


Department of Health | Office of Health Insurance Programs

The Importance Of Stable Housing In Long Term Care: New York City

March 20, 2017



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University at Albany School of Public Health/Center for Public Health Continuing Education


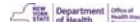
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- Handouts for today's presentation can be found at www.LTCDPtraining.org




Webinar Guidelines

- Turn on your computer speakers for sound 
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Continuing Education Credits & Evaluation

- For those who also watched **The Importance Of Stable Housing In Long Term Care: Statewide Focus** webinar, please note that today's webinar is going to cover much of the same content, with the exception of some specific resources and housing options only offered in New York City. For that reason today's webinar will provide .25 credits of CME, CNE or CHES. Visit <https://www.ualbanycph.org/eval/SPHeval.cfm?ID=323> to complete the evaluation and post test.
- If you would like to obtain an additional hour of credit for the "Statewide Focus" content, please go to the evaluation and post-test for the New York State webinar here: http://www.albany.edu/sph/cphce/icc_webinar_03062017.shtml. That program offers 1.0 CME, CNE, CHES and Social Work credits.

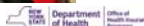


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- No commercial funding has been accepted for this activity.



Pascale Leone, MPP Senior Program Manager, Corporation for Supportive Housing (CSH)



Our Mission

Advancing housing solutions that:



Improve lives of vulnerable people







Maximize public & private resources





Build strong, healthy communities


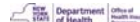
 

Today's Takeaways (webinar objectives)

-  Name at least three types of housing options specific to New York City
-  Describe the impact of stable housing on positive health outcomes
-  List at least two components of supportive housing
-  Identify at least three referral resources available in New York City

Housing Instability & Homelessness

Grace's Story

Grace is a 25 year old woman who has a history of serious and persistent mental illness and illegal substance use. She cycles through the hospital system's emergency department. She uses a manual wheelchair for long distances and a rollator for short distances. Grace was recently admitted for an injury sustained to her head while under the influence but has been cleared for discharge. However, while inpatient, Grace was legally evicted for non-payment of rent. Hospital staff know that without access to treatment and adequate housing, Grace will be back again and perhaps with a more serious injury.



Many People Experience Homelessness

On any given night
86,352

people in the New York State experience homelessness
73,523 (85%) are in New York City

Source: HUD, Annual Point-in-Time Count



Causes of Housing Instability and Homelessness

Structural Causes

- Lack of affordable housing, unemployment rates, poverty

Institutional Causes

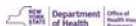
- People leaving care (prisons, mental health facilities, nursing homes)

Relationship Causes

- Family breakdown, DV, divorce, death

Personal Causes

- Mental illness, drug/alcohol use



Health Impacts Housing Stability

Medical Expenses

Poor Physical Health

Poor Mental Health

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Housing Is Healthcare

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Poor Health & Housing Instability is a Cycle

Homelessness/
Housing
Instability

Poor
Health

- Poor health puts one at risk for homelessness
- Homelessness puts one at risk for poor health
- Homelessness complicates efforts to treat illnesses and injuries

Source: National Healthcare for the Homeless Council, "Housing is Health Care", 2011

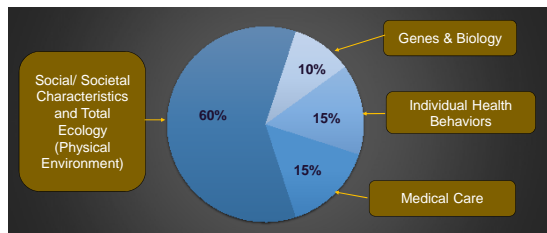
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Social Determinants of Health

The circumstances in which people are born, grow up, live, work and age, as well as the health systems they utilize.



Social Determinants of Health

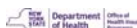
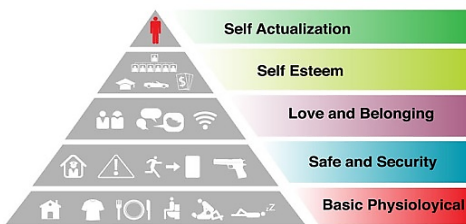


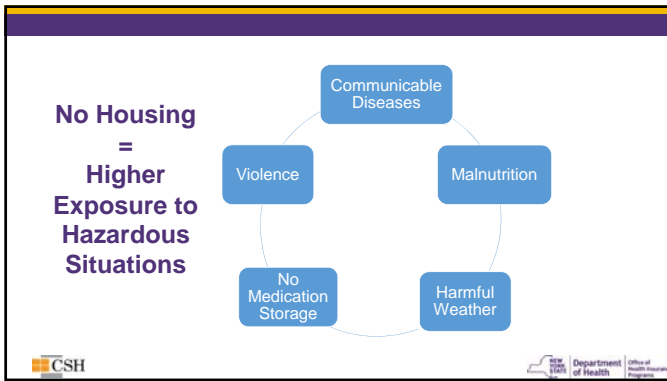
Estimates of how each of the five major determinants influence health. Source: Public Policy Frameworks for Improving Population Health. Annals of the New York Academy of Sciences, 1999. 896

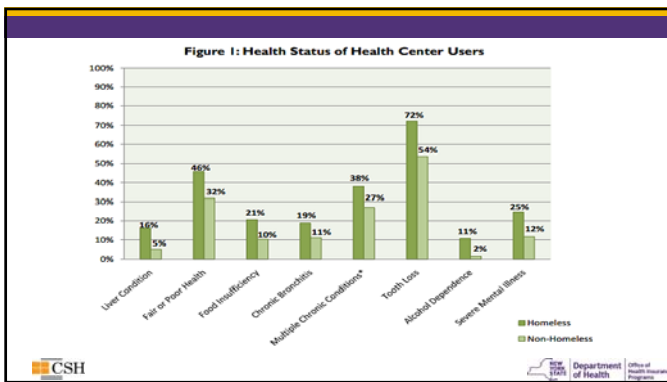


Maslow's Hierarchy

Basic human Needs







No Housing = More Frequent Emergency Dept. (ED) Use

Patients who were homeless or precariously housed were six times more likely to name the emergency department as their usual source of care or to say they had no usual source of care than patients who had stable housing.

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The strongest healthcare intervention for high utilizers is supportive housing

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
 HOUSING AND URBAN HEALTH CLINIC
 234 Eddy Street, S.F., CA 94102 Tel: (415) 353-5056

NAME: Don Berwick DATE: 1/22/11
 ADDRESS: _____ ZIP: _____ AGE: _____

Rx 1 supportive housing unit

LABEL AS SUCH (PLEASE CIRCLE) As directed

J. Bamberg M.D.
 License No: Joshua Bamberger DEA # _____

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Triple Aim Alignment

- Improving Quality of Care**
 - Continuity of care from hospital to community: patients get care they need
- Reducing Costs**
 - Reduced readmissions to ER and hospital
- Improving Health Outcomes**
 - Stabilizes very fragile individuals through housing and intensive case management services

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Housing Interventions and Solutions



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Types of Housing Interventions

- Crisis Response System Interventions
- Affordable Housing
- Supportive Housing

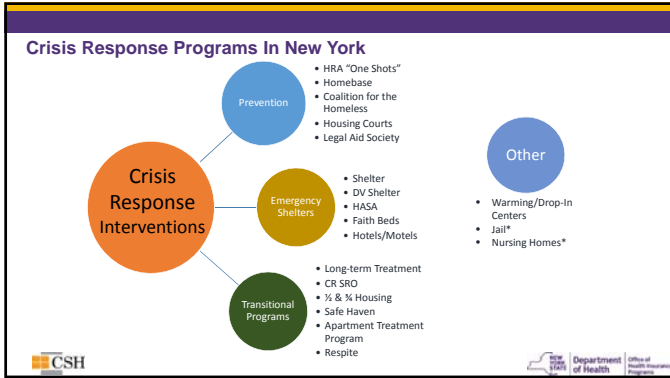
New York City Shelter/Housing Universe

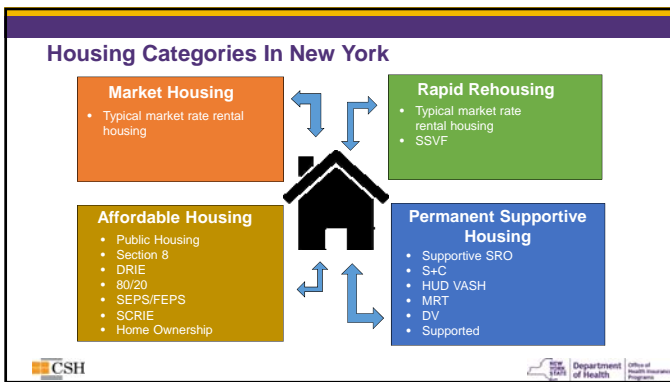



Congregate vs. Scattered Site

Units Are Located in One Building or Scattered Throughout Multiple Properties or Buildings





Crisis Intervention		Homeless Prevention	
Key Characteristics	Services	Examples	
<ul style="list-style-type: none"> Financial assistance to prevent housing loss For households currently housed 	<ul style="list-style-type: none"> Minimal 	<ul style="list-style-type: none"> Utility assistance Church funds Legal Aid 	

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Prevention In NYC

Prevention

Homebase

- Resource center meant for households on the brink of homelessness.
- Provides services to prevent homelessness including emergency rental assistance, tenant/landlord mediation, benefits advocacy, etc.
- DHS, 311

HRA One-Shot Deals

- A one-time grant for rental/utility arrears and emergency moving assistance offered through HRA. Applicants must demonstrate ability to pay future rent and utilities and have US residency status.
- HRA Info Hotline (718) 557-1399, Local Job Center

Coalition for the Homeless Eviction Prevention Hotline

- Eligible applicants may obtain one-time grant of \$1,000 to those who can demonstrate ongoing ability to pay their rent
- Eviction Prevention Hotline is open every Wednesday at 9:30AM
- Hotline 212-776-2039

Crisis Intervention
Emergency Shelter

Key Characteristics	Services	Examples
<ul style="list-style-type: none"> • Intended for short-term stays (0-3 months) • Often the first place people go to seek shelter 	<ul style="list-style-type: none"> • Limited or no services during stay 	<ul style="list-style-type: none"> • Warming, Drop-in centers • Overnight Shelters • DV Shelters

Accessing Emergency Shelter in NYC

1) HELP Women's Shelter 116 Williams Ave, Brooklyn

2) Franklin Shelter 1122 Franklin Avenue (near 166th Street) Bronx

What to bring

Picture ID (e.g. welfare ID card, green card, driver's license, passport/visa, or pictured employment card); birth certificate; social security card; Medicaid card; identity card in the Public Assistance system; pay stub if working

30th Street Intake Center
400-430 E 30th St 24hrs/7days

Prevention Assistance and Temporary Housing (PATH) 151 E 151 St, Bronx NY
24hrs/7 days (applications processed 9-5)

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Crisis Intervention		Rapid Rehousing	
Key Characteristics	Services	Examples	
<ul style="list-style-type: none"> • Time-limited subsidy and services • Members live in market-rate housing scattered in the community 	<ul style="list-style-type: none"> • Case management • Referrals 	<ul style="list-style-type: none"> • Supportive Service for Veteran Families (SSVF) 	

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Rapid Rehousing

<h4>Home to Stay</h4> <ul style="list-style-type: none"> • Enriched housing placement and support services to episodic and recidivist homeless families who appeared likely to require such 	<h4>Supportive Services for Veteran Families Program (SSVF)</h4> <ul style="list-style-type: none"> • Short-term rapid rehousing and homeless prevention services to homeless and at-risk Veterans and their families • VA, non-profit, CBOs
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Rapid Rehousing

LINC for Families		LINC for Singles & Adult Families	
<p>LINC I assists families in shelter who are working full-time but are unable to afford stable housing on their own to relocate from the City shelter system.</p> <p>LINC VI assists families with children to move out of shelter and reunify with "host families" consisting of friends or relatives.</p> <p>LINC III provides rental assistance for families recently affected by DV to relocate them from the City shelter system. These families are selected from HRA DV shelters and families in DHS shelters who HRA has certified as DV survivors.</p>	<p>LINC II assists families in shelter who are identified within vulnerable populations and who need additional assistance and supports to relocate from the City shelter system and become securely housed in the community.</p>	<p>LINC IV provides rental assistance to single adults and adult families in shelter that are either a senior (60+) or have a disability, and are unable to afford housing on their own to leave shelter.</p>	<p>LINC V assists single adults and adult families in shelter who are working, but are unable to afford stable housing on their own to relocate from the City shelter system.</p>

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Crisis Intervention	Transitional Housing	
Key Characteristics	Services	Examples
<ul style="list-style-type: none"> • Medium-term (3-24 months) • Highly-structured • Congregate Living 	<ul style="list-style-type: none"> • Intensive • Treatment or Goal Oriented (i.e. recovery, employment) 	<ul style="list-style-type: none"> • Treatment facilities • Nursing Homes • Half-way homes • DV Housing • VA Grant Per Diem

Transitional Programs

<p>Apartment Treatment (scattered-site)</p> <ul style="list-style-type: none"> • Shared apartments in community for individuals with mental illness or substance abuse. Provides an apartment in the community with staff visits as necessary to provide rehabilitative services designed to improve functioning and develop greater independence. Typically 18+, Level II • Eligible individuals must have Medicaid and/or SSI, SSD or be on public assistance. • NYS - OMH SPOA 		<p>Long-term Treatment (Scattered-site or Congregate)</p> <ul style="list-style-type: none"> • Shared apartments in community for individuals with substance abuse or substance abuse and co-occurring mental illness. Typically 18+, Level II • OMH, OASAS
<p>CR SRO (congregate)</p> <ul style="list-style-type: none"> • Community Residences/Single Room Occupancy: Usually 2-5 years before they transition to more independent living. Level II • Chronically homeless, SPMI or MICA single adults. Preference for those discharged from long-term psychiatric hospitalization. • OMH 		

Transitional Programs

<p>Adult Care Facility</p> <ul style="list-style-type: none"> • Assessment completed by RN; forms valid for 30 days for hospitalized individuals & 90 days for those who are in any other setting, including their home (required by NYS DOH) • For adult care, must apply to the individual, privately-owned facility 		<p>Three-Quarter Houses aka Sober Homes (congregate)</p> <ul style="list-style-type: none"> • The congregate sites are not licensed by a NYS authority • There are at least 500 such "Sober Home" beds on Long Island
<p>Safe Haven</p> <ul style="list-style-type: none"> • Housing and rehab services for hard to reach homeless population with SMI who aren't engaged in conventional housing/outpatient treatment • Drop-in centers are usually the portals of entry for Safe Havens 		

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AH
Affordable/Subsidized Housing

Key Characteristics	Services	Examples
<ul style="list-style-type: none"> No time-limit subsidy Can be project-based or scattered site 	<ul style="list-style-type: none"> Members find own services in community 	<ul style="list-style-type: none"> Housing Choice Voucher (Section 8) Public Housing

Affordable Housing

Public Housing	Housing Choice Voucher (Section 8)	80/20	Low Income Housing Lotteries
<ul style="list-style-type: none"> Affordable housing for low- and moderate-income residents 18+, income restricted/criminal background restrictions Local PHAs 	<ul style="list-style-type: none"> Tenant-based vouchers to extremely low-income (30% AMI), very low-income (50% AMI) and low-income (80% AMI) families living in the State of New York (project-based or individual "portable" vouchers) 18+, income-based, restrictions (background) Local PHAs 	<ul style="list-style-type: none"> Multi-family rental developments where at least 20% of units are set aside for very low-income residents (50% or less local AMI) Similar to 80/20 but targeted specifically to homeless, usually 10-30% HCR/HFA 	<ul style="list-style-type: none"> Completed application and enter it in an apartment lottery via the development/project HCR

Affordable Housing

Sect. 202	Home Ownership (Mitchell-Lama)
<ul style="list-style-type: none"> Supportive Housing for the Elderly program (Section 202) provides rent subsidies to make units affordable Available for very low-income household comprised of at least one person who is at least 62 years old HUD website for 202 developments 	<ul style="list-style-type: none"> Affordable rental and cooperative housing to moderate and middle-income families Income requirements set by each development HCR for lists, apply directly to development

Affordable Housing

Disability Rent Increase Exemption (DRIE)

- Offers qualifying tenants with disabilities an exemption from future rent increases
- Eligible persons must be at least 18, receive either SSI, SSDI, VA disability pension, or disability-related Medicaid, living in Mitchell-Lama housing, Article XI cooperatives, federally assisted cooperatives, or rent-regulated apartments
- NYC - Applications can be mailed to NYC Finance Dept, SCRIE/DRIE Walk-In Center, on online

Senior Citizen Rent Increase Exemption Program (SCRIE)

- Exempts low-income renters who are 62 or older from some or all rent increases.
- Elderly persons living in Mitchell-Lama housing, Article XI cooperatives, federally assisted cooperatives, or rent regulated apartments may be eligible
- NYC – NYC Dept. of Aging

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Affordable Housing

Special Exit and Prevention Supplement (SEPS)

- Offers eligible individuals and adult families in shelter, or at risk of entry to shelter, assistance to secure permanent housing and rental assistance so that they pay 30% of their income for rent; can be for an apartment or a rented room
- Households must fall into one of 4 eligibility categories and also have an Active or Single Issue Public Assistance case and a household income that does not exceed 200% of the federal poverty level

FEPS

- Offers eligible families with children in shelter, or at risk of entry to shelter,
- Households must fall into one of 4 eligibility categories, be eligible for Public Assistance and have an Active or Single Issue Public Assistance case
- In most cases, the full rent amount is paid directly to the landlord through PA shelter allowance and FEPS rent supplement

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SH Supportive Housing

Key Characteristics	Services	Examples
<ul style="list-style-type: none"> • Tenants have a lease • Provide rent subsidy and services • Targeted to people who need intensive support 	<ul style="list-style-type: none"> • Wrap-around, tailored services • Voluntary 	<ul style="list-style-type: none"> • HUD VASH • Section 811 • Homeless Dedicated SH

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What is Supportive Housing?

Supportive housing combines affordable housing with services that help people who face the most complex challenges to live with stability, autonomy and dignity.

It is **permanent, affordable, independent, tenant centered, flexible and voluntary.**



What Does it Look Like?



Housing

Access to Basic Needs

Reduces Stress

Relations and Interactions

Supportive Housing

Reduces Stress

Participant Engagement


Access to Basic Needs

Relations and Interactions

Access to Healthcare



Supportive Housing: Key Components



Targets households with barriers	Is affordable	Provides tenants with leases
Engages tenants in voluntary services	Coordinates among key partners	Connects tenants with community

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1. Targets households with multiple barriers

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A Closer Look

Residents of institutions who prefer to live in the community	Chronically homeless
People exiting jail or prison with chronic health conditions (esp. mental health)	Mental health, substance use and/or physical health disabling conditions coupled with housing need

Includes individuals, families and youth

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2. Housing is Affordable



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3. Provides Tenants with Leases



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4. Engages tenants in flexible, voluntary services

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Supportive Services

- Health/Mental Health Services
- Child Care
- Employment Services and Support
- Substance Abuse
- Independent Living Skills
- Community Building Activities
- Budgeting & Financial Management Training

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Supportive Housing Services

Tenancy Supports	Housing Case Management
Outreach and engagement	Service plan development
Housing search assistance	Coordination with primary care and health homes
Collecting documents to apply for housing	Coordination with substance use treatment providers
Completing housing applications	Coordination with mental health providers
Subsidy applications and recertifications	Coordination of vision and dental providers
Advocacy with landlords to rent units	Coordination with hospitals/emergency departments
Master-lease negotiations	Crisis interventions and Critical Time Intervention
Acquiring furnishings	Motivational interviewing
Purchasing cleaning supplies, dishes, linens, etc.	Trauma Informed Care
Moving assistance if 1 st or 2 nd housing situation does not work out	Transportation to appointments
Tenancy rights and responsibilities education	Entitlement assistance
Eviction prevention (paying rent on time)	Independent living skills coaching
Eviction prevention (conflict resolution)	Individual counseling and de-escalation
Eviction prevention (lease behavior requirements)	Linkages to education, job skills training, and employment
Eviction prevention (utilities management)	Support groups
Landlord relationship maintenance	End-of-life planning
Subsidy provider relationship maintenance	Re-engagement

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Services are Voluntary

What are voluntary services?

Participation in services is not a condition of tenancy	Services are voluntary for tenants...not staff Staff must work to build relationships with tenants	Emphasis should be on user-friendly services driven by tenant needs and individual goals
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5. Coordinates among key partners

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6. Connects Tenants with Community



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Supportive Housing in NYC

- NYNY I, II
- NYNY III
- HIV / AIDS Services Administration (HASA)
- HOPWA
- HUD VASH
- Medicaid Redesign (MRT)
- Shelter + Care

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NYYNY I,II, III Supportive Housing

NYYNY Agreement	Year of Agreement	# of Units	Housing & Services For ...
NYYNY I	1990	5,725	Seriously and Persistently Mentally III (SPMI), AND street/ shelter homeless
NYYNY II	1999	2,320	SPMI AND street/ shelter homeless
NYYNY III	2005	9,000	Chronically homeless, at risk of homelessness, and special need: <ul style="list-style-type: none"> Adults with Substance Abuse Disorder; HIV/AIDS; SPMI Young Adults (18-24) aging out of foster care and residential treatment Chronically homeless families / families at risk of chronic homelessness that have a disabled head of household with substance abuse disorder; HIV/AIDS; SPMI; Chemically Addicted Mentally III(CAMI) and/or a disabling non-SPMI clinical condition

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Potential NYYNY IV Agreement? Campaign 4 NY/NY Housing

- The Problem:
 - Recent statewide CSH study found unmet supportive need for 36,000 households
 - Homelessness in New York has nearly doubled in the last decade since NY/NY III was created
 - Most NYYNY III units are filled up
 - Not nearly enough supportive housing to meet demand. Four out of every five people found eligible for supportive housing in New York City have had to stay in shelter or on the street because there are too few supportive housing units left
- The Ask:
 - 35,000 units of supportive housing statewide

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HRA 2010e Electronic Housing Application NYC Supportive Housing

The HRA 2010e Serves 2 Purposes

- Residential placement into supportive housing for people with mental illness
- Determines eligibility for NY/NY I, II & III housing

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A Complete HRA 2010e Packet

- HRA housing application
- A comprehensive psychosocial summary, completed within 6 months (180 days)
- TB Test & Clearance (PPD) – within the past year
- TB Clearance (PPD) Chest X-Ray - only if PPD is positive
- If mentally: a comprehensive psychiatric evaluation, signed and dated by a psychiatrist, and completed within 6 months; if no mental illness, a psychiatric evaluation is not attached
- Provide thorough documentation of all street and shelter homelessness on letterhead in your application packets!



CUCS Vacancy List

The Center for Urban Community Services (CUCS) maintains a Housing Vacancy and Information Update that can be found www.cucs.org.



VACANCY AND INFORMATION UPDATE

Residential Placement Management System (RPMS)
Vol. 22, No. 12 FRIDAY, JUNE 07th 2014

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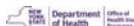
ANNOUNCEMENTS

SPOA CARE COORDINATION/ACT PROCEDURES TO CHANGE

On July 1, 2014 the NYC Department of Health and Mental Hygiene (DOHMH) will take over the administrative function of the Single Point of Access (SPOA) from the Center for Urban Community Services (CUCS) for Care Coordination and ACT services only.



Troubleshooting Housing Access: Tips & Strategies



General Strategies

- Connect with the right people
- Keep an updated account of housing resources and eligibility criteria
- Participate in your local Continuum of Care
- Consider initiatives, collaborations or partnerships to better coordinate healthcare and housing



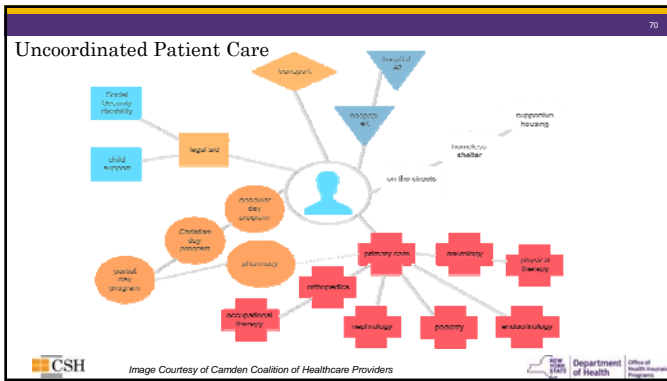
Partnerships are the Key



The Link: Coordinating Care with Housing

Care coordination requires the deliberate organizing of a patient's care needs and involving and sharing information among all pertinent providers involved in a patient's care to achieve optimal outcomes.





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- ### Why make care coordination a priority?
- Patients/ tenants hate it when we can't make this work.
 - Poor hand-offs lead to delays in care that may be dangerous to health.
 - There is enormous waste associated with unnecessary referrals, duplicate testing, unwanted and unnecessary specialist to specialist referral.
 - Primary care practice will be more rewarding.
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QUESTIONS?

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Thank You!

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Please visit: <https://www.ualbanycphp.org/eval/SPHeval.cfm?ID=323> to fill out your evaluation and post test

Today's presentation handouts and resources are available on the webpage for the program, along with archived recordings of past trainings

