what's next.

I want to go to...ACCESS-VR. They pretty much help place you in the work field. So I'm looking forward to that.

Perspectives on Program Strengths and Weaknesses

The participants reported that one of the greatest strengths of the program is the strong and positive relationships they have with staff. As one participant explained:

The workers here, they're attentive...they stick their necks out for you and try their best to help you.

The participants articulated that funding limitations prevent the program from offering some services that can be helpful. For instance, one participant described a mental health group that had been offered previously, which he found helpful:

(About a previous group) The funding fell through. We were talking about PTSD, I mean we were getting into some real deep stuff. But it fell through. That was one good group because that's how we started to learn each other, know each other²².

Champlain Valley

Administrative and Staff Perspectives

Program Context and Key Program Components

The Champlain Valley program provides supportive housing through scattered-site apartments with rental subsidies. Single individuals with substance abuse disorders are served, and there is a strong focus on facilitating recovery. The program collaborates closely with community partners to identify and target individuals at risk for homelessness for the program. Case management is provided, along with peer recovery coaching and referrals to substance abuse and mental health treatment. The program has served pregnant women who were opioid dependent and often reunifies participants with their families, allowing them to eventually regain custody of children who were placed in foster care.

According to program administrators, most participants come to the program from a mental health unit, jail, or crisis housing setting. Fewer have been discharged directly from an inpatient drug treatment facility. Most participants are actively using substances when they are first housed, and the program adheres to a harm reduction model informed by the Housing First approach.

The program employs a Director, a housing counselor, and recovery coaches. Staff conduct home visits with participants twice a week, and also meet with clients at the office. Staff help participants to move into their apartments and work with them to develop life skills. They also transport clients to medical appointments, as well as Alcoholics or Narcotics Anonymous programs. All staff have gone through training on motivational interviewing, and some are trained in Cognitive-Behavioral Therapy.

Housing is designed to be permanent, though staff noted that only one individual has been with the program since the beginning. Participants typically stay in the program for a minimum of nine months, though the administrators perceive 12-15 months as an ideal length of stay. Clients who move on successfully from the program reunite with their families or start working. Negative or unplanned discharges due to incarceration can occur; in such cases, the program holds the individual's slot in the program for 30 days. The slot is held for 90 days when participants enter substance abuse treatment.

Regional Factors

According to program administrators and staff, there are aspects of the Plattsburgh area that impact program operations. Public transportation is limited, which creates difficulties for participants. Staff described how accessibility

²² Per a personal communication with NYSDOH, these groups were not MRT-SH-funded.

to medical services can be challenging, particularly for dental care, as few dentists in the immediate area accept Medicaid. Additionally, appropriate housing can be difficult to locate in the area. Given the transportation difficulties, it is important to house participants in the city of Plattsburgh to facilitate accessibility to appointments and other supports.

Program staff noted that the program is located in a small community, since all of the apartments tend to be located in the downtown area. Thus, it may be difficult for participants to maintain anonymity, as community members can see staff going in and out of the apartments.

Targeting and Eligibility Determinations

The program targets single individuals struggling with addiction, with past histories of homelessness or housing instability. Though not an eligibility requirement, the program has served a number of pregnant women with opioid use disorders. According to program staff, there is a collaborative effort in place for referrals, with community agencies and DSS frequently referring participants. All individuals seeking shelter must initially go through DSS, so it is a common referral source. DSS checks the Medicaid eligibility required by the program.

Eligibility criteria for the program were determined by OASAS²³. Staff perceive some eligibility criteria to be ineffective, or more detrimental than helpful. The program administrators concurred, noting that it would be helpful if the criteria could be relaxed a bit to allow for earlier intervention. The administrators suggested that it is unfortunate that individuals have to get to an acute point with their addictions and medical needs prior to becoming eligible. They wondered if earlier intervention might result in greater cost savings, due to avoidance of high service utilization. As an administrator reported:

I would like it if the high end Medicaid use could be reduced a little bit. It's unfortunate, from my viewpoint, that they have to get that far – where going from inpatient to inpatient or going from many ER visits. Having the ability to house at an earlier point in their disease, I think could save a lot more money.

Staff members also reported that the requirement of two inpatient stays was not working well, recommending that the requirement should be only one stay:

With the inception of managed care being mandatory, it is difficult sometimes to do the two inpatients. Because you have someone that will go to detox and traditionally, managed care will not allow for an inpatient until you fail at outpatient. So I've got somebody in detox that's homeless that, with this service, would be successful. But I can't send them because they only have one inpatient... And that second inpatient will be inevitable or it'll be an incarceration...Because you send somebody to three, four days of detox and then you send them back to be in a shelter where drugs are rampant.

Additionally, there is a need to house families, as a DSS worker explained:

The funding is for singles, so it needs to be for families. That would be huge...We have individuals that meet criteria but their children haven't been removed, they may be with a preventive unit and they've got supports. And I've got moms with kids in shelter forever because they can't find a place.

The program administrators suggested that close collaboration with community partners has been essential for participant targeting, as well as the successful operation of the program:

Collaboration with a number of our community partners – in order for recovery coaching and the housing counselor to be successful with our clients, we need to interact regularly with a lot of other community supports...the first one was Clinton County Department of Social Services and they play a real critical role in the operation of this program. And they assist us with identifying homeless

²³ OASAS criteria for program entry specify that participants must have experienced five emergency department visits and two inpatient hospitalizations, or four emergency department visits and one inpatient hospitalization.

individuals, or individuals that are at high risk of homelessness, and they also assure for us that the clients have met the criteria for high end Medicaid use...And the other part that was absolutely critical during that process was to really have a good understanding of the Housing First model. So DSS has been a critical collaborator. We've developed strong relationships with Adirondack Health Institute... we refer a number of our clients through AHL for case management services, those that have some significant other medical issues...We've also partnered with NAMI-CV [National Alliance for Mental Health, Champlain Valley] in Plattsburgh. And together we have facilitated additional recovery coach training. We have a strong partnership with our local hospital, and we have attended monthly meetings focused on high users of emergency services. We have formed a really strong relationship with other housing programs in the area. And this has been helpful in a number of ways.

Program Changes and Innovations from MRT-SH Funding

The Champlain Valley program administrators reported using MRT funding to expand recovery coaching programs. Funding has also enabled the program to collaborate more closely with county partners.

Perspectives on Housing: Reflections on Housing First

Program administrators and staff identified aspects of the Housing First model that are advantageous, as well as challenging. According to program staff, stable housing is crucial to participants, as it offers them an opportunity to gain stability in other core areas of life. Staff described how maintaining sobriety is particularly challenging in a shelter; thus, participants are likely to enter the program still using. As a DSS worker described:

I think for us, because I work primarily with the homeless population, the Housing First model is crucial because to expect someone to live in a shelter, or a temporary shelter, and maintain sobriety is extremely difficult. At least if I have stable housing, I have the ability to focus on recovery.

Housing was identified as critical to participants who wish to regain custody of their children, which underscored the importance of low-barrier opportunities for supportive housing. As a staff member described:

There's a percentage of the population that we've placed that's single moms with children in care – in foster care. And that's been crucial because not only are you trying to deal with the recovery, you're dealing with family court, you're dealing with drug court, you're dealing with supervised visitation, sometimes you've got probation or parole involved, you've got all these things. And to add that "I don't know if I'm gonna have a place to put my head tonight and how am I supposed to look for housing?" makes a world of difference.

Staff identified challenges associated with Housing First, such as difficulties promoting recovery from substance abuse. Individuals who enter the program using substances sometimes do not wish to let go of their addiction, which creates difficulties maintaining housing. As a program administrator described:

The disadvantage is they're coming in drunk and high, and quite often years of abuse of a substance, and not wanting to let that go. So that can certainly cause problems with landlords and thus all of the home visits. And we knew [that not evicting due to substance abuse] would be valuable for the home visits but what we're really gratified about is that the clients think that that's the key thing that they appreciated most.

Perspectives on Housing: The Scattered-site Model

Program administrators and staff described the advantages associated with scattered-site housing. First, this model fosters a sense of independence for participants. From a logistical perspective, the administrators noted that apartments are centrally located in an area in which clients can easily access what they need without transportation. Staff further described how multiple units are provided by the same landlord, and the apartments are close to DSS and other community resources. This situation is convenient for participants, and also minimizes travel time for staff.

Staff noted that the key disadvantage of scattered-site housing is that landlords may choose not to partner with the program, due in part to the stigma associated with clients who are in a program for substance abuse. Negotiating with

landlords and building and maintaining these relationships is an important and time-consuming aspect of the work. Staff members noted that participants are encouraged to approach program staff first with issues, so staff can assist with these interactions. Staff described how positive relationships with landlords are important for the participants' success:

If I see something that would either have an impact on his program or one of his clients or something that just doesn't look or feel right, I'll pick up the phone and call him. And conversely, if he sees something going on in the building that I might not be aware of, he'll pick up the phone and call me. And even though it might not be his client, he might give me the heads up if there's an issue or there's some people that maybe shouldn't be there or whatever. So I think it works, from my perspective, because I've got somebody I can talk to if there's a problem.

Perspectives on Housing: Early Adjustment Issues

According to program staff, participants often require a great deal of support when they are initially housed. Participants who were homeless prior to program entry sometimes do not have any belongings, and the program helps to furnish what they need. Staff identified home visits as particularly critical during this time. Participants are aware that they can reach out to staff at any time of day for assistance. As a staff member explained:

Right from the inception: going in, establishing a rapport, a good both paraprofessional and professional relationship with the clients, knowing that they can count on us, knowing that they have our cell phone numbers, and that they can reach us and if they need to call us in the middle of the night – that they do that. And they do do that.

Staff connect participants with needed services for medical and recovery needs. A key goal at an early stage is empowering participants to advocate for themselves and to learn to successfully navigate systems for themselves to ensure that their needs are met.

Overview of Service Delivery

According to the Champlain Valley administrators, the services used by participants most frequently include outpatient clinics, self-help meetings, and workforce programs²⁴. Staff work closely with participants to facilitate their independence and living skills, and also encourage the participants to engage in various outpatient services from which they may benefit. Staff also work with clients to find primary care doctors and to follow through with medical appointments, noting that this practice decreased the need for hospitalizations. As a program administrator explained:

I would say being able to motivate them to participate in outpatient clinic would be key. If we're able to motivate them to attend some self-help meetings is very helpful. And then that whole area of employability and voc-ed; if we're able to help them get there and really work towards that independence, we have seen some wonderful rapid changes in individuals. Over time that esteem and believing that they can do it, because they are at that point.

The program administrators described the importance of harm reduction with the population served, noting that partnerships with community organizations are of particular import:

That's why we work with Alliance for Positive Health in terms of NARCAN, needle exchange. We certainly do a lot of motivational interviewing with our folks and attempt to get them involved and engaged and attending outpatient.

The administrators further suggested that home visits are critical, noting that recovery coaches are especially impactful, given their lived experience with addiction:

[Recovery coaches] have the ability to sit with our clients as somebody who had walked in their shoes and provide support, motivation, encouragement, and I think probably offer a tremendous amount of hope.

²⁴ Per a personal communication with NYSDOH, these services may not be MRT-SH-funded.

A recovery coach agreed with the concept that individuals in recovery themselves can be particularly effective:

I'm in recovery myself so I have no problem disclosing that. And that's part of being a recovery coach. I started off as a recovery coach and that's powerful in itself. Because when they see it...they know it's not empty hollow words. They know that they've [the recovery coaches] been there, they've lived it, and now look at them. And so that's possible for me too.

Reducing Medicaid Costs

The Champlain Valley program directly emphasizes reducing Medicaid costs. To meet this goal, the program links participants to a primary care provider and promotes the importance of primary care. As the administrators described:

We work diligently to get everybody hooked up with a primary care physician...we've established some good relationships with a few doctors in town that will work with our population.

It's also educating the client that a doctor, a primary care physician, will get to know you. And if you go to the emergency room they're just fixing the problem, they're not getting to know you.

To facilitate appropriate medical care, the administrators described how staff work closely with participants to educate them about medication management. They also provide the participants with daily planners, so they can record and remember their medical appointments. When participants are in crisis, staff visit them more regularly to prevent unnecessary hospitalizations.

The program works with two Health Homes, which are separate programs with separate funding sources. After participants sign a release, the program can connect with the Health Home, and shared meetings are held with care managers. The Health Home helps participants with medical transportation. The administrators suggested that these relationships are working well, describing a recent example of the close collaboration:

We had one woman who had major medical health issues, very long standing heroin addiction and mental health issues. And we got her hooked up with care management because of significant Hep C, and the insurance at that time was refusing to pay for the treatment. We worked closely with the care manager and that care manager was so excellent, when that woman celebrated a year of sobriety at AA, locally, the care manager went to her celebration. So we've had really good experiences with the care managers that we work with.

Perceptions on Participants' Progress

Both administrators and staff agreed that women who had lost custody of their children are benefitting most from the program. Many have returned to work and have reunified with their children. Staff also perceive that the program has had the greatest success with opioid addicts.

According to the Champlain Valley staff, some participants struggle initially within the program, as they may have never experienced stable housing before. The staff indicated that there is a need to work very closely with participants at an early stage, in order to get necessary support services in place. According to staff, clients who struggle most in the program are those with severe alcohol dependency, as they are often in a late stage of the disease and tend to be older. The staff also noted that individuals with Hepatitis C are also hard to serve, as they tend to be more difficult to reach and struggle most to sustain recovery.

The program has led to both successful and unsuccessful exits. According to staff, some individuals complete the program and go on to live independently or with family. Individuals who exit successfully may go back to school or re-enter the workforce, and continue to stay in recovery. Other participants who struggle in the program require a higher level of care, and may return to a setting such as a halfway house. Staff described how a few participants have returned to prison. When participants choose to leave the program, staff try to work with them to identify a positive and safe environment, and encourage them to stay away from old environments that were not helpful to them in the past. Staff work with participants for an extended period when possible to facilitate a positive discharge process:

I think overall, the people that we've suggested they leave, we've worked with them hard for at least

90 days before that happens. And I mean hard. We'll turn ourselves inside out to help them engage and to become successful. But it's at least a three-month period.

Program Strengths, Weaknesses, and Future Directions

Program staff identified close collaboration with community partners and the work performed by their recovery coaches as significant strengths of the program. They attribute success to consistent home visits and to the Housing First approach used by the program. The program provides a significant amount of supervision, which holds staff accountable and provides opportunities for them to improve their work. They reported being particularly proud of their work with families.

The administrators underscored the importance of housing for recovery, particularly for those who had experienced homelessness. They also described their surprise at serving pregnant women, noting the impact it makes on their lives:

We'll start right off with having a safe place to live. Having an address, for someone who has been either couch surfing or moving from one crisis housing spot to another – we've had a couple of folks who had been living underneath a bridge in the city of Plattsburgh – what a huge thing that is for our clients, to not only have a nice apartment, but to have their own address. That's just been key to helping the relationship and to help them move forward.

Certainly, when I wrote this proposal, I never thought that we would have a lot of babies; I didn't even think about that at the time. But I've got to tell you from my perspective, my chair, that's been so rewarding to watch these young women who are pregnant, to watch them to get clean, to watch them get free of opiates, to assist getting them into outpatient and to prenatal visits and then deliver healthy babies and all of those babies go back to the apartment with them; I can't even begin to describe how good that is, that these babies aren't dealing with withdrawal.

In terms of future directions, the staff noted that they would like to have the ability to serve more clients, with some housing designated for families. They also wished for funding for transportation. They would also like to intervene with participants in need more proactively, and suggested changing the eligibility criteria to allow for this (e.g., changing the required number of ED or inpatient visits). Staff also articulated that if funding allowed for follow-up with participants for about six months post-discharge, it would be critical for preventing relapses. As a staff member described:

If we were able to track them for say six months during that really vulnerable period – where it's easy enough to go backwards without the ongoing support and commitment to helping them.

When reflecting on the future of the program, the administrators described the work that has been accomplished with pregnant women who have entered the program. They would like to see the program expand to be able to continue serving new families:

In the past few years, we have had numerous women come into our program that were pregnant when they came to us and they have – I can say all of them have – delivered healthy babies in the MRT program. But the MRT program is set up for singles...certainly one of my recommendations would be that we have the ability to add multiple bedroom units to the MRT program so that we could continue to work with these women and their children when they absolutely do need it the most.

In terms of feedback to the State agencies, the staff at Champlain Valley were grateful for the unique opportunity to serve individuals with substance use disorder and mental health issues, and would like to continue to expand supportive housing. They also identified aspects about housing that are challenging. Particularly, the program carries a lease and sublets to clients; thus, when the unit is empty, the program still has to pay for it and has to cover damage to the units. Staff also noted that rent has continued to rise in the area, but the grant has not increased funding to cover this increase. The staff also articulated that cost savings may be in excess of what is saved in Medicaid dollars:

When you're looking at the money that the state, the county, the community's contributing; when you're looking at how much it costs to be in temporary shelter, how much it costs for transportation, how much it costs to have kids in foster care, how much it costs – the overall dollar figure of what's being saved is so much more than just that medical component of the ER visits.

Additionally, the administrators suggested that they would like to be able to provide multi-bedroom units, which would allow mothers to stay with their children in the program. They also noted that obtaining additional units would allow the program to reduce its waitlist:

I'm not looking for more money, just enough to have some additional units to reduce waitlists and some funding to help move our moms from a single one bedroom and stay in the program longer, they can use the support. And be able to reunify those kids in an appropriate manner back with mom. But I'm not saying throw money at, because that's not it, but if there were dollars that were available to increase the number of units, reduce the waitlist, and to add service in terms of...parents, reunify with their children who are in foster care or when they're bringing them home from the hospital because they just had a baby.

Participant Perspectives

Housing Status and Lived Experience Prior to MRT-SH Enrollment

Participants of Champlain Valley described significant periods of housing instability prior to program enrollment, in which they cycled between homelessness, rehab, halfway houses, motels, or incarceration. The participants described how such settings and the lack of stability exacerbated problems with substance abuse:

I've been struggling with addiction for a long time and it led up to legal [issues] which led up to my need for rehab, and from rehab I went to a halfway house. And I was in that halfway house for six months, completed there. And from the halfway house I went bed to bed into the program.

I was living in one of the motels, the homeless shelter-type motels. Not a good place to be – a lot of things that can really challenge my recovery. And prior to that I've been in jail a few times and in multiple rehabs, admitted to the hospital many times for health-related reasons.

Most participants reported a relatively seamless process to gain entry into the program, with staff providing helpful assistance throughout the process. Most participants were referred by another provider, such as a halfway house or the hospital. Others reported using the same program for outpatient services, and being referred for housing this way. The participants met with program staff and completed an interview and paperwork. Some had to wait a few weeks to receive housing. As the participants reported:

I was referred when I was in the halfway house but I did already know about the program from receiving outpatient prior to going to the halfway house.

I had a one-on-one meeting with them, and they explained the program to me and I quickly jumped on it...social services sticks you in these hotels and stuff around here and it's just not a good situation, to be in those hotels. So I was like, 'I'm definitely gonna take it and see where it goes.' And they were very forthcoming, they were polite and explained the program right into depth and I knew that's pretty much what I needed.

Perspectives Regarding MRT-SH Housing Accommodations

Overall, the participants described their current housing accommodations in quite positive terms, and noted that housing has been helpful to their recovery. The accommodations were described as clean, located in nice buildings, fully furnished, quiet, relaxing, and in convenient locations. A couple of participants were able to select an apartment; others accepted the first apartment offered, given difficulties securing apartments. As the participants reported:

It's really quiet, clean, an environment where I can recover; it's designed perfectly so that I can recover from my addictions.

Mine [housing] is nice. I was expecting a lot less I think, but when I went it there I had everything: furniture, dishes, shampoo even.

It was very inviting. It wasn't like, 'I'm scared, I'm going into a situation where I have nothing.' I've been there before, that's not too encouraging.

One participant described moving into the program while pregnant. She found staff to be accommodating and helpful, and she was able to live with her children without losing her housing:

I actually was pregnant at the halfway house and when I came home I was pregnant...I am on a waiting list for another housing program but they definitely accommodated the fact of having my new baby, and I actually obtained custody of my 10-year-old as well. So they moved me, I believe, into one of the only two-bedrooms that they have in the program so I could have my children and not leave them or my housing.

The participants reported receiving assistance from staff when they first moved in and during the transition process. One participant described the move-in kit provided by program staff:

They give you not what you want, what you need. And that's important. That's a big thing with moving into a place. Then you move in and you're settled but you don't have – I mean right down to dishes, toilet paper...There was very minimal stuff that I needed to get for the house. Which helped out in that I could get other things that I needed.

While the participants found staff and their landlords helpful and supportive, some noted that living independently can be lonely.

When asked where they might be residing had they not received housing through the program, the participants reported that they would likely have experienced continued housing instability, which would have compromised their health. Several noted that they would have continued cycling between homelessness, motels, and the streets; others believed that their substance abuse would have continued or worsened and that their health would have also declined, while others thought that they might have died. As the participants stated:

I did relapse, I did use, I did cave in, and I had legal repercussions. So in the long run, technically I could be in prison. And I have a lot of medical issues so using is scary. I mean for anybody, but because of my medical issues it's bad.

I'd be doing the same thing that I was doing before – out in the streets, running around place to place trying to find somewhere to stay for the night. This is really good for my recovery.

For participants who are parents, some believed that further housing instability would have made maintaining or regaining custody of their children impossible:

I wouldn't have custody of him [her baby], I'm sure of it. Because in order to have your children you have to have stable housing. And I wouldn't have had that. So I would have lost him when I gave birth to him if I didn't have stable housing to bring him home to.

Perspectives on Housing First

The participants described the harm reduction approach used by the program, which is consistent with the Housing First approach. The participants described how housing is critical to fostering recovery.

I never lived on my own and I was the type of person that – I didn't want to give up things, the people I hung out with. So when I first got into the program I kind of screwed up royally and they were there for me to keep pushing me to do what I needed to do. After the first time I relapsed but then when they told me I'm going to lose everything – my apartment, everything – and they just kept pushing me to do the right thing, I have been sober ever since.

They also described the helpful role staff play in encouraging recovery:

There's steps these guys have in place. Say if I was to go home and use today and call my recovery

coach and ask for support, he would be there and I would have to, if I wanted to stop using, I'd take their direction – go to the hospital, detox, whatever it was. It would minimize the impact of a lot of different things.

They're not being invasive. They're there to make sure that we're all alright and we're not having thoughts of our use again. And if we do have thoughts of it, they want us to call them and they'll talk to us and make sure that we're in a good place.

Perspectives Regarding MRT-SH Support Services

Of the services offered by the Champlain Valley program, the participants reported that staff support and home visits are the most helpful and essential. When describing the importance of home visits, the participants explained:

I was in a good situation, in a good mindset leaving the halfway house. But when I got to the apartment program, there were some challenges in my recovery that I couldn't have foreseen being on my own and not being in an institution anymore. And I found the staff to be very open and understanding and experienced, they've been through this stuff and they really understood what I was going through. And that was very helpful to me.

[What is helpful is] just them being there. You know what I mean? Just having that resource. And if it's something they can't handle, if it's something they can't do, then they can point you in the correct direction.

The participants noted that assistance with transportation, such as receiving bus passes or medical transportation, would be helpful. A few participants also described how housing with multiple rooms to accommodate children would be helpful:

Eventually I plan on having unsupervised visits, overnights, stuff like that. And I'm hoping that that'll be okay eventually with the program. But if it goes to that – I can move to a place and have my kids there and still be in the program while they help me, even if it's a transitional period while they help me get into something else – that would be amazing, such a weight off my shoulders.

Changes Experienced Since Entering the Program

The participants reported that their housing is stable, which allows them to build structure into their days. They contrasted this structure with the lack of structure associated with homelessness, as well as the excessive monitoring that is associated with halfway houses. They viewed independent housing as important to recovery:

Striving to survive to getting back on my feet to living in a halfway house, chaotic, to – took me two weeks to a month to readjust – to quiet, supportive living. Days changed 150%. I can recover now. I have the time, it's quiet, it's changed to where I can recover.

It helped me a lot with structure, structuring my days. Assimilating back into an everyday, normal life type scenario from a halfway house scenario – where everything is so regimented and controlled, you're told what to do – which is the common path for somebody today that is taking recovery seriously. That really helped me to learn real life behaviors, hour to hour, every day.

The participants described improved physical and mental health, which they attribute to housing. The stability of housing allows them to attend to their mental health and to address addictions. The participants described how reduced stress allows them to pivot toward addressing other health issues. Some participants have been able to develop exercise regimens. As one participant explained:

Exercise, for me – it's been since day one. It's mind, body, soul. I've been able to do that, each and every day, and to recover from the disease of addiction and how I feel about myself.

The Champlain Valley participants described improved access and use of primary care services since their enrollment in the program. This shift coincided with fewer emergency department visits and hospitalizations. The participants attributed this change to stable housing, as well as to living in areas with more accessibility to primary care providers.

As one participant explained:

I'm right around the corner from my doctor's office. So it's a lot easier for me to make appointments, not having to worry about this spotty transportation through Medicaid which, in turn, also causes the insurance companies and the state more money. No matter how cold it is, I'm literally a five minute walk.

Several participants described improved family relationships. Participants described better relationships with parents and siblings, and several noted that they can work toward regaining custody of their children, now that they are stably housed and working toward recovery. As one participant reported:

I was always a problem child and I never really had a relationship with my mother. We always butted heads. And now we go out for Sunday breakfasts and we go grocery shopping together, and it's just a whole different atmosphere now. I've always wanted to bond with my mother and now I have it and it just feels great.

The participants also reported that they endeavor to establish and cultivate more positive relationships in the future. For one participant, improved relationships will come from continuing to work on himself and his recovery:

Started with me first – I have the ability to understand who I am, fully and completely. Past relationships with women, I've had the opportunity to go back in time and disconnect emotional attachments I've had to them, to where I could have...wonderful relationships come in the future, instead of dragging the past into the present to destroy the future of relationships.

The participants described how stable housing through the program has enabled them to focus on life goals. Some described intentions to return to school or become a counselor. Others are focused on maintaining recovery or regaining custody of children. As the participants reported:

I have goals. I have objectives. I have thoughts that are in creation to build my life, not sit there and sit in a rut saying, "Poor me." I could see the future – beautiful. And I can manifest it. It can be done. Before I didn't have that, I didn't have the opportunity.

That was a huge goal for me – was to get out of that scene. This is my own space. This is where I know I'm safe, where I know that I'm not gonna have these things around me that might jeopardize my recovery, therefore my life, therefore my kids. So it really helps with my goals. Now my goals are pretty much my kids and my recovery, that's really all I have going right now.

Perspectives on Program Strengths and Weaknesses

When reflecting on program strengths, the participants articulated that strong relationships with staff make a key difference in their lives and recovery. As the participants reported:

Being in this program, it does help with recovery. If I had a problem, I know I could call these guys. I have cell phone numbers. I know that that would be okay.

There's no judgment at all. They have all been through what we've been through.

The program itself is good but I think it has a lot to do with people that run the program. A program by itself might be a good program but that people that run it, if they're not as good as the program, then that program can't stand by itself. So I think it has a lot to do with the people.

In terms of program weaknesses, the participants noted a need for more housing units to consider. They would prefer larger apartments and apartments with more bedrooms to accommodate relationships and children. The participants also articulated that more funding would allow the program to help more people like themselves. One participant articulated that more supportive housing can allow more individuals with addictions to offset their use of emergency departments:

More buildings like that. Especially because the cost of raising a building like that is so much cheaper than if I went to the ER five times. I haven't gone into the ER at all.

OFFICE OF MENTAL HEALTH: CRISIS/STEP DOWN

St. Joseph's Medical Center

Administrative Perspectives

Program Context and Key Program Components

The St. Joseph's Medical Center program offers respite to individuals experiencing a mental health crisis, with the goal of reducing hospital admissions for mental health issues. The program is designed to divert participants from the hospital, and act as a step-down for individuals who were in the hospital, prior to their return to the community. The program provides a short-term respite setting to participants, which is designed to be comfortable and relaxing. During the stay, participants are provided with informational resources. Participants go through a check-in/check-out process in which they are asked about goals, plans, and options for managing crisis situations. All participants are required to have stable housing resources to return to post-discharge.

The crisis program employs three peer specialists and a program supervisor, but non-crisis program staff will also assist crisis program staff and participants as needed. In addition to managing administrative work, including paperwork and reporting vacancy updates, the Program Supervisor conducts outreach, intakes, and screening for the program. The Peer Specialist has more direct contact with clients in group sessions, Wellness Recovery Action Plan reviews, and more casual interactions. Despite these separate roles, all staff are cross-trained, enabling them to execute tasks that are outside of their positions.

The maximum stay in the program is three weeks, though participants may stay an extra day or two, as needed. Most participants return to a prior residence, which for some may be a community residence or housing program. According to the program manager, a successful outcome for client occurs when the client does not return to the program. Staff complete follow-up contacts with participants twenty-four hours after admission, and then again fifteen and thirty days post-discharge.

Regional Factors

The program is located in Staten Island, New York. According to program staff, the location is convenient for those living on Staten Island, though the program occasionally serves individuals from other boroughs as well. As a staff member explained:

Well for us, we're the only ones on Staten Island so it's more convenient for the Staten Islanders. However, we have received referrals from other boroughs as well. Some people just want to get out... and I guess break from where they actually are. Although a lot of people, in talking to folks, they don't want to leave the island, they don't want to have to travel across the ferry. The folks who may stay in New York City where there are more respites and as well as Brooklyn - they feel more comfortable coming to a borough where they live.

According to program staff, being the lone program of its kind on Staten Island can be challenging at periods when demand is high:

Right now we're the only ones here on Staten Island so it affects it pretty greatly. A lot of folks don't

want to go off the Island and go across the water to Manhattan or to Brooklyn to receive services. So it definitely has impact... There are ups and downs. There are cycles where we could be really busy, then there are cycles where it slows down. And you want to service everyone, so when that cycle is busy and the beds we have – all three beds – are filled and people are calling for a need, it can be challenging for the individual because you want to try to get them services or support as quickly as possible, especially if they are in a crisis.

Targeting and Eligibility Determinations

According to the administrators, the St. Joseph's program targets veterans and other single individuals with serious mental illness. Participant targeting heavily involves outreach to a number of sources, including former clients and health care facilities. Eligibility criteria include Medicaid status, enrollment in Health Home care coordination, HARP status, and high Medicaid service utilization, which is flagged through DSRIP²⁵. As the program manager explained:

The criteria were established with combination of meetings with senior management, myself, and the VP of residential and behavioral health. And we also looked into the criteria and the guidelines as well, that was established by OMH...We are a non-medical crisis enriched program so because of that we wanted to make sure that the individual that's coming in is psychiatrically stable, but they are presenting with, let's say, a psychosocial crisis happening in their living environment, for example. And if we try to remove them from that trigger it's going to address their crisis so that way they can be able to return back without further stress on their overall health. So that way they don't end up in the psych inpatient...That's why when we developed the environment of their stay, we wanted to make sure that it meets the theme of serene, home-like environment, peaceful.

Once staff have received a referral from a treatment provider or from a potential client, they conduct a screening of the individual to determine eligibility, request a referral form, and discuss the program in greater depth with the individual to ensure they want to enter the program. The crisis program receives most of its referrals from treatment providers but also receives some self-referrals. Program administrators noted that the program receives many inappropriate referrals, in that individuals referred do not have a stable housing resource in place to return to post-discharge.

According to program staff, outreach is a key component of their work. As a staff member described:

I spend a lot of time doing the outreach. The peers do assist with that as well during their downtime, sending out faxes or reaching out to other peers, following up with former guests and letting them know and spreading the word. And like I said before, the new protocol that they have for both the city and the state where we do daily call ins, or daily updates, which we do twice a day, and that helps...it made a pretty big impact in the outreach. We started to get way more calls than before. And I would reach out to the hospitals, inpatient, local inpatient, even the care coordination programs – care Health Home agencies that are out there – we've been getting a lot of referrals. And even the housing program. Just reaching back to those who sent referrals before and just reminding folks that we're still here and just utilizing all the resources in regard to outreach.

Staff highlighted one problem they have experienced in recruiting participants, which involves "respite hoppers" who go from program to program for shelter rather than for help with an emotional crisis, or those wishing to use the program as a "holding spot":

The only issues or problems that we tend to see are disposition issues where individuals may be respite hopping, what we call it, when they don't have stable housing in place so they would go from program to program or different respite programs. Or treaters not really understanding that we're not a "holding spot" for an individual because they don't have a housing option right now. Because the question we always ask is, 'What is the emotional crisis? What is the crisis need?'...So we're just a temporary stay.

Another challenge, according to the program managers, is that this setting is not equipped with on-site medical staff.

²⁵ While these criteria differ from those written in the relevant RFP, they reflect what was shared during the interviews.

Thus, it is difficult to address the acute medical needs some participants are experiencing when in the program.

Program Changes and Innovations from MRT-SH Funding

MRT funding established this crisis enriched program, which was not in existence before. The pre-existing building that consisted of twenty-four community residence beds was renovated to allocate three of those beds to the crisis program. Staff emphasized how the housing environment is set up to be healing for participants:

When we open up the room to give the guest a tour it's like, "Wow," that's the first reaction out of everyone, "This is really nice." And I remind them that this is what it is; it's to have that relaxation, home-like setting, and to feel comfortable and to be able to open up when they're meeting with staff, or to take away that fear or anxiety that comes with coming into a new environment.

Program staff explained that providing a calm setting with supportive staff can give participants time and space to reflect on the psychosocial crises they are experiencing. The program manager provided the following example:

To give an example, one particular guest was having issues with her family and she didn't understand – she thought that her family was trying to poison her. But then after talking with her, going over the WRAP (Wellness Recovery Action Plan) plan, she realized that, oh maybe there's something that I'm not doing right, my family isn't trying to hurt me, they really do care for me. So just having that "lights on" moment, that "Aha!" moment is a really good point, or one of the good things that happens here at Crisis.

Placing Participants into Housing

Staff are actively involved throughout the program entry process, ensuring that clients are able to acclimate to the new environment and can seek out staff if needed. Initial challenges for clients upon entering the program vary, and may involve unwillingness to be open or adjusting to a new routine. Staff noted that they strive to keep clients engaged and will find ways to be most useful to clients. In light of this, staff highlighted initial engagement, peer support, and providing resources and information as some of the most important services when clients first enter the program. Staff described how proper support and structure for clients is critical so community residents in the shared space are not impacted.

When clients exit the program, the majority return to their place of residence. However, some may leave to an alternative setting, including a community residence or apartment treatment program. Upon discharge, staff meet with the client to review progress and to develop plans for next steps. These conversations are designed to help the participant to successfully transition to the community, but also provide helpful feedback to the program regarding whether it is meeting the goal of diverting individuals from the hospital. As the program managers explained:

We ask that question – without coming here, would you have gone to the hospital? Is this a prevention or is this a crisis? So we kind of ask those questions at the very beginning to see if this is something that they use us as an alternative rather than going to the hospital.

We have a discharge, we call it the "check-out"...We sit down with them and just pretty much go over their time spent here and what their plans are, if they're following up with their medical appointments, following up with a peer advocacy program that was referred to, or just even following up with the original goals that they came in with...We let them know we're going to contact them over the next time period – the 24, 15, and the 30 day – just to see how they're doing.

Overview of Service Delivery

According to program administrators, since participants are welcomed into a more home-like space than a hospital, they tend to be more willing to open up to staff to discuss problems and how to work through them. Staff noted that needs vary with each participant, as do challenges. They work to address each person's needs and to be as responsive as possible:

It varies, sometimes it can be that they're guarded and not open to disclose. So it depends and so

we have to approach it differently and find ways to...really help this individual rather than just coming here and just using the space, just taking up a bed, pretty much. How can we be of help to that individual? And just going around and thinking outside the box to find ways to engage them.

Program participants utilize peer support services while in the program. The focus is often on skill building and the development of coping strategies. Program staff also teach participants how to stay on track with recovery. Staff members described the services provided as follows:

Coping skills – while they're here, that's from day one. Just showing them how to tap into their own skills, and talking about medication and either a better understanding of medication, where they are with that, how to deal with a crisis and working on their strengths and building on those strengths. A lot of wellness self-management...How to have healthy fun, how to have healthy clean fun, learning how to be happy in the moment, and being able to actually sit back and smile. It's kind of hard to pin point because there's so many different things that fall under support services. Because it's just learning – we're helping them to learn how to deal with crisis...whether it's with a family member that's aging out and that individual needs to become more independent and move out on their own and they don't quite understand that, to the individuals that are just having trouble with their family or their providers. Just learning how to communicate.

I just want to give an example: One individual, this individual actually had some medical issues and he was dealing with some housing issues. And it got to the point where he felt as though he wanted to relapse. And he told himself he wasn't going to do it and he made it all the way back to the unit – to the crisis – and spoke for almost two hours with one of the staff. And he said if it wasn't for coming back here and being able to talk with the staff, he knew he would have relapsed and started drinking again. So little things like that means that those types of support services that have just even a listening ear, means a lot.

Staff viewed the initial engagement with participants as especially critical, and also noted how peer support (staff with lived experience) is especially helpful for engagement and trust. Staff also connect participants to peer advocacy activities for continued support once they leave the program:

[We provide] resources of what is available within the peer advocacy groups. Does the person have a socialization issue? Giving them [?] information of the peer to peer group that meets three times a week throughout the month. Letting the individual know they have options and they have supports, just need to tap into them.

Reducing Medicaid Costs

Staff noted that there is constant communication between program staff and care coordinators. Staff collaborate with the Health Homes to identify participant needs and determine who is able to assist with what. Other than reducing hospitalization, staff did not outline an explicit goal to reduce Medicaid costs, although they acknowledged how decreasing hospital stays impacts Medicaid expenditures.

Program Strengths, Weaknesses, and Future Directions

To reap the benefits of being in the program, staff noted that clients need to be open and willing to receive the help they need or want. After completing the program, some clients have expressed interest in obtaining a peer position or volunteering for groups. Not only does this reflect their increased confidence, but it also demonstrates their desire to give back what they received through the program. Staff identified their dedication to building trust with clients, as well as emphasizing positive thinking, as some of the greatest strengths of the program. In doing so, staff are able to create a safe space for clients that promotes hope and support.

Staff highlighted peer support and honesty between clients and staff as the most important supports to achieving positive outcomes. Additionally, various means of education are offered to aid in improving clients' health, including individual sessions, groups, and informational pamphlets. Staff identified coping skills as critical to achieving positive outcomes.

The staff reported struggling with recruiting and retaining team members, and is in the process of examining and addressing the barriers that contribute to this challenge. An additional area that necessitates improvement, according to staff, is developing a streamlined method of identifying individuals who are “respite hopping,” including guidance on how to address such cases. Staff further identified the size of the program as a challenge, as it only has three slots. Additionally, program staff indicated that the program is challenged by individuals experiencing certain chronic conditions, such as diabetes and hypertension. The crisis program continues to educate them about their conditions, and staff noted that continued emphasis on health education is important to the population served.

The program managers indicated that it would be helpful if the State can increase supportive outreach, so providers can meet to share their practice and experiences. For instance, it would be helpful to consult with other programs about how to identify individuals who are “respite hopping,” and how to best manage this. Training on pertinent issues and feedback regarding areas for improvement would be welcomed by program staff. They further indicated that more beds are needed, as they sometimes do not have a vacancy for eligible individuals.

OFFICE OF MENTAL HEALTH: RENTAL SUBSIDIES STATEWIDE

Unity House

Administrative and Staff Perspectives

Program Context and Key Program Components

The Unity House program targets individuals with mental illness who have housing needs. A subsidy for scattered-site housing is provided, in addition to case management services. Participants are assisted with daily activities and are connected to supports and resources in the community. The majority of the MRT program participants come from the agency's apartment treatment program. The program manager described a backfill process, noting that when there is an opening in the program, an individual moves from a state psychiatric facility into a community residence; then someone moves from a community residence into an apartment treatment program. Finally, a participant moves from an apartment treatment program into the MRT program.

As program staff explained, participants typically stay with the agency for life and are able to build close relationships with staff. Key goals of the program include long-term housing stability, as well as client-specific goals. Client-specific goals often entail engaging and integrating into the community, paying rent and bills on time, and re-engaging with mental health treatment. The program manager described client-specific goals more specifically:

For some folks it could be getting out of the house more, paying their bills on time for other folks. It could be re-engaging with mental health treatment. It's really very diverse and client-centered. Some of our folks are very high functioning, pay their bills on their own, navigate public transportation on their own. And some of our folks don't even know how to take a bus. It's very client specific.

The program employs case managers, who oversee day to day activities, attend appointments with participants as needed, and facilitate referrals. Unity House also has a Health Home program on-site, which is a separate program with separate funding sources. As the program manager indicated:

My staff may help [the participants] at DSS, they may help them recertify their Medicaid or their food stamps, help them at Social Security, take them grocery shopping when their food stamps come in, help with food pantries if they have a need, hook them up with other socialization activities. We do some clinical or med review appointments but our caseloads are too high to go to all of them. But if there's something, if there's a change in their meds and they need extra support or if they're decompensating and they want our support or we want to be up there with them we'll go to their clinical appointments. If they have a health concern that's not a routine primary checkup we'll go to the doctor with them. But that more falls on their Health Home worker.

Regional Factors

Housing affordability is a key challenge in Troy, where the program is located, according to program staff. Finding one-bedroom apartments at fair market rent for clients, the majority of whom are single, has been a challenge. Program staff try to locate apartments that are close to a bus line to facilitate easy access to transportation to the participants. Program staff perceived that landlords favor renting to college students over program participants. As the program manager explained:

There's a lot of colleges in this area so a lot of the one-bedroom apartments are taken up by students. And with the landlords knowing that that's an option, they're not as willing to lower their rent to a fair market rent value or to tolerate the inspections or the code standards that we have for our clients.

Targeting and Eligibility Determinations

The target population for the program is individuals with a serious mental illness who are homeless or unstably housed. While the program serves some families, the majority of clients are single. The criteria for the program were specified in the grant. Program staff utilize the PSYKES system to look up Medicaid claims for potential enrollees. They noted that SPOA (Single Point of Access) prioritizes participants based on high-cost Medicaid service utilization.

According to the program manager, staff engage well with potential clients. The program is well known in the county, as the agency offers a number of services. The program receives steady referrals, so outreach activities are typically unnecessary. The program manager noted that there is more need than slots available in the program; need also trumps available housing within the catchment area:

The biggest challenge is that there's more need than what we have beds for. So typically when I get an opening, one opening, I have at least five to 10 people applying for it.

Program Changes and Innovations from MRT-SH Funding

The primary use of MRT funding was housing and case management. The MRT-SH funding has also been used by Unity House to provide additional supports to participants, including medication monitoring, transportation (e.g., bus passes), household supplies, and furniture. The program received a separate grant from OMH to support MRT clients who were discharged from state psychiatric facilities.

Placing Participants into Housing

According to program staff, SPOA prioritizes clients who have the highest needs for intake. Once enrolled, participants are connected with case managers and begin looking for an apartment. Those who are already housed complete paperwork to access a rent subsidy. While filling an MRT slot happens quickly, it can take one to two months to find a suitable apartment in the area. Finding an apartment is typically a joint effort between the case managers and clients:

It kind of depends on the client. If they're pretty independent and already know what they want and they know where to look, sometimes they bring us apartments and we'll call the landlord and set up a visit. But most of the time it's pretty 50/50 – clients are out and about in the neighborhoods, they call us, we'll look on Craigslist, we'll talk to our Housing Coordinator.

Housing is permanent, with the tenant's name on the lease. According to the program manager, Unity House provides services to the participant for as long as they require them, but the ultimate goal is to get them on Section 8 or another subsidy. There is little turnover in the program. In general, some clients move in with family as their medical needs increase; the program manager noted that one client in the program has been incarcerated. When clients leave the program, staff work with them on next steps:

We'll always talk to the landlord if someone's leaving the program and make sure they have what they need before we discharge them...We don't really just discharge people ever so even if they're moving to a different county or out of state we try to make sure services are set up for them.

Perspectives on Housing: Reflections on Housing First

Staff noted that the Housing First model promotes trust and honesty between clients and staff, in addition to the benefits to participants that come with the stability the model offers. According to the program manager, housing stability allows participants to focus on their medical needs. Some are able to go back to school, work, and re-engage with mental health treatment. She perceives that participants are more honest with staff about their needs, since they will not be penalized for substance use:

We also find that by practicing this model, folks are a lot more honest with us about some of the choices that they may be making or some mistakes they've made along the way because they're not penalized for those choices. So we don't discharge if people don't take their meds or if they relapse. So we find it builds trust. People always come back to us after, say they end up getting unfortunately incarcerated or leaving the area, they tend to return because they know this is a safe spot for them to receive services and that we'll help them no matter what's going on.

While the program manager described many benefits of the harm reduction approach associated with Housing First, she noted complexities associated with it:

I think it's that fine line between supporting someone and enabling them. I think we find that a hard line to walk. We do a lot of team meetings and support around that. And allowing folks to feel the natural consequences – we can't always bail folks out when there's certain choices made. But we can still provide non-judgmental, client-centered services.

Perspectives on Housing: The Scattered-site Model

Program staff identified a number of advantages to scattered-site housing. Scattered-site housing upholds participants' choice in housing location, enabling them to live near their service providers and/or family. Neighborhood selection can also allow participants to reside close to the doctors and medical services that they require. In some cases, participants are able to select neighborhood where they feel safe and less likely to relapse:

If they feel safer in a certain area due to relapse issues – maybe there's a neighborhood they used to use in – we can put them in a more rural area of Rensselaer County if being in downtown Troy doesn't make them feel safe.

The program staff also indicated that negotiating relationships with landlords is a difficult aspect of scattered-site housing, particularly if participants damage the apartments. As the program manager explained:

Landlords get mad at us a lot. Some of our folks don't always leave the apartment in the best shape. So it does burn some bridges with landlords because the lease is in the client's name, not Unity House's name.

Overview of Service Delivery

According to the program manager, advocacy (e.g., negotiating medical care, working with landlords) and crisis intervention are the most critical services for the participants. Additionally, participants frequently use living skills trainings provided by the program. As the program manager described:

I would say advocacy because most of the folks have been really marginalized by the system and don't possess those skills or the confidence to do that on their own.

Advocacy and life skills training were identified by program staff as frequently used support services, and advocacy and crisis intervention as those most critical to achieving positive outcomes. These services teach participants important skills to maintain their independence and well-being. Additionally, participant feedback has indicated that clients are appreciative of the non-judgmental environment of the program and supports offered.

Health Homes care coordination was also described by program staff as important to the well-being of the clients. The Health Home is located on the premises of the program, so case conferencing happens constantly. Case managers and Health Home care managers discuss participants' medical appointments, overall service needs, crises, and addiction issues. Case conferencing happens more formally if there is an emergency with a client. The program staff described this relationship as helpful, in that they are able to problem solve and share resources to the benefit of the clients.

Reducing Medicaid Costs

Reducing Medicaid costs is a key goal of the program. To approach this goal, staff at Unity House provide education about preventative care, advocate harm reduction approaches, and provide a hotline for when the office isn't open.

The Health Home generally takes the lead on providing education on preventative care to clients, but MRT staff also assist in this area and teach participants alternatives to the high cost services they would typically utilize. As the program manager described:

We do a lot of education around preventive care. The Health Home takes the lead with that, but the housing case managers certainly reinforce that. And if the Health Home care manager can't attend an appointment and it's a routine physical or urgent care visit or specialty visit and the client needs support around that, we will help with transportation to the best of our ability to make sure they get to that appointment so then they're not ending up in an ER over the weekend.

Program staff struggle to provide the level of support they would like to due to large caseloads. This is compounded by long waitlists to access mental health providers in the county:

I think the caseload size makes it hard for us to be able to go with folks to all of their appointments. Everyone has, I think it's a one to 25, 27 ratio right now. But the money that comes with the beds doesn't allow for us to increase our staffing so we do the best we can with that. In terms of a system barrier, the waitlist to get a clinician in the major mental health provider in the county has always been a barrier. So folks sometimes find themselves needing to access, appropriately access the ER for a mental health crisis if they haven't been assigned a clinician. There's a long waitlist here for mental health.

Program Strengths, Weaknesses, and Future Directions

The agency has extensive experience in providing supportive housing, but noted that more staff are needed to better support clients. The program has been successful in a number of areas, including reducing Medicaid costs, maintaining connections between participants and providers, and facilitating housing stability. However, staff identified substance use as a barrier to achieving such outcomes. The program manager underscored the critical need for housing for the participants served, and how it impacts their lives:

Being Housing First, we believe that unless your housing is stable you can't prioritize any other service needs, even basic needs. So I feel if we can secure permanent, safe housing for folks then they can apply for food stamps appropriately, recertify for other entitlements, make preventive care appointments instead of using the emergency room or urgent care centers for a cold or dental need, re-engage in mental health, set up regular transportation to get to and from their providers, medication, pharmacies. All of that stuff falls to the wayside when folks aren't stably housed.

Program staff noted that they would ideally like to hire more staff by increasing the bed rate. As the program manager explained:

I think an increase in the bed rate would help because then we could hire more staff. It's a higher rate which allowed us to do security deposits and moving furniture and financial services, which was helpful. But the caseload ratio is really too high. I think 18, around 18 to 20 max – they have recommended guidelines but unless it's a firm edict, agencies are always going to try to stretch the dollars so we can serve more clients.

Participant Perspectives

Housing Status and Lived Experience Prior to MRT-SH Enrollment

The participant explained that prior to enrollment in supportive housing, she experienced significant domestic violence and family discord, which contributed to and exacerbated mental health problems. She experienced frequent upheaval associated with moving from one abusive situation to another, from house to house, and from state to state. She did not want to leave her abuser to live in a domestic violence shelter, since she had lived in a shelter in the past, and did not feel safe or comfortable there. When residing with an abusive boyfriend prior to moving into supportive housing, she made a suicide attempt that was almost successful.

The participant was referred to Unity House by a care coordinator; she had learned about the program from another

client, and inquired about it with her care coordinator. Prior to the referral, case managers had recommended shelters, but she was not interested in this option. Before enrolling in the program, she completed an interview and received a call from program staff a couple of weeks later. The participant noted that she was very scared and anxious about the prospect of entering the program, particularly regarding the financial component, since she was only receiving a very small amount of money in benefits each month; this financial struggle was a key reason why she was staying in the violent domestic relationship.

She noted that had she not gotten into the program, she probably would have eventually gone into a shelter. She noted that a previous boyfriend offered her a one way ticket, and she would have had to "figure it out."

Perspectives Regarding MRT-SH Housing Accommodations

The participant reported being very pleased with her housing accommodations. Her apartment is small but has a nice layout with big windows, and is located in a quiet area. She referred to it as "my own, distinctive little place." She appreciated being close to supermarkets as well as public transportation. The participant had options and was able to choose an apartment within the specified price range. She noted that the apartment is a great alternative compared to the unsafe situation she was in prior to entering the program.

Perspectives on Housing First

When reflecting on the substance use policy, the participant noted that she doesn't personally use substances, but believes it is a good policy, particularly for those who need help with recovery.

Perspectives Regarding MRT-SH Support Services

The participant noted that all of the services associated with the program are helpful. She reported having a good rapport with the case worker, which was especially helpful:

My case manager is pretty straightforward. I tend to worry a lot and she'll be pretty straightforward and blunt.

Changes Experienced Since Entering the Program

The participant described how supportive housing has allowed her to establish a positive routine. She reported feeling less stressed, overwhelmed, and anxious. While mental health struggles still present difficulties in regards to organizing her day, she finds that she is taking better care of herself:

I'm starting to get a routine. This might sound contradictory but I am starting to get relaxed but that doesn't mean that I am doing less. It means I am able to plan more. It means, I guess I am able to relax and not to plan...to actually, to be like this all the time, I have PTSD so it's really hard.

The participant described physical challenges that she continues to face due to an eating disorder. These medical issues have not changed, though she reported feeling calmer overall. The participant uses outpatient mental health services to address this issue. The participant reported that her significant mental health and medical issues are ongoing. While she described these conditions as stable, she noted that they require the services of multiple professionals. She most frequently sees a primary care provider or urgent care, where she is referred to a number of specialists. She takes medication to address mental health and physical conditions.

The participant noted that she has improved her relationship with one of her daughters since entering supportive housing. It was unclear if this improvement was due to stable housing or other dynamics within the relationship.

Perspectives on Program Strengths and Weaknesses

The participant described feeling very grateful for the program, and for the staff in particular. She reported that entering the program felt like "winning the lottery", and reported having significant trust in the program and in the providers. The participant did not indicate any perceived weaknesses of the program. As she explained:

I don't know enough about it but I can't say enough about them. I can't imagine how bad I would be if I hadn't gotten the help.... they give people chances that the public, the general public, and the general services out there overlook. A lot of people that are hard enough, programs...there are so many people who are overlooked.



OLMSTEAD HOUSING SUBSIDY PROGRAM

Contractor: New York Association on Independent Living (NYAIL)
Subcontractor: Independent Living Center of the Hudson Valley, Inc.

Administrative and Staff Perspectives

Program Context and Key Program Components

The New York Association on Independent Living (NYAIL) program works to provide housing in the community for individuals living in a nursing home for 120 days or more. The program works with MLTC and Open Doors based on participant needs. For instance, they will connect participants to at-home services through MLTCs, if needed. The program provides participants with household goods and furniture upon move-in. Housing through NYAIL is designed to be permanent.

The program in the Troy location (Independent Living Center of the Hudson Valley, Inc.) employs a manager and a part-time housing specialist. The housing specialist works with participants to select an apartment and to move them in. The housing specialist reaches out to local landlords and sends information packets about the program, emphasizing that the program provides very secure, stable renters, and that the program acts as a mediator through the process, if needed.

Regional Factors

In terms of regional factors that shape program implementation, the staff noted that in the area, service providers tend to be aware of this population and are making housing available to this population. This reaction differs by specific communities, as providers in some communities tend to be very helpful regarding housing this population (e.g., Latham), while others do not consider it a critical focus area (e.g., Albany). The staff indicated the importance of keeping younger participants in mind as local communities are building rehab facilities. The young population has some unique characteristics that are not being served as readily. For instance, individuals under the age of 50 are ineligible for senior housing, but still may have significant needs due to disability.

The statewide coordinators (not specific to the Troy program) further identified factors of other regions in which the program is offered. As the coordinator described:

Each region kind of has its own barriers. In New York City, and the lower Hudson Valley, we really face an issue of finding units that are in the FMR and we're not allowed to go over that FMR HUD amount, so that's an issue. And then in some of the other areas like Binghamton, Southern Tier region, a lot of issues out there are lack of aides. On Long Island, a lot of the MLTC companies have pulled out. There's only four left on Long Island, so the waitlist of trying to get someone on an MLTC service is a huge issue for them. For the Syracuse area, they seem to be doing pretty well. There are some more rural areas where transportation, like you mentioned, is an issue for them, but also the lack of aides as well. More so in the Capital Region here, there's definitely a lack of aides. Transportation does not seem to be an issue here. There's a lot more services. But aides across the region is a big one. There seems to be a shortage, or they're committing and then they're not completing their hours.

Targeting and Eligibility Determinations

The target population is nursing home residents. The program gathers information to determine eligibility. Some individuals are automatically ineligible, such as Level III sex offenders. When the program staff are unsure about eligibility, they gather documentation and confirm with NYAIL. Staff indicated that they also communicate with the potential participant and social worker, if applicable, throughout the process. Most referrals come to the program from within the program or from related agencies.

According to the statewide coordinators, the eligibility criteria were laid out in the RFP, and they worked with DOH to make some tweaks. The criteria were revisited as the program was implemented and appear to be working well, as the programs are serving those who are essentially stuck in a nursing home but want to leave:

They were laid out as the RFP process when the State put together the RFP for the program, but then as NYAIL has been developing the program and implementing it, we definitely revisited some of the eligibility criteria with DOH based on what our experience was. So like [Program Manager] mentioned, obtaining the UAS for people who were already in the nursing home was proving to be onerous and obviously the nursing home eligible are nursing home level of care since they're living there. So DOH eliminated that criteria for us. So they were laid out in the RFP but they've been tweaked here and there as we've been implementing the program, based on what we were encountering.

Housing Specifications and Placing Participants into Housing

As participants enter the program, apartments are located by staff based on the individual's needs and preferences. The time required for individuals to be discharged from the nursing home and to get MLTC services in place, if required, varies. However, once the apartment is leased, the program has a window of time to move the person in. According to the regional administrator:

I think one of the benefits to this program, which [Program Manager] just alluded to, is that in some of the programs that offer subsidies there's a requirement that you can't lease up the unit until you're ready to make that move, which is very much often a timing challenge in terms of getting services in place, etc. You find a unit, you have a small window to sign a lease or you're going to lose it. So we have the ability to sign a lease with the understanding that it may take a month for the individual to get their services in place and actually be able to transition back into the community.

Perspectives on Housing: The Scattered-site Model

The program consists of scattered-site apartments in the community. According to program staff, it is a challenge to find apartments at fair market rent. Most participants wish to live alone, and it is particularly challenging to identify one-bedroom apartments at fair market rent. As the regional administrator reported:

The independent living model is very focused on individual choice and independence. Oftentimes in supportive housing, your option is taking a roommate or you can't make this move to the community. We're more focused on letting the individual live in the community that they choose, which is more often independently, and in the community of their choice, in the type of unit of their choice, etc.

Staff reported that it takes significant time to build relationships and trust with landlords. However, once these relationships are established, they tend to be long lasting. Housing specialists make themselves available to landlords to resolve any issues, and this facilitates the development of positive relationships. As an administrator suggested:

It's taken a long time, certainly, for us to build relationships with landlords – that's probably the toughest part. People obviously get a little burned with other subsidies that are available. So trying to get them to trust us. So that's one of the biggest barriers that we've found. But in a lot of areas, we've found that once we've made that relationship, landlords continue to rent to us because they really like what we can do. They get their rent on time, obviously that's the most important, but our housing specialists are also available to the landlords. If the landlord, say, has requested rent from someone and they haven't paid it, they can reach out to the housing specialist. Once we've made

that relationship, we do get more people coming together in the same kind of complexes, so there is a little bit more people around the same age coming together.

When reflecting on housing arrangements, the staff noted that congregate care is important for certain individuals who require more support. However, those who wish to be more independent are often happier in apartments in the community.

When individuals are initially placed into housing, staff noted that it can be daunting for some. While certain participants embrace the independence right away, others find it scary to live alone in the community. The program encourages the participants to join peer support groups to address the experience of loneliness and anxiety. Staff also work with the participants to address their concerns, and provide welcome home packets with their contact information, as well as information about groups and activities in the community.

Perspectives on Services: Services Viewed as Most Critical to Housing Stability

The NYAIL program provides housing, but not services. However, the staff noted that Adult Protective Services can help with service coordination. NYAIL's other DOH-funded program, Open Doors, has more frequent contact with participants, and one week after transitioning to an apartment, participants are connected with a variety of services in the community. However, not all participants have access to Open Doors.

Reducing Medicaid Costs

According to the regional administrators, the program has a goal of reducing Medicaid utilization and cost. By taking individuals out of nursing homes and moving them into apartments, Medicaid savings are realized (due to the price difference in the settings). As the regional administrator reported:

Monetarily, it costs a significant amount of money each month for someone to live in a nursing home and receive the services. So when we're taking someone out, we're reducing that significantly by providing them with even just monthly rent and supplies, and then the aides on top of that.

As stated above, the program works with MLTCs to meet the health needs of participants, as well as waiver programs, based on participant needs. As the regional manager described:

It depends on the MLTC that you're working with – everyone's a little bit different on their processes. But we also work with not just MLTCs but NHTD waiver, TBI waiver, depending on what the person needs for services. We work a lot with the Open Doors program, which I know we keep referring to that, but they're really kind of our partner in getting people housed and they're usually the ones reaching out to the MLTCs and putting those services in place. So basically what we have to do with MLTCs is we have to reach out to them and let them know this person's signed a lease, when can you come out and evaluate them for the hours of service? They come out, they evaluate the person, then they like to see the home which is fine with us because we currently have the lease and the keys so it's very easy for us to do. And then usually by the following month, as long as it's done by a certain timeframe, the services are put in place for discharge. That's ideally how it runs. We do run into bumps with the MLTCs from time to time that prohibit us from getting services, such as a disagreement on the amount of hours.

Perceptions on Participants' Progress

The staff suggested that participants' motivation dictates their success. Those who are motivated to live independently tend to do well in the program. Also, those with a support network tend to progress well. When participants leave the program, which does not occur frequently, it may be to return to a nursing home; others pass away, as their conditions worsen or as they age. Should participants choose to move on from the program, staff works closely with them to ensure a safe transition. The majority of discharges are returns to a nursing home; staff indicated that these returns sometimes occur due to a lack of home health aides.

Program Strengths, Weaknesses, and Future Directions

According to the program staff, a strength of the program is that a burden is lifted from the participants by removing financial barriers to housing. It is also helpful for clients to be able to choose their housing and its location. The program requirement of having a support network makes it more likely that participants can be successful. The most important program benefit, according to staff, is the improved quality of life that participants experience due to moving from a nursing home to an apartment in the community. As the regional administrator reported:

They have a better quality of life when they leave the nursing home, more comfortable living in their own unit, they have their own space to live in, their own privacy. Their quality of life seems to be much greater.

The staff indicated a need for more interactions between the counties providing this program. In particular, they wished for in-person rather than phone meetings. In-person collaborations within agencies would be especially helpful, and the staff suggested creating regional leads in this process.

The NYAIL staff wished for the state agencies to provide more clarity in terms of policies and procedures, particularly regarding non-compliant participants (e.g., clients who smoke in their apartments). Additionally, they would like the State to help address the issue of bad landlords, as they can be a significant hurdle. For instance, some landlords arbitrarily decide that a potential renter needs to make four times the rent cost in income in order to get an apartment, which is not possible for participants. Other landlords increase rental prices for apartments that make them out of reach. This situation is especially problematic for the low-income population, as clients are being denied apartments because of prejudice against older individuals with disabilities. Additionally, the NYAIL administrators suggested that they hope to see funding for the program continue, noting that they are working with NYSDOH on a two-year extension. Sustainability is a key goal for the program moving forward.

Participant Perspectives

Housing Status and Lived Experience Prior to MRT-SH Enrollment

Participants of the NYAIL program indicated that they were residing in a nursing home prior to entering the program. The participants described the nursing homes as terrible for their health and well-being. Two participants were discharged to nursing homes from hospitals or rehabilitation facilities, while another experienced a house fire that led to homelessness. All of the participants indicated that they are coping with several chronic conditions, including diabetes, kidney disease, and ulcers. One participant indicated a history of domestic violence, which complicated her housing situation.

The participants indicated that it took a long time to enter the program—several months in most cases, which they described as very difficult, as they wished to leave the nursing home as quickly as possible. One participant learned about the program from a Medicaid attorney, while the others were referred by case workers.

Perspectives Regarding MRT-SH Housing Accommodations

The participants described their apartments in positive terms, indicating that their apartments are clean, newly renovated, and in nice buildings with security features. They also reported living in neighborhoods where they can access needed services and desired amenities. The participants indicated that they accepted the first apartment they were shown, as there were no other apartments available.

The participants indicated that they were uncertain of where they might be living if they did not enter the NYAIL program. One participant indicated that she might live with family, though this would be a difficult situation, given her need for a wheelchair accessible accommodations.

Perspectives on Housing First

The participants perceived that drugs are not allowed by the program, but were uncertain if this was part of the lease agreement or a program rule.

Perspectives on Support Services

While the NYAIL program offers housing only, the participants indicated that they access services outside of the program. These services included personal care aides, though the participants noted that aides are difficult to find; others indicated that they use a local independent living center, which offers yoga. Some participants indicated a desire for the program to help with coordinating support services.²⁶

Changes Experienced Since Entering the Program

When describing changes in their typical days, the participants indicated experiencing fewer boundaries and more freedom to live as they choose, in contrast to life in a nursing home. One participant indicated seeing her children more frequently. Another, however, noted that a sense of isolation continues to be a struggle. One participant indicated that she has more frequent connections with family, and improved family relationships.

Perspectives on Program Strengths and Weaknesses

When reflecting on the program, the participants indicated that the best aspect is that the program enabled them to exit nursing homes. They widely described the dignity associated with having their own apartment to call home.

²⁶ Per a personal communication with NYSDOH, under the RFA, NYAIL provides rental subsidy Community Transitional Services (security deposit, household goods, household furniture, utility deposit, mover's fees), small Environmental Modifications, linkages for services in the community, and a Housing Specialist.

OPWDD EXPANSION PROGRAM

Chautauqua County ARC/The Resource Center

Administrative and Staff Perspectives

Program Context and Key Program Components

The Chautauqua County ARC program is designed to assist individuals with developmental disabilities in moving from certified settings into less restrictive apartments in the community. Ten participants are currently served. The MRT funds enabled staff to enhance their supportive housing model and move more individuals into this less restrictive environment.

The program employs supported living specialists and a service coordinator. Community habilitation staff work with MRT clients, though they are not MRT funded. Staff provide wraparound services to participants in the program to promote autonomy. There is also a staff team (the SELF team- Supporting Everyone to Live Fully), who speak with participants to analyze their needs, strengths, and weaknesses, including how to develop a plan accordingly. These staff work to change people's philosophy and skillset to promote independent living.

The program is designed to support individuals in living independently. A goal of the program is teaching individuals the skills they need to live independently. The participants served by the program typically are not eligible for a Health Home, though the agency is currently a Health Home provider.

Regional Factors

The program is located in a rural area. According to the program administrators, transportation is a challenge to the program. As an administrator explained:

We live in a rural setting. Transportation is a big issue, we don't have bus system or anything that runs after five or on the weekends. The other barrier would be people who utilize wheelchairs, there's not a lot of transportation for those folks either.

Accessibility is a challenge in the context of housing as well, as there are few suitable apartments that are wheelchair accessible.

Targeting and Eligibility Determinations

In contrast to other MRT-SH programs, the OPWDD Expansion Program does not specifically target individuals who are high Medicaid users. By virtue of living in a 24/7 supervised OPWDD setting, participants in this program have the highest pre-period expenses of any MRT-SH program. The program eligibility criteria were determined by the grant. The program administrators suggested that OPWDD criteria are limiting, noting that the Balancing Incentive Program is less so:

We found [the criteria] to be within the scope and the terms of the project. OPWDD eligibility is always very limiting. And that's why we rolled over into this Balancing Incentive Program through

Department of Health and it hasn't been as limiting at all, the common factor only has to be Medicaid eligible. Because as we know, OPWDD eligibility is not easy to obtain.

The administrators identified positive aspects to targeting, in that it provided a focus to the agency in terms of transitioning participants. Participants are able to live more independent lives, which is in line with their goals. However, the program administrators suggested that the current criteria do not target individuals with complex medical needs. At present, the program cannot build in enough supports for individuals with complex medical needs within the current funding stream.

Additionally, the program managers highlighted contextual factors that create challenges for participant targeting, such as gaps in the current OPWDD system that do not incentivize independent living. As they indicated, little support is in place for the transition from certified settings to less restrictive ones. They further reported that some mandates by OPWDD and the Justice Center that are designed to protect clients actually become a barrier to independent living in the community within less restrictive settings. As an administrator described:

When you say targeting individuals, I think that there's a gap in the overall OPWDD operational system that doesn't necessarily incentivize agencies or individuals to live on their own. There's not a really good bridge. People live in certified settings and get a lot of support and then they move out and get very, very little support. There's very little transition available. We created this model with the MRT and with our BIP project and dedicate unpaid resources and supports; I mean unfunded, not unpaid...We've invested in that because it's the right thing to do as an organization; that's not being funded by anyone to do that. It requires a lot of resources, a lot of expertise to do correct person-centered planning, to do correct community connections and bridge building. It doesn't happen overnight...People need natural supports. You can't walk up to somebody and say, "Hey, I'm your new neighbor, can you help me with all my care needs?" That takes facilitation and that takes development, and the current system doesn't fund for that.

Program Changes and Innovations from MRT-SH Funding

The program used MRT funding to enhance pre-existing services. More people are able to be served, which means that the program is moving a greater number of people into less restrictive housing settings:

We assisted 10 people. If we hadn't had this extra influx of MRT dollars, maybe that would have been one or two, if even that. It's not like we weren't moving on the continuum of that's just the right thing to do with everybody, this just allowed a really short term influx of dollars to have focus and to move a much higher number of people into a less restrictive setting than we have in any other year up until then.

The administrators described how the funding is a mechanism for shifting attitudes about the ability of people with developmental disabilities to live on their own.

Placing Participants into Housing

The administrators explained that the program helps participants with the housing search, but noted that the program does not actually place participants into housing (e.g., securing housing, helping with the move-in process, etc.). There is a life coach (not funded with MRT dollars) who works with participants in filling out housing applications and building supports. This role was previously carried out by the group home.

Housing is designed to be permanent, as subsidies are continuous. According to the administrators, there is a high retention rate. In terms of the rare transitions that have taken place, one participant moved into a more restrictive environment, and another passed away.

Perspectives on Housing: The Scattered-site Model

The administrators describe benefits and drawbacks of scattered-site housing. Positive aspects include the ability for clients to choose where they wish to live, including selecting housing that is near amenities that suit their lives and preferences, in contrast to group home settings:

I'd say some of the advantages are people could pick their housing obviously based on where there was an apartment to rent but they could pick it near where they were working or near where their families lived. They could – not just where a group home had an opening – they could really pick what community they wanted to live in, what town, or what's important to them, they could be there.

Disadvantages include difficulties hiring appropriate staff. The program administrators noted that OPWDD and Justice Center requirements are stringent, which creates difficulties hiring those who can support individuals in scattered-site apartments. Another difficult is the long time required to get self-directed plans approved, as individuals need these plans to be in place prior to moving in; this condition often disrupts the ability to secure apartments:

I would say one of the other things that hinder us a bit, and again this is an OPWDD thing, is the time – when someone's doing a self-directed plan and the time for their plans to get approved, especially when we were doing this project with the MRT, could take months sometimes. And when you're trying to help somebody find housing, a landlord's only going to hold an apartment with them for a very short period of time. And so somebody finds an apartment and by the time it gets approved and all of the hoops that a person has to go through for their self-directed plan to get approved, those apartments could be gone two and three times over. So to try to secure housing in a quick time frame and allow the person to move and get everything done that they need to do once the adequate housing is found, can really be a problem.

Overview of Service Delivery

According to the program administrators, participants most frequently use service coordination through the program, as well as Individualized Supports and Services (ISS), self-directed services, and community habilitation. The administrators view self-directed supports and the financial support assistance, which is built into the plans, as particularly critical to the participants. One administrator highlighted the highly individualized nature of service-related needs:

It's a unique combination. Every person is so different that every person's plan and what services we've accessed has been different, probably in every single case. The common threads are service coordination, the ISS in a couple cases but not all, the self-direction again in a couple cases but not all. It's very unique, not just a one size fits all. And I think that's what requires the intensive coordination that having the role of the Support Options Coordinator – she's kind of the guru of all things towards that independence and can pull together the right teams, the right components of what community-based supports are, what internal supports we have, whether that be OPWDD or whatnot. But they're just extremely unique and that's probably the main attribute of the program, is individualized and unique. There's no one size fits all to assist somebody to move from a group home into a community-based setting.

Reducing Medicaid Costs

As noted above, the provider indicated that the program does not specifically target high Medicaid users. However, the administrators reported that program participants are using fewer Medicaid dollars when living in their own apartment on a rental subsidy, compared to the previous restrictive setting. All savings are accrued from budget changes associated with these settings:

Just from a big picture standpoint, somebody is gonna be using less Medicaid dollars when they're living in their own apartment drawing on rental subsidy, than living in an Individualized Rental Alternative (IRA) or an Intermediate Care Facility (ICF). So all of the savings was through each individual. We looked at every individual and what each individual budget was at the time and then what their budget was when they were living in the community. And somebody that's getting 24/7 around the clock is much, much different than somebody living in their own apartment getting a rental subsidy, getting 20 hours a week of community hab.

The administrators noted that they only have access to OPWDD data to date, so they can view Medicaid saving as a whole, but not for individuals. They do not currently access data on ED use and medical costs, though they would find this helpful:

The missing link is that we only have access to OPWDD data when it comes to Medicaid. When you talk about Medicaid savings, organizations and projects like this in the future would have complete access to a Salient database, we would be able to know what the Medicaid savings was as a whole for the person. And that would help us be better prepared for the managed care and working with the MCOs.

Perceptions on Participants' Progress

The administrators did not highlight a particular type of participant who benefits most from the program. Instead, they noted that progress is highly dependent on the individual. In their view, if staff are committed and if clients are motivated, success is likely. As the administrators reported:

I think there's people that we've supported through this MRT that nobody thought would be successful and they're doing fine three years later; they're still living on their own, doing very, very well with supports in place. And people often, I think, are surprised by some of it.

One of the common things is that they all wanted to live on their own. They all wanted change in their life, they all wanted to do it. And I think that if people don't have that personal drive, they have to have that personal drive otherwise it's not going to come together.

Program Strengths, Weaknesses, and Future Directions

The program enables people with disabilities to move from a certified setting to a less restrictive environment. The administrators indicated program successes, in that individuals can now afford to live independently due to housing subsidies; they are also learning skills needed to be on their own. The administrators described continuing to see participants living happy, healthy, and quality lives in the program, noting that independent living has made a significant difference in their lives.

The administrators also highlighted several challenges associated with the MRT program. Supports to make this transition to independent living are lacking, and staff noted that the OPWDD system doesn't effectively promote independent living. They also characterized the fiscal intermediary as a struggle, with little reimbursement available. According to the administrators, it will be very challenging to continue these programs in the long-term with a continued focus and financial investment. The administrators also described rigidity in the OPWDD system, which creates barriers. As the administrators reported:

I think we have demonstrated, through both of these projects – the MRT and the BIP – that we can save millions of dollars in Medicaid spending by doing this but we need money invested back in so that we can afford to continue to do that. So we're doing it at a loss, from a program perspective, in many instances right now but we can only do that for so many people and for so long. So if it's going to continue to grow and people can continue to have these great outcomes, we would hope that some of these Medicaid dollar savings that we're demonstrating through our projects could be reinvested back into programs like this to provide ongoing supports for people.

As we were moving people out, the system – OPWDD in general – wasn't necessarily fluid enough. We had a very bad financial year that year because when somebody moves out of a group home or one of those higher level settings, we were not able to fill that vacancy in a timely manner based on the constraints put on us by OPWDD. So therefore, we had difficulties in our residential operations because so many people moved out in that one year time period, it affected the bottom line because approval from taking somebody off a waiting list to move somebody into one of the houses can take a really, really long time. So as we were moving quickly, the other end could not keep up...our division was doing innovation and helping people live life fully; the other division was getting upset because they had vacancies and were having that operating deficit.

Moving individuals to a less restrictive housing setting has yielded significant Medicaid savings, although the program does not specifically target high Medicaid users. A challenge to the program is that a significant amount of paperwork is required for ISS; the administrators reported that there are many steps necessary for individuals to maintain their

housing subsidy. They suggested that if individuals are not communicating properly, they program may end up paying more of the rental subsidy than is needed.

The administrators provided suggestions as to how the state agencies can support this program. Overall, they relayed a need to look closely at current regulatory barriers and the overall financial structure for this population. They also proposed that it would be helpful to have funding for technology that would support participants in becoming more independent, such as cell phones. They would welcome the opportunity to speak with and collaborate with similar programs to share lessons learned.

Fulton County ARC/Lexington Center

Administrator and Staff Perspectives

Program Context and Key Program Components

The Lexington Center program provides supportive housing to individuals with developmental disabilities, who are transitioning from congregate group home settings. MRT funding has been used by the program provide three units within an apartment building, with Lexington holding the leases. The goal of the program, according to administrators and program staff, is to assist participants in becoming as independent as possible through skill development, while helping them to reach the goals that are important to them.

Supportive housing through Lexington is designed to be permanent. Participants can stay as long as they wish. According to administrators, there is no ideal length of stay, as this is based on the individual and his or her needs. However, the program is designed to help participants to work toward independence, which can lead to independent living or transition to another type of supportive housing with less intensive support services. Participants who transition from the program tend to move on to more independent settings, or can return to a supervised IRA with more intensive supports.

The program employs direct support specialists, as well as a residential manager. Direct support specialists are senior staff with experience in IRAs. These staff shift their focus in supportive housing to help participants to maintain an apartment on their own, which includes helping with upkeep, teaching participants to cook, help with budgeting, assistance with scheduling appointments, and teaching participants how to access Medicaid transportation. According to program staff, direct support specialists also work with participants to resolve issues with roommates, show them the potential apartment, and perform home visits with participants.

Regional Factors

Program administrators and staff noted several region-related challenges that impact participants' experiences. Bus service in Gloversville, where the program is located, is not reliable, and taxi service tends to be cost-prohibitive. Additionally, staff noted that the program does not allow female residents to be alone with male drivers, which may prevent them from having normal experiences in the community. Transportation barriers are significant, in that unreliable transportation makes it difficult for participants to adjust to accessing buses, according to staff:

I've had a hard time teaching one of my ladies how to use the bus because it doesn't show up on time. You tell her gotta be there 10 minutes early and then the bus just never shows up because it showed up half an hour before it was supposed to. So that was a big problem and it was super confusing for her, it was confusing for me!

The apartments are located in the downtown area, so some amenities are in walking distance for participants. However, staff noted that activities are limited in the area, especially for participants on a tight budget:

And even just activities, compared to other areas, we don't have – I mean, we have activities and stuff offered but it's not like Albany or something where there's pages in their to-do ad...Our guys work on a very limited budget so that becomes a problem. It becomes a deterrent to try to find activities because they don't want to have to spend the money because they don't have that much money.

Targeting and Eligibility Determinations

The target population for the program is individuals with developmental and physical disabilities who are currently in congregate group home settings but are more appropriate for a less restrictive level of care. Program administrators noted that a supportive apartment was already in place prior to MRT funding, so eligibility determinations have been a continuation of “something that was working.”

To determine eligibility for the program, prospective participants complete an assessment and interview process. If a candidate is deemed an appropriate fit for the program, the staff team will begin working with the individual to secure a housing placement. According to the program manager, the program tries to draw participants from supervised settings, and high Medicaid utilization is a consideration. However, the cost savings occurring from the program centers more around costs related to the settings, in that the restrictive, supervised setting costs about a third more than the MRT apartments.

Program administrators noted, however, that the program cannot currently target individuals with physical disabilities who are not ambulatory. Potential participants need to be able to get in and out of their apartments within three minutes. They would like to eventually provide supportive apartments for individuals in wheelchairs.

Program Changes and Innovations from MRT-SH Funding

According to program staff, MRT funding allowed Lexington to offer supportive apartments to a wider variety of participants. Following the program, many have moved on to their own apartments, or a “standard” supportive apartment (non-MRT) that has less staff presence.

Placing Participants into Housing

When first placing participants into housing, staff perform assessments with the participant to identify strengths and challenges. This allows the participants to identify goals and work on challenges while in the program. According to the program manager, the team makes a recommendation to put the participant on a list for housing or on a waiting list, should an apartment become available. Participants who are eligible are shown an apartment alongside their family or guardians and can decide if they are interested. The program also facilitates several visits with the potential roommate to assess the fit. Some participants will have an overnight visit prior to making a decision.

Perspectives on Housing: Reflections on Housing First

Consistent with Housing First, participants are able to choose their apartment (being able to select one of the three offered units, based on availability). Program staff were in theoretical agreement with Housing First’s harm reduction principles, suggesting that mandating sobriety and abstinence promotes sneaking around and a general lack of trust:

It’s best if they’re just supported in what they need and what they want to do. It’s best if we can support them in doing that.

People, if they want to do those things, they’re going to do them. So if you mandate that they can’t, they’re just going to be sneaky about it.

The program administrators noted that participants in the program tend not to have addiction issues, since most are moving from an IRA setting.

Perspectives on Housing: The Congregate Model

Staff cited advantages associated with congregate housing settings. With all participants in the same building, staff are able to check in with them in one visit and can immediately address any issues that arise during that time. The congregate setting also facilitates group interaction among participants:

It’s nice because when [a client’s] birthday was last week, [staff] brought the girls over and they all sang happy birthday and then they were going to have either pie or make a cake the next day. So,

they still get that, maybe they still feel the support if needed, even if from the other roommates if they need it.

Staff also noted, however, that congregate settings and having roommates can sometimes cause interpersonal conflicts for the participants:

But we have the opposite too, where they hang out too much and get annoyed with each other because they're so close in proximity so they're like, "Oh there's that guy again." So, it's like, it depends on the week, like some weeks they're all best friends and then some other weeks they can't stand looking at each other.

Perspectives on Housing: Early Adjustment Issues

According to program staff, participants commonly experience adjustment challenges upon moving into supportive housing. Some of these challenges center around daily living skills, such as cooking. The apartments have gas stoves, but participants are often used to electric. Some overeat due to having more freedom and autonomy. Others struggle with boredom and loneliness due to not having staff around them constantly:

Dealing with boredom. Not having a staff there to constantly ask questions. They tend to call a lot because they just don't know what to do with themselves, they don't know how to be alone. They eventually learn it, but when they first move in that's a big problem.

Challenges can be relational in nature as well, according to program staff. Staff noted that clients are sometimes so eager to enter the program that they will agree to any roommate, which has led to some challenges later on. Participants have to learn how to respect a roommate's space. Further, staff noted that participants can be vulnerable to engaging with the wrong community members as they begin venturing out:

I think, also, going out when you're bored into the community and running into people that are looking to prey on people that have disabilities. They don't always hook up with the greatest people in the community. There are definitely people, especially in the downtown area, who see somebody who has challenges and they know that they get a check every month and, you know – I'll hang out with you while you got your money and then I don't want anything to do with you when you don't.

An administrator contextualized this further, noting that the experience of independence leads participants to experience both positive and negative aspects of life decisions that come with greater freedom:

I liken the move from a supervised setting to a supportive apartment, sort of like when someone goes away to college. You run into the same sort of issues, the positive and negatives with that new-found freedom. People try things they have never tried before. You know, people will have a drink. People may try marijuana. People try to find out what it is like to live on junk food. It is all the same things. They date someone they might have dated before. All of those things we expected. Not anything new.

Additional challenges upon entering supportive housing included interacting with neighbors. Staff work closely with clients to teach them the necessary skills to resolve such issues.

Overview of Service Delivery

Staff work collaboratively to support clients in completing their daily routines and developing independent living skills. Flexibility is critical, as clients' routines and schedules tend to change frequently. To keep up with these changes, staff are constantly communicating and will fill in for each other when needed. Staff highlighted clients' support network as one of the most critical supports. Staff are key in this, as they provide trust and stability. As staff members described, they endeavor to understand the specific goals and needs of each client, so they can connect them to the right support system. They work with clients to come to a point where they are confident making their own decisions.

Staff noted that participants also have access to dieticians, as well as exercise classes. There is a fitness center within the day program that some use. They also encourage participants to walk and ride bikes in the community.

Additionally, participants sometimes use a Medicaid Service Coordinator, who can be within or outside of the agency. Others receive day habilitation; some participants work during the day. Program administrators highlighted the importance of employment services for participants:

I would say employment services [are most important]. I find that people who are able to supplement what they get for benefits are more successful. And they are more motivated to have their own apartments, often people who have their own employment, they want to get their permits, they want to their licenses, purchase a car. That isn't really possible if you're JUST living on benefits.

Reducing Medicaid Costs

According to program administrators, Lexington does have a goal of reducing Medicaid costs. This goal is achieved by moving individuals to the independent setting from a supervised setting as soon as possible, as the setting related cost decrease is mostly responsible for overall cost savings. The administrators noted that there are no specific services in place aimed at reducing Medicaid utilization, but noted that participants are encouraged to be independent, with the indirect goal of lowering Medicaid costs. For instance, participants are encouraged to walk or ride their bikes to reduce Medicaid transportation costs. Participants are also encouraging to see primary care providers, as opposed to using emergency medical services. At present, the program does not coordinate with Health Home care managers. As an administrator noted:

We counsel people in the use of urgent care versus the ER. What constitutes a doctor visit as opposed to going to urgent care as opposed to the ER. If your tummy hurts, you don't necessarily need to go call an ambulance and go to the ER. That is something you can talk to a staff about and they can help them set up an appointment with their doctor.

Perceptions on Participants' Progress

Staff noted that supportive housing is overwhelming for some clients, who then choose to return to a supervised setting. The trajectory back to a supervised setting tends to occur for individuals who feel uncomfortable adjusting to independent living. As a staff member described:

We had one gentleman, independence was just too much. He could've done it, it was just too much on him. He wasn't comfortable, he wasn't doing well. He vocally asked to go. He needed more people around him. Being alone was too much for him. So again, some people really thrive in that – our one lady...absolutely has blossomed. Other people, it's scary and it's just not their time so maybe you can re-approach it in the future. But at that time, you have to listen and go with what they need.

Other participants have exited the program to live with family or in the community. With any discharge, the staff team supports clients in pursuing next steps and securing alternative housing.

Program administrators perceive each participant's motivation and goals as key to success, noting that those who wish to be independent like their friends or family members might be are more motivated to move toward this goal. Those with less internal motivation tend to struggle more in the program. As an administrator described:

If someone is less interested in having their own employment, in having their own apartment. If they are more comfortable in where they are, they tend to be less motivated to learn how to do things independently. The people who really want to live like everyone else. People they know in their families. Or their friends. Tend to be more successful.

Program Strengths, Weaknesses, and Future Directions

According to staff, the participants' success is facilitated by providing an encouraging and supportive environment for participants to learn and grow. Staff viewed their support of one another and of the participants as the program's greatest strength. Additionally, the program manager indicated that the overall goal is to encourage participants to become independent, noting that the program has been successful in this regard. As an administrator reported:

When people are able to be independent, it gives them a huge amount of self-confidence. It boosts overall their wellbeing. We have participants that I know are very proud to be in the supportive housing program.

Staff noted several areas for program improvement, including less restrictive regulations, greater handicap accessibility, and a faster housing approval process. In particular, staff indicated that men should be able to drive female clients in program vehicles, as this presents barriers to the program, and also creates obstacles for female participants as they learn to negotiate independent living in the community, where they may encounter male taxi drivers, for instance. Program administrators noted that the program can do a better job marketing itself. Specifically, they can do more to educate individuals about the positive aspects associated with living more independently, particularly since some individuals struggle with the concept of leaving the supervised setting and taking on more responsibility.

Of note, staff identified a challenge specific to their population. They perceive that many individuals in IRAs have the capacity to do well in supportive housing and are interested in the program, but parents or guardians are not on board for the move. Guardians sometimes do not feel confident with their relative living independently and prefer constant supervision, which hinders the ability of individuals to move into the community. Staff described that OPWDD has a program separate from MRT, which is a step between a supervised setting and supportive housing. It is designed to be a less than 18-month setting with evaluation of skills every 6 months, and can sometimes provide the bridge needed between supervised and supportive housing settings.

When asked to provide feedback to state agencies, the program administrators and staff suggested that they would like to see more opportunities introduced for persons with physical challenges. They would like to find landlords who can provide accessible apartments to open the supportive housing opportunity to individuals with physical disabilities (e.g., individuals who use a wheelchair). They also see the need for assistance educating landlords on the benefits of renting apartments to program participants. Additionally, staff noted that it would be helpful to the program if new living arrangements can be approved faster.

Participant Perspectives

Housing Status and Lived Experience Prior to MRT-SH Enrollment

All participants of the Lexington Center program were living in an IRA, or a 24-hour supervised setting for individuals with developmental disabilities, prior to entering supportive housing. The participants were interested in gaining independence and living in the community. There was a desire for freedom and privacy. Several participants indicated that they felt competent to live on their own, and that they did not wish to be “held back” or “underestimated”. As the participants reported:

[The IRA was like] day care...No, I'm serious, that's what I call it because that's how it was. Nobody did anything themselves, everybody got things done for them.

It's also the fact that it changes your point of view – when you know that you are independent but yet you're being kept in a supported placement. And then you start viewing other people differently. And it just...I didn't like it.

Most participants indicated that they learned about the program and were referred by staff from their previous placements, with one person indicating that he learned about the program from a friend. To enter the program, the participants indicated that they had to develop independent living skills, such as learning to cook, learning how to contact the administrator on call, and developing time management skills. Some indicated that they already had these skills, which made the process easier. The participants were assessed prior to entering the program:

Took a couple steps before the meeting and the supportive housing. I had to learn to cook, which I don't like to do very much...and I had to learn, home alone assessment, call AOC on call, and I had to do a community independence assessment.

It was hard to get here. Once I got here I was fine. It was just because you had to do everything, something harder [than before]. It wasn't the best but I did it and here I am.

Perspectives Regarding MRT-SH Housing Accommodations

The participants described positive and negative elements of their current housing accommodations. Some indicated that they are living in spacious and beautiful apartments. Others appreciated living within walking distance to work or other locations of interest. The most significant concerns centered around living with a roommate. The participants noted that their privacy was compromised, and sometimes found it difficult to share a living space:

It drives me nuts because I'm like a germaphobe, clean freak. And if I was by myself I would have more control over what the apartment looks like and how it's presented. Living with a roommate is hard because I feel like I'm almost doing everything.

Perspectives on Housing First

When asked to provide perspectives regarding the harm reduction approach associated with Housing First, most participants focused on the importance of being considerate of the individuals living with or near them. As one participant indicated:

It's more about consideration. Like it doesn't matter whether or not you can drink in the apartment, it's just with an apartment mate there's more of just being respectful.

Perspectives on Support Services

The participants found particular support services to be most useful; support provided by service coordinators, and connections to employment that are fostered through the program. The participants described enjoying their jobs and attending work. The Medicaid Service Coordinators (MSCs) were described as helpful by most, though one participant indicated that his MSC is located in an outside agency and is often difficult to access.

Changes Experienced Since Entering the Program

The participants described the ability to integrate into the community as the most significant daily changed experienced since entering housing. They indicated that housing allows for more freedom to be in the community, to stay out as late as one wishes, and to engage in preferred activities (e.g., riding a bike to local spots of interest). As one participant reported:

I get more freedom in the community and I can stay out as late as I want as long as I check in with the staff.

Several participants remarked that they experienced weight loss upon entering the program. Some noted that staff are encouraging them to adopt a healthy lifestyle that includes proper nutrition and exercise. As one participant reported:

I still got a ways to go, but I'm losing a lot more weight. When I first came into supportive, I was way overweight. But I'm still kind of a little past normal weight but I'm losing it more and more.

The participants reported that the program is structured to support engagement with primary care providers. This system allows the participants to regularly attend health appointments.

Several participants indicated that they have greater contact with loved ones since entering supportive housing. The participants noted that they are spending more time with family members or a significant other, and that they are now able to visit their families more easily.

The participants also related some additional goals that have been positively impacted by the program. These goals were in the areas of improving physical health, becoming more independent, and developing a sense of agency in their lives. More specifically, participants are working on losing weight, becoming more active, moving to accommodations that are even closer to family members, seeking employment, saving money, or buying a car.

Perspectives on Program Strengths and Weaknesses

The participants indicated that the strongest element of the program is the sense of independence it has allowed them to foster. They noted that they are responsible for their own actions and for maintaining their apartments. The participants described relationships with certain staff members as particularly helpful. With independence, they noted that they are responsible for natural consequences of their choices:

The best part is that, just being able to control what goes on in the apartment. It's just like having practically your own house. You can invite whoever you want, pretty much, as long as [staff member] knows...And also just basically whatever happens in there is your responsibility. [Staff] can't really say no you can't do this. Well you do it, you suffer the consequences. It's just that simple.

Cross Cutting Themes

The sites selected for inclusion in the study are diverse and varied, differing in populations served and housing and types of services provided. But across this sample, several cross-cutting themes emerged in the analysis, particularly in the areas of housing provision and program implementation. We summarize these key themes below, and then elaborate on each in greater detail.

Summary of Section 1: Housing-Related Themes: (1) social isolation and difficulty with daily living skills are common early adjustment challenges; (2) congregate and scattered site housing models present opportunities and challenges that should match participants' needs and goals; (3) a Housing First approach facilitates stability and well-being, but presents challenges to staff and participants; (4) housing provides participants with the stability needed to facilitate improved health and well-being.

Summary of Section 2: Program Implementation Themes: (1) programs are approaching the goal of reducing Medicaid costs through service linkages and psychoeducation; (2) case management, including home visits, is critical to promoting success; (3) bureaucratic hurdles often slow the process of placing participants into housing and present challenges to service provision; (4) program staff are interested in connecting with other providers, and would appreciate greater flexibility as they conduct their work.

Housing-Related Themes

Early Adjustment Challenges.

While participants, administrators, and staff widely described the benefits of supportive housing in terms of participants' health and well-being, early adjustment challenges were also commonly identified. These challenges frequently revolved around the social isolation many participants face when first moving into housing. This issue appeared to be most acute for participants moving into scattered-site apartments, though participants in congregate settings reported this challenge as well. Most participants reported trajectories that contributed to social isolation prior to moving to supportive housing; for instance, relationships with family were strained or non-existent due to homelessness, housing instability, and struggles with mental health and addiction. For participants moving into housing from congregate settings (e.g., OPWDD participants), it is a significant transition to move from living in a home with a 24-hour staff and peers to living on one's own.

In addition to social isolation, many participants struggle with the skills needed to be independent, such as making regular rent payments and maintaining an apartment. Participants who had been homeless prior to entering housing, as well as those who had been in restrictive settings, are often inexperienced at money management and other daily living skills. It is conceivable that some have never developed such skills before. Staff described how simply living indoors can be new and anxiety-provoking for individuals with mental health issues who had been chronically homeless. These

difficulties can have concrete negative consequences: when participants fail to pay rent on time or struggle to maintain an apartment, it can threaten their housing stability and retention in the programs.

At the program level, staff commonly described practices designed to ease the transition to housing. For instance, several programs identify initial move-in as a time in which they work intensively with participants to ensure needs are being addressed. They may perform more home visits at this stage, and work to establish the linkages needed for health and mental health services. Staff across a number of programs endeavored to provide social support to participants to foster a sense of connectedness. Others facilitated social activities, such as holding social or educational groups for participants or by coordinating outings in the community (e.g., movies). Staff at some of the scattered-site programs tried to familiarize participants with their surrounding communities to promote integration.

Opportunities and Challenges Associated with Congregate and Scattered-Site Housing.

Across the stakeholder groups, several benefits and limitations emerged in terms of congregate settings. Administrators and staff appreciated being able to provide services on-site, as well as the ability to be responsive to participant needs around the clock. Staff described the importance of this availability when serving participants with complex needs, such as serious mental illness. They also perceived that 24-hour support is a critical way to reduce unnecessary hospitalization, as staff are positioned to respond to participants in crisis in a proactive manner. Similarly, participants appreciated the ability to easily find staff in the building if they are having a problem or concern. In terms of limitations, staff reported that congregate settings may be more stigmatizing for participants, since this type of housing is known to be for individuals experiencing particular issues (e.g., mental illness). Arguably, this setting may not facilitate community integration to the same degree as scattered-site housing. Both staff and participants indicated that congregate settings can be challenging when participants are using substances, which may threaten the sobriety of other participants in recovery. Also, participants may grow tired of being around one another, and interpersonal conflicts within the building are common.

With scattered-site housing, staff need to travel significantly to visit participants who are located in different parts of a city or town. This travel requirement is particularly challenging when participants require significant support, such as during the transition to housing or during times of crisis. Staff described significant challenges regarding interactions with landlords and reported that it is difficult to secure apartments for participants at fair market rent. Staff widely cited issues of stigma and discrimination, as landlords are hesitant or unwilling to rent to program participants. These challenges to securing housing often limit the choice of apartment and/or neighborhood that can be offered to participants. Once housed, staff frequently negotiate with landlords to resolve any issues that may arise as the participants acclimate into the new setting. Participants had varied landlord experiences within scattered-site programs, with some finding their interactions appropriate and others problematic.

Housing First: Benefits to Participants and Challenges to Implementation.

A complicated picture emerged regarding the low barrier to entry and harm reduction principles associated with Housing First from both administrative/staff and participant perspectives. Administrators and staff widely acknowledged the critical role of housing in the lives of participants. They addressed how the security and stability associated with housing is a need that must be met before participants can pivot their focus toward health and well-being. They also highlighted how harm reduction promotes participants' engagement in the program, as they are more open with staff when they do not fear program removal or eviction due to using substances. This stance also provides participants with a sense of unconditional acceptance, which can facilitate recovery. However, some administrators and staff also highlighted how participants with acute, complex needs who are using substances can create significant challenges for a program. Serving the needs of these participants requires a substantial amount of staff time and energy, and substance use and associated behaviors often creates challenges with landlords, who may wish to evict participants. A common perspective is that in order to mitigate these challenges, programs must wrap intensive services and supports around a participant with such needs. However, administrators and staff in some programs reported that they do not provide the necessary services or service linkages meet the needs of participants with these acute and complex needs, or that they have insufficient resources for meeting these needs (e.g., not enough staff).

Interestingly, program participants also held mixed views regarding the harm reduction approach associated with Housing First. Some see harm reduction as critical and necessary, as participants with addictions are going to use regardless of a program's policies. The ability to reach out for help and communicate with caseworkers without the fear of losing one's housing can be an important step in continuing the path to recovery. A number of participants indicated that they believe this approach saves lives. However, the participants also highlighted how being near participants who are using substances can threaten the recovery and stability of others. Some suggested that while it is up to individual if s/he chooses to use while in the program, s/he should ensure that they are not infringing upon the rights of others (e.g., using in one's private apartment and not in public spaces). The participants also commonly pointed out that substance abuse within scattered site housing often comes with natural consequences; while the programs may not remove a participant, landlords may elect to do so.

Housing Promotes Improved Health and Well-Being.

Administrators, staff, and especially participants described the critical role of housing in facilitating health and well-being. The participants highlighted how housing provides them with a sense of peace, dignity, and personal safety. Most described sincere gratitude and a sense of luck or grace for the opportunity to enroll in the MRT-SH programs, contrasting the sense of comfort and security they currently experience in the programs with the trauma associated with being precariously housed, homeless, or institutionalized.

In terms of how housing facilitates health and well-being, the participants commonly described how having a place of one's own reduces stress that exacerbates their chronic conditions, mental health problems, and/or substance abuse. Having a safe place to stay and relax positively impacts their well-being and improves their conditions. Many noted that they are able to cook healthy food at home and to begin establishing other healthy routines. The stability provided by housing also allows participants to establish and follow through with primary care and preventative appointments. Many participants indicated that housing reduced their need for emergency department visits. For example, participants who had been homeless reported going to the emergency department to get out of the cold, to have a safe place to stay for a while, or because they were tired or feeling unwell due to walking around all day with nowhere to go. Some indicated that even primary care doctors could be seen less since they entered the MRT-SH programs, as they are more effectively managing their health conditions.

Though the results were mixed, some participants described how housing allowed them to strengthen relationships with family and loved ones. Some were able to reunite with families, since they can now invite relatives to their apartments. The participants described being able to see their children, with some working to regain custody. However, other participants described relationships that continue to be strained, in spite of housing.

Program Implementation Themes

Reducing Medicaid Costs through Linkages and Psychoeducation

There was consistency across most programs in terms of approaches to reducing Medicaid costs. Administrators and staff described how a central component of reducing Medicaid costs is facilitating access to primary care and preventative services, which participants can use in place of unnecessary or inappropriate hospitalizations. At an early stage, the programs work with participants to establish linkages with primary care doctors, as well as community-based mental health and addiction services. The administrators and staff indicated that this shift in the type of care used by participants is contributing to cost savings.

Programs that target individuals who had resided in institutional placements, such as nursing homes or IRAs for individuals with developmental disabilities, reported a different mechanism for cost savings. In these programs, administrators and staff noted that a change in the cost of the setting itself is accounting for decreased Medicaid costs (i.e., institutional placements and nursing homes are significantly more expensive than supportive housing).

Program administrators and staff also described the important role of educating participants about the types of services available to them, encouraging primary and preventative care over high-cost hospitalizations. For instance, the staff explain to participants how establishing a relationship with a doctor who will get to know them is helpful,

and highlight how preventative care is an important way to maintain one's health and wellness. Some staff noted that participants may go to hospitals when they are not feeling well because it is the only form of care they know. Thus, it is important to educate them about better alternatives. Several programs also provide psychoeducation, which entails teaching participants about their mental health conditions and how to adhere to medication regimens. Staff hope that these activities will help participants engage in preventative care and choose the most appropriate care venues, thus reducing Medicaid costs.

The Role of Case Management and Support Services

Case management was highlighted as critical to participants' success in all programs including such a service. Case managers work with participants to establish linkages with primary care doctors, mental health and addiction services, and other supports. The case managers also commonly described working closely with participants to help them remember their appointments, including sometimes transporting them or accompanying them to appointments. Additionally, case managers play an important role in helping participants to develop the skills needed for independent living, such as money management, paying rent, navigating public transportation, cooking, and self-advocacy.

In scattered site programs, case workers and housing specialists play a mediating role in working with landlords. When participants exhibit behaviors that can lead to eviction, case managers and housing specialists are able to intervene to help stabilize the individual. By providing a buffer in this manner, landlords are willing to continue working with the programs.

In addition, the staff often described how social support through caseworkers' home visits is an important way to reduce unnecessary hospitalizations. They noted that participants sometimes need compassionate, human interactions to discuss anxiety, depression, or health concerns. Participants identified this resource as particularly helpful as well, noting that talking with a caring worker, who might take them for a walk or help to lift their spirits, can improve their sense of well-being and help them avoid simply going to the hospital. Participants with complex needs and those who are socially isolated often have few relationships, making interactions with case workers especially important.

Bureaucratic Hurdles Present Challenges

Administrators and staff within several programs described bureaucratic hurdles that present challenges in the context of targeting and enrolling participants, as well as providing needed supports. Some staff viewed their program's eligibility criteria as rigid, arguing that individuals are still high-need and high-cost even if they do not meet a specified number of emergency department visits, for instance. Also, a few programs noted that they would like to be able to serve participants more proactively or preventatively, before they become such high utilizers. Another impediment is the requirement of documented homeless status through shelter utilization. Several administrators and staff described how this requirement causes programs to overlook key segments of the homeless population, such as those who are precariously housed in settings other than shelters (e.g., couch surfing) as well as those who are living on the streets. The New York City-based program staff described lengthy and complex application processes for housing, which take considerable time to complete while individuals are unnecessarily remaining in shelter or a nursing home.

Administrators and staff often articulated that while a central charge is to identify and target high Medicaid utilizers, they had received little guidance about how to operationalize this guideline. The OASAS programs are a notable exception, as the criteria were clearly defined and standardized across the providers (however, some questioned these criteria). In addition, most programs do not have access to Medicaid data to confirm high Medicaid cost.

Staff Feedback: Learning Opportunities and Implementation Flexibility

Program staff and administrators commonly noted that they would welcome the opportunity to be in closer communication with NYSDOH, as well as other supportive housing providers. The staff and administrators were interested in learning about how other programs manage challenges similar to their own, and hearing about potential innovations and lessons learned.

Additionally, administrators and staff often provided feedback about the need for greater flexibility in program implementation. This response was most often articulated in the context of the budget and allowable expenses. For

instance, program staff noted that they would like to be able to purchase air conditioners for participants, particularly those with chronic health conditions, to keep them more comfortable at home. Others described how amenities such as a small television, radio, or DVD player could go a long way in easing the anxiety some participants experience when they are first housed.

The need for flexibility was also articulated by administrators and staff in some programs as it relates to targeting and eligibility criteria. For instance, some suggested that mandating a certain number of emergency department visits is counter-productive, as the programs may be missing those who are high-need but could be served well. Others suggested that the need to document homelessness through shelters is burdensome, and also causes the programs to miss vulnerable populations, such as individuals who are couch-surfing or living on the streets or other settings not suitable for human habitation.

Summary and Conclusions

This qualitative analysis highlights the diversity of the MRT-SH programs, in terms of housing and service configurations, as well as populations served. Despite this diversity, commonalities emerged across the data with implications for policy and practice.

The analysis underscored how critical housing is in the lives of individuals who had been unstably housed or homeless, as well as those who were institutionalized. Housing allows many to reclaim a positive sense of identity, experience peace and stability, become independent, and address health and recovery needs. Support services, such as case management, are essential to fostering the skills needed for participants to become independent and to retain their housing. Case management is also critical to facilitating linkages to physical and mental health providers and other support systems.

While supportive housing is positively impacting health and quality of life for most participants, it is not a panacea. Many individuals continue to struggle with mental health issues, chronic conditions, and addictions; others contend with social isolation and strained relationships. The participants described trauma and significant adversity prior to entering supportive housing, which is likely compounded by structural injustices, such as poverty, discrimination, racism, and marginalization. Thus, the complex needs they are experiencing when entering MRT-SH programs are unlikely to be fully ameliorated by supportive housing.

The analysis also underscored how programs should anticipate early adjustment challenges as individuals first enter the program. Many participants struggle to pay rent on time, maintain their apartments, remember and follow through with medical appointments, and navigate their new communities. It is especially important for programs to provide intensive services at this stage, and to continually assess the specific supports each participant requires in order to retain their housing.

A complex picture emerged in terms of the benefits and drawbacks of congregate and scattered-site supportive housing models. The analysis suggests that the characteristics, needs, and goals of the participants might suggest a better fit with a certain model. For instance, participants with acute mental health needs who experience significant anxiety in an apartment environment might be best served by a congregate program with on-site staff. Those who can acclimate into the community and who wish to reclaim their lives with identities that are less stigmatized might prefer and be successful in a scattered-site program.

Similarly, perspectives on the Housing First approach emerged as complex and nuanced. While the benefits of the model were widely described by administrators, staff, and participants, limitations and challenges were highlighted as well. Program staff often struggled to address the addictions of individuals residing in the programs, which often complicate landlord relationships. Participants were sometimes hesitant to endorse harm reduction, as they indicated the possibility of becoming destabilized when surrounded by other individuals who are using. To address these challenges, it is important to have intensive supports in place for those with complex needs, such as addictions. These supports may include medical resources for those struggling with addiction that can be aimed at decreasing use or promoting safer use when participants are unable or unwilling to abstain, peer recovery coaches, mental health or

addictions referrals, or intensive and frequent home visits from case managers. Further, programs may benefit from promoting a respectful and safe environment for all residents, such that those who may be using are encouraged to do so privately, and in a manner less obtrusive and risky to others (e.g., not inviting drug dealers to the building).

Since a key goal of the MRT-SH programs is to reduce Medicaid costs, the programs could greatly benefit from additional guidance about how to operationalize and validate high Medicaid utilization. Drawing from the evaluation findings (e.g., upcoming cost and targeting findings), guidance can be provided regarding how to target and prioritize participants for the program who are the highest utilizers. NYSDOH might also consider ways to provide program staff with streamlined access to Medicaid data to confirm high utilization.

The findings further suggested the need to address bureaucratic hurdles to the extent possible, in order to expedite the process of enrolling participants into the programs. Administrators and staff of the programs described burdensome application processes and requirements (e.g., proving homeless status) that create hurdles to rapidly housing those who are most vulnerable. Often these hurdles derived from the requirements of other funders outside of MRT. Further, the programs may benefit by greater flexibility within the budget to address the needs of participants, such as offsetting the cost of transportation and providing amenities that allow individuals to feel more comfortable and less anxious in their apartments (e.g., air conditioners, radios or DVD players, funding for an occasional movie outing, etc.).

Finally, the analysis suggests that providers are eager for opportunities to interact and obtain feedback from one another, as well as from NYSDOH. One approach to achieve this would be to develop a learning community for the providers, consisting of virtual and in-person meetings to share ideas about innovative approaches. Learning communities can also be a forum for discussing challenges that the providers are experiencing, so staff can share ideas about approaches that others have found successful.

While the study provides a rich and contextualized look at MRT-SH program implementation, several limitations warrant discussion. First, the providers who were selected for the study are not necessarily representative of the full complement of MRT-SH providers. These programs were selected, in part, because they were performing well or implementing innovative practices. The extent to which other providers are doing so is unknown. Further, participation in the participant focus groups was voluntary. It is conceivable that those who volunteered for the focus groups are higher functioning, more likely to be doing well, or more likely to feel strongly about the program (either positively or negatively), compared with other participants. Those who were unsuccessful in the program (e.g., individuals who were asked to leave or who were evicted) were missing from the analysis; thus, the voices of those who struggled significantly in spite of supportive housing were not heard. Finally, as is the case with any qualitative data collection, interpersonal interactions between participants and the research team can impact the type and nature of information shared. For instance, the participants' comfort level and perceptions of the interviewers may influence what is ultimately discussed in the groups. Further, administrators and staff may be influenced by knowledge that their programs are being evaluated, which can conceivably result in a biased portrayal of on the ground operations.

Medicaid Redesign Team
Supportive Housing Evaluation
**IMPLEMENTATION
STUDY REPORT**

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