Alaska Supportive Housing Plan

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I. Executive Summary

In April 2014, the Alaska Department of Health and Social Services (DHSS), its Division of Behavioral Health (DBH), and the Alaska Mental Health Trust Authority (the Trust) formally embarked on a statewide strategic supportive housing planning process. The purpose of the process was to develop a three-year action plan that would enable Alaska to achieve the following objectives:

1. Maximize the development of integrated, affordable, lease-based permanent supportive housing (PSH) for Alaskans with serious behavioral health conditions served by DHSS and the Trust.
2. Identify, develop, and implement the services that individuals need to succeed in PSH.
3. Coordinate efforts among state and partner agencies working to develop and ensure access to PSH.
4. Leverage additional federal financial participation through modifications to state Medicaid services.

DBH and the Trust contracted with the Technical Assistance Collaborative, Inc. (TAC), a national non-profit consulting and technical assistance firm and recognized leader at the intersection of affordable housing, health care, and human services policy and systems to facilitate the planning process and develop strategic goals for these partnering state agencies to implement.

DBH and the Trust recognize permanent supportive housing (PSH) as a best practice and see a role for PSH as a frontline intervention to serve people with significant disabilities in community-based settings. Research shows that PSH is more cost-effective than institutional or restrictive housing options, and that it demonstrates positive outcomes such as reduced hospitalizations and homelessness and improved behavioral and physical health. The United States Substance Abuse and Mental Health Services Administration (SAMHSA) describes PSH as "decent, safe, and affordable community-based housing that provides tenants with the rights of tenancy under state and local landlord tenant laws and is linked to voluntary and flexible support and services designed to meet tenants' needs and preferences."[1] In addition to SAMHSA, other federal agencies — specifically the Department of Housing and Urban Development (HUD), the Centers for Medicare and Medicaid Services (CMS), the Department of Justice (DOJ), and the US Interagency Council on Homelessness (USICH) — all recognize PSH as a best practice.

In Alaska, there is significant demand for PSH. However, the primary residential options for individuals with disabilities who need housing are predominantly in assisted living facilities, funded through General Relief Assistance (GRA), a 100% state-funded program that was established to pay for room, board, and services in assisted living homes. Over the years, assisted living facilities expanded significantly due to a shortage of other integrated, affordable housing options. Anecdotal information suggests that a large number of residents in assisted living facilities could live in more integrated, affordable housing settings, and that they would

[1] SAMHSA. (2010). Permanent Supportive Housing Evidence-Based Practices (EBP) KIT. PowerPoint Presentation: http://store.samhsa.gov/product/SMA10-4510.

prefer this option. Alaska currently has approximately 630 assisted living facilities with approximately 3,700 beds[2] used mostly for people with mental illness or intellectual or developmental disabilities. In addition, according to its 2014 Point-in-Time count, Alaska has approximately 1,784 people who are homeless, of whom 206 meet the definition of chronically homeless.[3] For Alaska's most vulnerable populations, the cost of housing is out of reach. In fact, nowhere in Alaska can an individual living entirely on Supplemental Security Income (SSI) afford federally determined fair market rents (FMR).[4]

This report discusses several policy, legal, and financial considerations as Alaska moves to expand PSH opportunities for vulnerable populations. The US Supreme Court's Olmstead decision (1999) upheld Title II of the Americans with Disabilities Act (ADA) and the right of individuals with disabilities to live in the least restrictive, most integrated settings possible.[5] The decision required states to plan affirmatively to serve people in integrated, community-based settings. In addition, the federal agencies that recognize PSH as a best practice are working to align their approaches to Olmstead and to homelessness. This alignment of Olmstead and homelessness policy at the federal level has implications for both funding and enforcement, and is a strong influence on how states like Alaska move forward to serve people with disabilities and other complex needs in the community.

Alaska's current budget climate poses significant challenges to expanding the supply of affordable housing and services. Yet, the state unnecessarily relies on state funds to pay for services to individuals who could be served in integrated PSH. Many states use Medicaid to pay for services and housing supports, but Alaska does not. Medicaid expansion through the Affordable Care Act (ACA) provides additional opportunities to cover vulnerable populations with Medicaid, and to receive federal support for services that can be provided in PSH. While additional resources are needed to meet the demand for services and housing, savings generated as a result of leveraging Medicaid could be reallocated to housing assistance. During the strategic planning process, there was significant discussion of Medicaid mechanisms for Alaska to pursue, including the 1915(i) HCBS State Plan option that could be used to pay for best practice services such as Assertive Community Treatment and crisis services.

The report recognizes that the supply of affordable housing is limited, and that access to it is far from universal. The vastness of Alaska's geography is a major consideration for policy and the development of strategic recommendations for affordable housing. The reality is that many areas of the state will not have the infrastructure or resources for the foreseeable future to develop new, affordable housing for people with mental illness and other disabilities. Recognizing that not all communities have the same resources, we considered various approaches in formulating housing recommendations for this plan: new development, rehabilitation and modifications, leasing, and homelessness prevention.

[2] Source: Alaska DHSS, Division of Health Care Services. http://dhss.alaska.gov/dhcs/Pages/cl/all/default.aspx
[3] HUD: https://www.hudexchange.info/resource/reportmanagement/published/CoC_PopSub_State_AK_2014.pdf
[4] TAC, Priced Out in 2014. http://www.tacinc.org/knowledge-resources/priced-out-findings/
[5] *Olmstead v. L.C.*, 527 U.S. 581

Based on the information learned throughout the planning process, TAC developed the following goals for Alaska that are integral to the development of PSH. In the report, each goal contains suggested action steps that DBH will need to work on with its partners, such as assigning implementation responsibilities and creating timeframes for implementation in order to advance the plan in a meaningful way.

Goal 1: Develop a policy framework to guide implementation of PSH as an essential component of DBH's service system.

Goal 2: Establish a coordinated and consistent approach to housing and housing related services across all DHSS Divisions.

Goal 3: Establish a PSH pipeline to create between 465 and 615 PSH opportunities over the next five years.

Goal 4: Establish a PSH Clearinghouse to coordinate the timely referral of eligible households for PSH opportunities.

Goal 5: Establish a funding source for services delivered in supportive housing settings that is sustainable and tailored to the needs of individuals.

Goal 6: Expand service delivery in home- and community-based settings to promote housing stability and community integration.

Goal 7: Strengthen community provider workforce capacity to deliver home- and community-based housing services that promote wellness, recovery, and community integration.

II. Introduction

A. Overview of the Task/Key Objectives of the Plan

In April 2014, the Alaska Department of Health and Social Services (DHSS), Division of Behavioral Health (DBH) and the Alaska Mental Health Trust Authority (the Trust) formally embarked on a statewide strategic supportive housing planning process. The purpose of the process was to develop a three-year action plan that would enable Alaska to achieve the following objectives:

1. Maximize the development of integrated, affordable, lease-based permanent supportive housing (PSH) for Alaskans with serious behavioral health conditions served by DHSS and the Trust.
2. Identify, develop, and implement the services that individuals need to succeed in PSH.
3. Coordinate efforts among state and partner agencies working to develop and ensure access to PSH.
4. Leverage additional federal financial participation through modifications to state Medicaid services.

DHSS and the Trust contracted with the Technical Assistance Collaborative, Inc. (TAC), a national non-profit consulting and technical assistance firm and recognized leader at the intersection of affordable housing, health care, and human services policy and systems. Between April and June 2015, TAC evaluated the current system of housing and supports for individuals served by DHSS and the Trust, engaged stakeholders through a workgroup process, and met with key informants from DHSS and the Trust.

Much of the planning process built on the work of DBH, the Trust, the Alaska Council on the Homeless, and the Alaska Housing Finance Corporation (AHFC). The initial focus of this process was on people with mental illness served by DBH, but as planning conversations advanced, it became evident that focusing only on this population could inhibit opportunities for those with mental illnesses who are served by other divisions within DHSS. For example, many individuals with mental illness also have co-occurring disorders, or are involved in the criminal justice system. In addition, rather than have different groups planning independently, it was felt that a coordinated approach to supportive housing for populations served by DHSS would improve collaboration, maximize housing and services funding, and minimize duplicative and possibly conflicting policies and efforts.

As a result of this process, TAC has identified seven overarching goals for Alaska to work toward over the next three years. Each of these goals is described in greater detail in Section V of this report, and a table of the goals with assigned responsibilities and timeframes is provided in Appendix A.

Goal 1: Develop a policy framework to guide implementation of PSH as an essential component of DBH's service system.

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B. Policy Framework for Permanent Supportive Housing Strategic Plan

Publicly funded disability systems across the country are challenged by a confluence of issues at the federal, state, and local levels that shape how systems are designed and administered. Like other states, Alaska will need to consider the recommendations in this report in the context of these and other factors. TAC considered several known issues as context for developing the goals in this plan. Successful implementation of the goals will depend upon the commitment of DHSS, DBH, the Trust, the AHFC, and their partners. The following issues are presented as context for development of the three-year action plan.

Federal Landscape

Best Practices

Permanent supportive housing is recognized as a best practice and is increasingly being used as a frontline intervention to serve people with significant disabilities in community-based settings. Research shows that PSH is more cost effective than institutional or restrictive housing options, and that it demonstrates positive outcomes such as reduced hospitalizations and homelessness and improved behavioral and physical health. The United States Substance Abuse and Mental Health Services Administration (SAMHSA) describes PSH as "decent, safe, and affordable community-based housing that provides tenants with the rights of tenancy under state and local landlord tenant laws and is linked to voluntary and flexible support and services designed to meet tenants' needs and preferences."[6] In addition to SAMHSA, other federal agencies — specifically the Department of Housing and Urban Development (HUD), the Centers for Medicare and Medicaid Services (CMS), the Department of Justice (DOJ), and the US Interagency Council on Homelessness (USICH) — all recognize PSH as a best practice. Yet, states struggle to implement PSH to scale due to various reasons, including resistance from traditional residential providers and developers and lack of funding for services and housing.

While PSH was previously thought to be successful only for individuals who were "high functioning," it is increasingly recognized that PSH is also effective for individuals with complex needs, such as those with severe mental illness or substance use disorders, people coming out of inpatient settings, and those who are chronically homeless. DBH and the Trust embarked on this strategic planning process in recognition that PSH is a best practice and should be increased in Alaska in order to better serve individuals with complex needs.

Olmstead and Homelessness:

The US Supreme Court's Olmstead decision (1999) upheld Title II of the Americans with Disabilities Act (ADA) and the right of individuals with disabilities to live in the least restrictive, most integrated settings possible.[7] The decision required states to plan affirmatively to serve people in integrated, community-based settings. Since the decision, many states have worked to transition from institutionally-based systems of care that rely on congregate residential

[6] SAMHSA. (2010). Permanent Supportive Housing Evidence-Based Practices (EBP) KIT. PowerPoint Presentation: http://store.samhsa.gov/product/SMA10-4510.

[7] *Olmstead v. L.C.*, 527 U.S. 581

settings (e.g. state hospitals, assisted living facilities, residential care homes, and adult care homes) to more integrated models like PSH. Some states have been sued or have entered into settlement agreements with DOJ or legal advocates as a result of an overreliance on segregated settings, with PSH included as a primary remedy to serve people in more integrated settings.

The federal agencies that recognize PSH as a best practice are also working to align their approaches to Olmstead and homelessness. For example, the principles laid out in SAMHSA's PSH Toolkit, a DOJ statement on community integration[8], a HUD Olmstead statement[9], and a recent CMS final rule on home and community-based services[10] all serve to align these agencies' policies on integrated and segregated settings, individual choice, and person-centered planning. Further agreement among these partners is established in USICH's Opening Doors, the nation's first comprehensive federal strategy to prevent and end homelessness.[11] This alignment of Olmstead and homelessness policy at the federal level has implications for both funding and enforcement, and is a strong influence on how states like Alaska move forward to serve people with disabilities and other complex needs in the community.

In Alaska, the primary residential options for individuals with disabilities who need housing are predominantly in assisted living facilities, funded through the General Relief Assistance (GRA) program described below. Alaska currently has approximately 630 assisted living facilities with approximately 3,700 beds[12] used mostly for people with mental illness or intellectual or developmental disabilities. While most of these facilities are small (two to five beds), several have much larger capacity (six to twenty beds or more than twenty beds).

Many states are currently working to end chronic homelessness, supported by a strong push at the federal level. From a policy perspective, there is a strong alignment between addressing Olmstead and ending chronic homelessness. Often, the target populations have similar needs, and the solutions too (e.g. PSH) are similar. Indeed, it can be argued that those who are chronically homeless[13] fall within the scope of the Olmstead decision, in that their homelessness puts them at risk of being served in a more restrictive setting than is needed.

According to its 2015 Point-in-Time count, Alaska has approximately 1,956 people who are homeless, of whom 182 meet the definition of chronically homeless.[14]

Medicaid

Several recent changes and to Medicaid at the federal level are influencing state activities. As states recognize the costs of serving individuals with complex needs in long-term care settings,

[8] DOJ Olmstead Statement: http://www.ada.gov/olmstead/q&a_olmstead.htm
[9] HUD Olmstead Statement: http://portal.hud.gov/hudportal/documents/huddoc?id=OlmsteadGuidnc060413.pdf
[10] CMS HCBS Final Rule: https://www.federalregister.gov/articles/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider
[11] USICH Opening Doors: http://usich.gov/opening_doors/
[12] Source: Alaska DHSS, Division of Health Care Services. http://dhss.alaska.gov/dhcs/Pages/cl/all/default.aspx
[13] HUD has defined **chronic** homelessness as an individual or family with a disabling condition who has been continuously **homeless** for a year or more or has had at least four episodes of homelessness in the past three years.
[14] https://www.hudexchange.info/resource/reportmanagement/published/CoC_PopSub_State_AK_2015.pdf

as well as individuals who are uninsured or underinsured, CMS is working with states to implement best practices designed to serve people in more integrated, cost-effective settings. States are increasingly adopting managed care strategies and services known to produce positive outcomes (e.g. Assertive Community Treatment, care coordination strategies, housing support services) into their Medicaid plans. Previously, these services were not available or were funded solely by states. For example, Alaska has only recently begun to implement Assertive Community Treatment, and it is currently supported by state funds. Other states are using Medicaid options to strengthen and fund their services through mechanisms like the 1915(i) Home and Community Based Services (HCBS) and Health Homes State Plan options, the rehabilitation option, and managed care waivers. CMS recently released an Informational Bulletin for state Medicaid directors regarding ways to pay for housing-related supports with Medicaid funds.[15]

The Affordable Care Act (ACA) significantly changed the landscape for many states that have opted to expand Medicaid coverage to individuals with incomes up to 138% of the federal poverty level. States that have chosen Medicaid expansion have been able to provide insurance coverage to individuals, many of whom have complicated health conditions such as mental illness and substance use disorders, who were often costly to hospital and other emergency systems due to their lack of coverage. A report by The Lewin Group, updated in 2013, suggested that by expanding Medicaid, Alaska could expand its Medicaid population by approximately 40,000 individuals in 2016 and see significant federal revenues that would offset any increased state spending.[16] As of this report, Governor Walker is pursuing Medicaid expansion for Alaska.[17]

State Landscape

Alaska State Budget

In Fiscal Year 2013, Alaska ranked first in fiscal performance and solvency.[18] While many states were still recovering from the Great Recession, Alaska's economy was strong. Approximately sixty percent of Alaska's revenue is based on petroleum which, at the time, was increasing in value while other state budgets were still struggling or showing modest revenue growth. Accordingly, Alaska increased its appropriations during this period by $2.1 billion, but a combination of factors, largely associated with a rapid decline in oil production and value as the national economy recovered, has increasingly strained the state budget — leading to pressure on state agencies such as DHSS to reduce spending. The fiscal year 2016 budget signed by Governor Walker reduced total spending by 19 percent, with a reduction in spending at DHSS of 6.7 percent.

Leading up to this strategic planning process, there has been increased interest in utilizing Medicaid to pay for services for individuals with disabilities served by DHSS. For many Alaskans with disabilities living in community-based settings, services are largely paid for by state general

[15] CMS (June 2015): http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf
[16] The Lewin Group. *An Analysis of the Impact of Medicaid Expansion in Alaska.* June 2013.
[17] http://gov.alaska.gov/Walker/press-room/full-press-release.html?pr=7229
[18] Eileen Norcross. "Ranking the States by Fiscal Condition." Mercatus Research, Mercatus Center at George Mason University, Arlington, VA, July 2015.

funds. However, many states have shaped Medicaid programs to pay for many of these services. Leveraging additional federal financial participation through the Medicaid program enables states to serve more people, provide better service packages, or, in times of economic volatility, minimize cuts in services. During the strategic planning process, there was significant discussion of Medicaid mechanisms for Alaska to pursue, including the 1915(i) HCBS State Plan option that could be used to design best practice services and generate additional federal funding.

As discussed above, Governor Walker is pursuing Medicaid expansion under the ACA which should expand health insurance coverage to low-income individuals, increase federal funding to pay for related costs, and reduce the state burden of paying for the health care costs of uninsured individuals.

Assisted Living, General Relief Assistance, and Services

The primary residential options for individuals with disabilities who need housing are predominantly in assisted living facilities, funded through the General Relief Assistance (GRA) program for individuals with little or no income. The General Relief Assistance program is administered by DHSS through the Division of Senior and Disabilities Services (DSDS) and DBH. As in other states, assisted living in Alaska emerged primarily as a way to provide housing for older adults who could no longer live independently. Due to a shortage of affordable housing and supervised housing, assisted living homes became a primary residential option for people with mental illness and intellectual and developmental disabilities. The GRA program is 100 percent state-funded and was established to pay for room, board, and services in assisted living homes. Over time, however, as the assisted living industry in Alaska grew, so did GRA.

The recommendations in this report address concerns about the number of individuals living in assisted living homes who could live in more integrated settings if these options existed, and about the costs of these facilities to the GRA program, particularly in the context of state budget reductions.

Systems that rely less on congregate living situations emphasize the availability of flexible services that can be delivered in home-based settings. Best practices such as Assertive Community Treatment, related community support strategies, and peer services, along with emerging tools such as telemedicine and telepsychiatry, can reduce the reliance on assisted living homes and GRA. Services like ACT are known to be evidence-based, have fidelity tools, and can be reimbursed by Medicaid, thus reducing the burden on state funds.

Affordable Housing Development

Like health care-related services, Alaska's affordable housing is organized through federal, state, and local agencies, including the Alaska Housing Finance Corporation (AHFC), the US Department of Housing and Urban Development, the Office of Public and Indian Housing (PIH), the Alaska Office of Native American Programs (ONAP), Tribally Designated Housing Entities and Tribal Housing Authorities. Using federal, state, local, and private funding, these agencies create and manage affordable housing with the housing development community. AHFC works

closely with DHSS, the Trust, the Alaska Department of Corrections, and other agencies to inform affordable housing policy.

The vastness of Alaska's geography is a major consideration for policy and the development of strategic recommendations for affordable housing. The reality is that many areas of the state will not have the infrastructure or resources for the foreseeable future to develop new, affordable housing for people with mental illness and other disabilities. Recognizing that not all communities have the same resources, we considered various approaches in formulating housing recommendations for this plan: new development, rehabilitation and modifications, leasing, and homelessness prevention.

Permanent Supportive Housing for American Indians and Alaska Natives

According to US Census data, approximately 20% of the population in Alaska is American Indian or Alaska Native (AI/AN). State policy pertaining to mental health, social services, and affordable housing for the AI/AN population must consider the needs and choices of AI/AN people.

The Indian Health Service (IHS) is the primary federal agency responsible for the provision of health services to AI/AN people. Either directly or through contracts, IHS provides health services to members of federally recognized tribes based on treaty obligations between the US government and AI/AN tribes and corporations.[19]

The IHS regional office in Alaska, the Alaska Area Indian Health Service, works in conjunction with Alaska Native tribes and tribal organizations to provide comprehensive health services to 143,078 Alaska Natives (Eskimos, Aleuts, and Indians). Tribal health services are delegated contractually by IHS to the Alaska Native Tribal Health Consortium (ANTHC), a not-for-profit health organization that provides statewide services in specialty medical care and operates the 150-bed, state-of-the-art Alaska Native Medical Center hospital in Anchorage.

According to the IHS website, approximately 99% of the Alaska Area budget is allocated to tribes and tribal organizations that operate under the authority of the Indian Self-Determination and Education Assistance Act, Public Law 93-638, as amended. The Alaska Area maintains 13 Title I contracts with Alaska tribes and tribal organizations, and negotiates one Title V compact with 25 separate tribal funding agreements each year. The Alaska Tribal Health Compact is a comprehensive system of health care that serves all 228 federally recognized tribes in Alaska. IHS-funded, tribally managed hospitals are located in Anchorage, Barrow, Bethel, Dillingham, Kotzebue, Nome, and Sitka. There are 44 tribal health centers, 160 tribal community health aide clinics, and 5 residential substance abuse treatment centers. The ANTHC in Anchorage is the statewide referral center and gatekeeper for specialty care. Other health promotion and disease prevention programs that are statewide in scope are operated by the ANTHC, which is managed by representatives of all Alaska tribes.

[19] Kaufman & Associates (May 2011). *Health Care Reform: Tracking Tribal, federal and state implementation.* https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/CMSHealthCareReform5202011.pdf

This intricate system stands parallel to, and interfaces with, the public and private health care systems for non-AI/AN people in Alaska. However, the IHS budget is only sufficient to provide about half the health care services required. Specific provisions in the Indian Health Care Improvement Act, the Children's Health Insurance Program Reauthorization Act, the American Recovery and Reinvestment Act, and the ACA have all affirmed that AI/AN individuals and Indian health programs (IHS, Tribal, and Urban) can access federal programs (e.g. Medicaid and Medicare) without diminishing federal treaty obligations or related legislative responsibilities.

IHS mental health funding, for example, is generally directed toward crisis-oriented, outpatient services programs with few specialized services due to a lack of resources and difficulty recruiting a trained workforce. As a result, AI/ANs frequently encounter Alaska's mental health and social services that are funded with state appropriations, block grants, and Medicaid funds. For example, emergency and long-stay hospitalizations are often provided by state psychiatric hospitals, making discharge planning and coordination back to tribal health services a challenge. There are very few home-based outreach or residential living programs in IHS or tribal operations so these too are obtained from local or state resources, when available. AI/AN individuals are usually fully eligible for state and local public mental health systems, but access issues and lack of cultural sensitivity are barriers.

While approximately 20 percent of Alaska's population is AI/AN, nearly 40 percent of Medicaid clients are Alaska Natives and account for a significant portion of Medicaid spending in Alaska, according to DHSS. Complicating the financing of service delivery is the fact that most services provided to AI/ANs are offered by private or contracted health providers due to a lack of tribal providers, and are therefore reimbursed by the federal government at only 50 percent. However, health care services for Medicaid-eligible AI/ANs are reimbursed 100 percent by the federal government.[20] Essentially, contracted and private providers cost the state more money due to less federal financial participation. An estimated 16,561–26,911 AI/ANs, many of whom could benefit from PSH, could gain health insurance if the state continues to pursue Medicaid expansion under the ACA.[21]

The availability of supportive housing options for AI/ANs with mental illness and other disabilities is limited, as it is for others in Alaska. In fact, nowhere in Alaska can an individual living entirely on Supplemental Security Income (SSI) afford federally determined fair market rents (FMR).[22] The affordable housing that does exist for people with mental illness and other disabilities is often in urban centers far from individuals' families. To access this option, individuals in need of PSH or residential programs need to leave their home communities, causing them to be disconnected from their families and cultural support systems. New affordable housing development in villages and rural and frontier areas is constrained due to limited infrastructure

[20] Federal support for the Medicaid expansion population would be significantly higher than the State's current FMAP for the traditional Medicaid program.
[21] Kaufman & Associates (May 2011). *Health Care Reform: Tracking Tribal, federal and state implementation.* https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/CMSHealthCareReform5202011.pdf
[22] TAC, *Priced Out in 2014*. http://www.tacinc.org/knowledge-resources/priced-out-findings/

(e.g. roads, water, sewer), making homelessness prevention and housing preservation through home modifications, weatherization, and home energy assistance programs vitally important.

Although the focus of this strategic plan was on the use of public behavioral health services funded through DBH and the Trust, it is clear that collaboration and coordination among many more agencies will be necessary to fully address the housing and service needs of Alaskans with mental illness and other disabilities. Potential partners include ANTHC and its tribal organizations, DHSS, DOC, HUD Continuum of Care programs (CoC), and the HUD regional office, AHFC, and other related organizations. A good example is the recent creation of an office of tribal health programs within the Commissioner's Office to collaborate across divisions, working to ensure that Tribal Health Organizations are a partner to the Department in the delivery of health care to the Alaska Native Medicaid population.

III. Strategic Planning Process

Methodology

The Alaska Department of Health and Social Services, Division of Behavioral Health, in partnership with the Alaska Mental Health Trust Authority engaged Technical Assistance Collaborative, Inc. (TAC) to assist with the development of a three-year Strategic Supportive Housing Plan to expand permanent supportive housing opportunities for individuals with serious behavioral health conditions. Between March and July of 2015, a TAC team with expertise in behavioral health, Medicaid, and affordable housing systems met with leadership and relevant staff from DBH, DSDS, the Trust, and AHFC; stakeholders; and key entities including the Governor's Council on Disabilities and Special Education; the Office of the Long-term Care Ombudsman, the Governor's Council on the Homeless, and the Alaska Coalition on Housing and Homelessness to help formulate the basis for the strategic recommendations in this report.

Just prior to the planning process getting underway, the Alaska Housing and Finance Corporation was informed of its successful HUD Section 811 Project-Based Rental Assistance award. This HUD program creates affordable supportive housing for persons with disabilities. HUD strongly encourages applicants to create a cross-disability program, which Alaska proposed to do in its application. As a result of this award, and of the state's recognition of the number of individuals with multiple disabilities who cross systems, stakeholder input was broadened to include providers serving individuals with intellectual and developmental disabilities, and a brief exploration was made into the needs of Alaska Natives served by both the tribal health and public behavioral health systems. Because this work focused on individuals served by the public behavioral health system, a recommendation for a DHSS-wide assessment of housing needs is included in order to encourage a coordinated and cross-system approach to housing.

Planning with DBH and Trust Staff

Beginning in February 2015, TAC worked closely with Sherrie Hinshaw, coordinator for the Office of Integrated and Supportive Housing at DBH, and Nancy Burke, senior program officer at the Trust to plan focus groups, organize workgroup membership, and conduct interviews with key informants and remote stakeholders. Bi-monthly conference calls were held discuss the

planning process, share updates, request information or documents, and arrange access to focus group members and key informants.

Housing and Services Inventory

TAC specifically looked at resources pertinent to supportive housing, both to inform the thinking of workgroups and leadership staff, and to better understand existing resources and operations. In addition to conducting key informant interviews and stakeholder focus groups, TAC reviewed service descriptions and definitions for existing Medicaid behavioral health services, including recently established Assertive Community Treatment and Intensive Case Management teams jointly funded by the Trust and state general funds.

Stakeholder Participation and Meetings with Key Informants

Stakeholders from community provider organizations and relevant state agencies and associations, as mutually identified by TAC and DBH staff, were actively involved in the planning process. This effort included participation in two separate workgroups; key informant interviews; visits to different housing programs; and a focus group specifically for Assisted Living Facility operators. This specific focus group discussed the issues that operators experience when providing housing to people with disabilities, and regulatory and payment concerns related to operations.

The general purpose of the workgroups was to provide an opportunity for stakeholders to share current experiences delivering services to individuals living in community settings, suggest areas for improvement, and provide information to be used by TAC to develop a series of recommended strategies for DHSS to consider.

Four initial workgroups were developed to solicit feedback and recommendations on ways to increase PSH, with two groups to focus on housing-related issues and two on services-related issues. Since membership was consistent among the housing and services groups, the four workgroups were collapsed into two — housing and services, covering the following topics:

Housing workgroup:

- Housing Utilization and Maximization: These discussions explored ways to increase and maximize the supply of affordable housing and targeted PSH opportunities.
- Supportive Housing Eligibility and Allocation: These discussions examined mechanisms to establish uniform and equitable eligibility and allocation criteria for SH.

Services workgroup:

- Service Needs: These discussions identified strengths, duplication, and gaps in the community and residential services continuum and generated ideas to better promote community integration and living in more independent supportive housing.
- Workforce and Training: These discussions examined workforce issues related to serving individuals in residential and PSH settings.

IV. Housing and Services Inventory

TAC reviewed the current array of housing resources and community-based services to identify resources and services already available to individuals living in supportive housing settings, and others that may be modified or adapted to better support these individuals. Alaska has a variety of supportive housing models, ranging from integrated supportive housing to single-purpose supportive housing, an advantage not shared by all states. TAC also found that there are a range of pathways or entry points for these existing PSH opportunities including DBH-sponsored programs, two CoCs, and individual housing providers. Through the Moving Home program and the Section 811 Project-Based Rental Assistance program (PRA), AHFC has recently partnered with DBH on two initiatives to create integrated permanent supportive housing. These two initiatives offer an opportunity for AHFC and DBH to develop a closer partnership, bringing a significant number of integrated PSH opportunities on line.

Existing Housing Resources

Below is an overview of the key housing resources available to create and sustain PSH in Alaska. TAC's overview breaks down the resources between capital sources available for acquisition, rehabilitation or new construction and operating or rental assistance resources available to support deeply affordable rents to disabled and/or homeless households.

Capital and Operating Resources

Depending on the program, federal capital funding typically produces affordable rental housing opportunities for households between 40 and 60 percent of area median income, although Alaska has made efforts to target households with lower incomes. A substantial commitment of capital funding per unit — as well as a permanent rent subsidy — is needed to develop a PSH project. In addition to existing capital resources, there is a new capital funding source that may become available during the next federal fiscal year:

Greater Opportunities for Affordable Living (GOAL): AHFC has combined the Low Income Housing Tax Credit (LIHTC) program, the HOME Investment Partnership Program, and the Senior Citizens Housing Development Fund into the GOAL program in order to advance multi-family affordable rental production in Alaska. Through the GOAL program over the past three years, AHFC has sponsored the development of on average five affordable housing projects, or 167-191 rental units, per year. The current Qualified Allocation Plan, which governs the use of the LIHTC program, requires that five percent of the total units in each of these housing projects be set aside for a "special needs" population.

*Special Needs Housing Grant Program (SNHG)***:** AHFC, in collaboration with the Trust, sponsors an annual SNHG funding round to foster the development of long-term supportive housing for disabled and homeless households. The SNHG funding typically includes non-competitive four-percent LIHTC financing, HOME funds (at AHFC discretion), and SNHG funds. SNHG funding is offered for a range of uses including capital development, operating assistance, and support services. AHFC offers a three-year funding commitment for operating costs and support services, especially those that are ineligible for reimbursement through Medicaid. Renewal funding is available on a noncompetitive basis, subject to funding

availability. In FY 2015, the Municipality of Anchorage with a commitment of HOME and Community Development Block Grant resources joined the SNHG funding solicitation to support increase its supportive housing opportunities. Based on current SNHG/HOME funding constraints and a preliminary analysis of renewal demand for operating and support services on existing PSH projects, AHFC does not expect to be able to move forward with the SNHG solicitation for new PSH development in FY 2016.

*Community Development Block Grants (CDBG)***:** The CDBG program can be used for either affordable housing or other community development activity. The Alaska Department of Commerce, Community, and Economic Development administers the allocation of the state's CDBG funds. Historically, Alaska has utilized these limited funds to support programs addressing health and safety needs, economic development, and community self-sufficiency in rural communities. Through Anchorage's Consolidated Plan, the Municipality of Anchorage has reserved the right to use some of its allocated CDBG funds for rental housing development to compensate for reductions in HOME funding levels in recent years.

National Housing Trust Fund (NHTF): Authorized by the Housing and Economic Recovery Act of 2008, the NHTF is a rental housing production and preservation program created by Congress specifically to address the nation's critical shortfall of rental housing units dedicated to extremely low income (ELI) households. In December of 2014, the Federal Housing Finance Agency lifted its six-year suspension of Fannie Mae's and Freddie Mac's obligation to contribute to the NHTF, allowing the program to begin functioning. NHTF resources are scheduled to be allocated to state housing agencies during the summer of 2016, and according to the most recent estimates from the National Low Income Housing Coalition, approximately $196 million will be available for the inaugural year of the program. Based on this allocation level and subject to final approval of the FY 2016 federal budget, Alaska will receive the minimum allocation of $3 million in 2016.

It is expected that AHFC will be named to administer the NHTF on behalf of the state. Several features of the NHTF statute make it an important resource for new PSH development:

- NHTF is a permanent program on the mandatory side of the federal budget, with dedicated source(s) of funding not subject to the annual appropriations process.
- HUD will use the NHTF statutory formula to determine the amount of NHTF resources allocated to each state. Under the formula, each state must receive a minimum of $3,000,000.
- At least 80 percent of NHTF funding must be directed to the production, preservation, rehabilitation, and operation of rental housing.
- At least 75 percent of the rental funds must benefit ELI households

- Two kinds of rental housing activities are authorized: capital for rental housing development, rehabilitation, and preservation; and operating subsidies or operating reserves[23].

Private Philanthropy: The Alaska non-profit development sector has leveraged private philanthropic support in the development of supportive housing. Notably, the Rasmuson Foundation, one of Alaska's leading philanthropic organizations, has made critically important capital contributions (in the form of program-related investments) to specific Housing First PSH projects including Karluk Manor, a 46-unit Housing First project developed in Anchorage by the Rural Alaska Community Action Program. In addition, the Foraker Group offers pre-development financing, specialized technical assistance, and capacity-building support to Alaska's non-profit sector. Many of Alaska's non-profits have successfully leveraged this capital support and specialized assistance to fill critical gaps within PSH development projects.

Existing Rental Assistance Resources

AHFC also acts as the state's public housing authority, administering rental assistance programs that can be utilized to support a range of supportive housing opportunities (i.e. supportive housing development, integrated supportive housing, and tenant-based supportive housing opportunities). Since 2008, AHFC has been designated a Moving to Work (MTW) public housing agency through HUD. AHFC's MTW agreement with HUD, which has been extended until 2018, provides regulatory flexibility to "test out new approaches" within its public housing and Section 8 Housing Choice Voucher programs.

Below is a brief discussion of the range of rental assistance resources administered by AHFC and an explanation of their relevance to creating PSH opportunities:

Section 8 Housing Choice Voucher Program:
According to the State of Alaska's Five-Year Consolidated Plan released in May of 2015, AHFC serves 4,074 households with Section 8 housing choice vouchers. As part of its efforts as a MTW agency, AHFC has moved from a system based on preference to a structure with no preference but a number of set-asides for vulnerable populations. The Moving Home program reserves 150 rental vouchers for persons with disabilities referred by DHSS. The Empowering Choice Housing Program offers 254 vouchers (funded through Section and state funds) to families displaced by domestic violence or sexual assault, and 45 vouchers to non-elderly persons with disabilities. AHFC has dedicated 46 sponsor-based vouchers for the Rural Alaska Community Action Program to support chronically homeless tenants at Karluk Manor (the Housing First PSH project in Anchorage) and manages 230 VASH vouchers targeting homeless veterans.

HOME Partnership Program's Tenant Based Rental Assistance:
Both AHFC and the Municipality of Anchorage administer HUD's HOME Investment

[23] Based on the NHTF Interim Rule released in January of 2015, a 33% cap has been placed on the amount of a state's NHTF annual grant that may be used for operating cost assistance or reserves. HUD is expected to release further guidance on the use of operating assistance and operating reserves in the form of a Notice during the spring of 2016.

Partnerships (HOME) program in Alaska. The HOME statute permits the use of these funds to create renewable two-year tenant-based rental assistance programs, which could be targeted to PSH. Community development officials have traditionally been reluctant to use HOME funds for this purpose, preferring to invest them in one-time expenditures for affordable rental housing development and homeownership opportunities. AHFC currently manages a HOME tenant-based rental assistance program targeting Alaskans on parole or probation and youth aging out of foster care.

Section 811 Project-Based Rental Assistance (PRA) Program:
In March of 2015, AHFC was awarded funds to support 200 project-based rental assistance opportunities with federal and state resources. The initiative's tier 1 priority target population is non-elderly persons with disabilities transitioning from ALH or from institutional care such as an inpatient psychiatric or residential treatment facility, jail/prison, or long-term nursing care. The initiative's tier 2 priority is non-elderly persons with disabilities who are re-entering the community from institutional care: i.e. those discharged (within last 12 months) from an inpatient psychiatric or residential treatment facility, jail or prison, long-term nursing home stay (over 6 months) or transitional-age youth who are aging out of foster care or institutional settings. Tier 2 would only be utilized if an insufficient number of potential participants will be identified from tier 1. PRA will provide project-based rental assistance within affordable multi-family rental housing to create integrated supportive housing in up to 25% of the units in the project. As part of its leverage commitment, AHFC has also committed 100 Section 8 vouchers to serve non-elderly persons with disabilities. AHFC is working in close partnership with DBH and DSDS to implement the Section 811 initiative, recently releasing a Request for a Statement of Qualification to identify multi-family rental properties appropriate for integrated supportive housing in Anchorage, Fairbanks, Juneau, and the Matanuska-Susitna Valley.

Continuum of Care Program:
HUD has offered historically low levels of funding for the Continuum of Care (CoC) program in its past two competitive funding rounds, resulting in very little opportunity to fund new PSH projects and forcing many local CoCs to reduce funding for existing projects. However, the 2015 NOFA for CoC made available relatively higher levels of funding, allowing local CoCs to propose new PSH bonus projects and to reallocate funding from existing projects to fund new PSH in their communities. Alaska's two CoCs (the Anchorage CoC and the Alaska Balance of State CoC) both took advantage of this opportunity to propose new PSH projects in the most recent CoC competition. Based on a review of its 2015 CoC applications, the Anchorage CoC proposed three new PSH projects through a significant reallocation planning process and the Alaska Balance of State CoC proposed one new PSH project as its bonus project. TAC applauds the work of these local CoCs and anti-homelessness advocates to direct CoC resources toward the creation of new PSH opportunities for the chronically homeless, many of whom have serious mental illness.

Table 1: Permanent Supportive Housing Resources and Application to PSH

Program	Resource Description	Application to PSH
Greater Opportunity for Affordable Living (GOAL)	Low Income Housing Tax Credit Program (9% LIHTC): Provides equity to fund acquisition, rehabilitation, or new construction. A tax credit investor purchases the low income housing tax credits in exchange for equity to support the development of affordable multi-family rental housing.	Offered statewide to support the development of integrated PSH as part of an affordable multi-family rental development project or to create a single-purpose PSH project.
	HOME Investment Partnership: Provides grants or zero-interest loans to fund acquisition, rehabilitation, or new construction of affordable multi-family rental housing.	
Special Needs Housing Grants (SNHG)	Low-Income Housing Tax Credit Program (non-competitive, 4%): Provides equity from 4% LIHTC to fund acquisition, rehabilitation, or new construction. SNHG and HOME Capital: Funds from these two sources provide grants or zero-interest loans. (AHFC's HOME funds are not available for projects in Anchorage.)	Offered statewide to develop and sustain a deeply affordable, long-term PSH project especially targeting Trust beneficiaries who have been evicted or refused by other self-supportive housing programs because they present the most challenging behaviors to retaining residential housing due to their disability.[24]
	SNHG Operating Assistance: Allows participants to charge deeply affordable rents in a PSH project. Applicants may request these funds as project-, sponsor-, or tenant-based rental assistance. SNHG Supportive Services: Funds for supportive services to supplement existing social services rather than supplanting them. Both operating and supportive services funding is made available through a 3-year grant. AHFC anticipates renewal on a noncompetitive basis, subject to funding availability.	
National Housing Trust Fund (NHTF)	Capital to support acquisition, rehabilitation, or new construction of multi-family rental housing with a focus on creating deeply affordable rents for extremely low income households (defined by	Offers Alaska a flexible source of capital or operating resources to create integrated permanent

[24] See AHFC's FY 2015 Special Needs Housing Grant Program's Notice of Funding Availability (NFA) on Page 7 for a more detailed description of the target population.

	HUD as families at or below 30% of Area Median Income).	supportive housing (pending funding availability).
	Operating Assistance/Operating Reserve: Offers the option to dedicate up to 33% of a NHTF allocation for operating assistance or operating reserves to make rents deeply affordable for extremely low income households.	
Section 811 Project-Based Rental Assistance Program	Project-Based Rental Assistance: Offers a 20-year commitment of rental assistance assigned to specific units within a multi-family rental property. The Section 811 PRA allows the tenant's rent to be set at 30% of their income. The Section 811 PRA initiative is responsible for making timely referrals of priority consumers and for linking participants with community-based supportive services.	Targeting Anchorage, Fairbanks, Juneau, and the Matanuska-Susitna Valley to create integrated supportive housing opportunities for the state's Section 811 target population.
	Leveraged Tenant Based Assistance: Offers an additional 100 Section 8 HCV rent subsidies for non-elderly persons with disabilities.	
Section 8 Housing Choice Voucher Program	Rental Assistance: Offers long-term rental assistance through the project or sponsor-based options for PSH development. AHFC also offers tenant-based Section 8 vouchers to support PSH through the Moving Home Initiative. Section 8 allows the tenant's rent to remain at 30% of their income.	Offered by AHFC to support integrated PSH models through tenant-based vouchers and to support PSH development through the use of sponsor-based rental assistance.
Continuum of Care Program (CoC)	Capital: Offers CoCs the flexibility to commit resources to support acquisition, rehabilitation, or new construction of PSH development.	Offered through the state's two Continuum of Care programs to create PSH opportunities for homeless individuals and families, particularly those that have been chronically homeless.
	Rental or Operating Assistance: Offers long-term rental or operating assistance to make rents affordable for homeless individuals and families in SH. These funds are typically renewed annually through the CoC funding competition.	
	Supportive Services: Provides the ability for CoCs to dedicate resources for supportive services linked with supportive housing.	

Rasmuson Foundation/Foraker Group (Private Philanthropy)	Capital: The Rasmuson Foundation offers program-related investments as gap financing to support capital costs within PSH projects.	Makes available flexible gap financing and specialized expertise to create high-quality, sustainable PSH projects throughout Alaska.
	Pre-development: The Foraker Group offers specialized guidance and technical support to non-profit developers to assess feasibility and create a sustainable PSH development.	

Existing Services and Supports

The major aim of this Strategic Supportive Housing Plan is to help DBH and its partners identify strategies to increase supportive housing opportunities for individuals with serious behavioral health issues, especially those individuals with more complex needs who cross systems. Therefore, as part of the strategic planning process, TAC looked specifically at services pertinent to supporting individuals in community-based PSH settings. Stakeholders frequently raised the need for other types of residential services including longer-term, community-based crisis stabilization programs, recovery housing for individuals with addiction disorders, and transitional housing for individuals who providers feel are unable or not yet ready to live in PSH. The need to more comprehensively assess and determine the need for other residential models and to offer an appropriate balance of residential options is discussed in the recommendations.

Division of Behavioral Health (DBH)

Alaska's public behavioral health system consists of three components: community behavioral health programs, the Alaska Psychiatric Institute, and designated evaluation and treatment services. Within DHSS, the Division of Behavioral Health manages an integrated and comprehensive statewide behavioral health system, providing a continuum of health services ranging from prevention, screening, and brief intervention to acute psychiatric care. Within each service area there is a comprehensive behavioral health agency that provides services to all adults experiencing psychiatric crisis, individuals with serious mental illness, seriously emotionally disturbed youth, and youth and adults with substance use disorders.[25]

DBH directly operates the state's only public psychiatric facility, Alaska Psychiatric Institute (API). API provides emergency and court-ordered inpatient psychiatric services. Designated Evaluation and Treatment and Designated Treatment and Stabilization services are funded in four communities so that individuals living in remote areas can receive treatment closer to home. DBH contracts with comprehensive community behavioral health agencies within each designated service area. To meet the behavioral health needs of Alaskans living in rural, remote, and frontier areas, API provides behavioral tele-health services that include a virtual clinic serving the larger health care facilities, and the Frontline Remote Access Behavioral Health Clinic.

DBH makes available an array of community services through contracts with approved provider organizations. Eligible organizations must meet requirements to become a Community Behavioral Health Services provider in order to deliver and receive payment for eligible Medicaid services. In addition to Community Behavioral Health Services providers, DBH also establishes provider grants and agreement contracts with eligible community mental health and substance use treatment providers, financed through state general funds and other sources (e.g. the Trust and mental health/substance use disorder block grant funds).

Medicaid Behavioral Health Services

Increasing permanent supportive housing opportunities and promoting community integration requires services to be available in the community that can support housing stability. Individuals living in PSH often require specific types of wraparound services and supports. These include assistance with accessing housing resources; daily living and tenancy-related skill-building; budgeting/money management; disability, illness, and medication management; advocacy with landlords and eviction preventions; and access to natural and community supports (e.g.

[25] https://www.dhss.alaska.gov/dbh

transportation, furniture, clothing, food, recreation, spiritual/religious, and social networking resources).

Medicaid behavioral health services are available that could be well suited to assist individuals living in PSH, with some adjustments to how these services are currently delivered and reimbursed. These services include: comprehensive community support services (CCSS), peer support, case management, short-term crisis stabilization services, and in certain circumstances recipient support services (RSS). Table 1 outlines current service definitions and their possible application to PSH.

Offered in combination or as individual components, these services form the basis of what most individuals living in supportive housing settings require to become successful tenants and maintain their housing. CCSS offers essential rehabilitation interventions such as teaching tenancy-related skills. Peer support provides recovery and social support to help people establish support networks and participate in community living. Short-term crisis stabilization provides intervention in times of acute distress and exacerbation of symptoms, with the aim on helping the person to remain home and reduce hospitalization days. Case management links to desired services and monitors effectiveness of service delivery. The combination, frequency, and intensity of each service will vary depending on an individual's current and emergent needs.

RSS is another Medicaid behavioral health service that may have some applicability to supportive housing. This service provides structure, support, and sight or sound supervision, and may be delivered in the recipient's home or other appropriate community setting. The need for heightened vigilance must be assessed and documented, including the target symptoms and how staff will respond to and resolve high-risk behavior. This service may be provided during the recipient's waking or sleep hours, and may be provided to more than one individual at the same time.[26]

During recent years, there have been some questions as to how RSS was provided and reimbursed, resulting in audits of provider agencies and a reluctance to continue to authorize this service. Although in some cases RSS has been used simply as a mechanism to fund overnight staff coverage in congregate living settings, the service is intended to address targeted, high-risk behaviors via time-limited enhanced supervision and structure.

This service has the potential to provide temporary increased structure and support, with appropriate authorization and controls in place. The initial weeks of tenancy or periods of increased emotional distress are times when additional support and structure are beneficial. For example, if a person is experiencing increased anxiety or distress below the level warranting short-term crisis stabilization, a staff person scheduled to visit for a few hours during the evening could provide support and the opportunity to intervene if the individual is engaging in troubling behaviors that may jeopardize housing.

Most if not all of these services are currently offered primarily in facility or program settings and infrequently in a person's home. Providers described various barriers to providing these services on an individualized basis or in a person's home or other community locations. The primary barrier identified was the reimbursement rate for CCSS.

Providers reported that the current rate and fee-for-service structure creates a financial disincentive to deliver this service on an individual basis in scattered community settings.

[26] Behavioral Health Services Integrated Regulations, 7 AAC 135.230

Transportation is not a reimbursed cost for adult behavioral health rehabilitation services and staff members often need to drive significant distances to meet with individuals, especially those who live in remote communities. CCSS is designed to be delivered face to face, and time spent trying to locate individuals or driving to meet with someone who is not home when staff arrive is not reimbursed, leaving the agency to make up the cost.

Focus group participants acknowledged that peer support services are valuable and effective, but find the supervisory requirement a barrier to utilizing this service more routinely to support individuals in community settings. The CMS requirement that peer specialists be supervised by Master's level staff is difficult for many states to meet. The significant workforce capacity challenges faced by Alaska may contribute to this perceived difficulty.

Alaska Mental Health Trust Authority (the Trust)

The Alaska Mental Health Trust operates very much like a private foundation, using its resources to implement improvements in Alaska's mental health continuum of care. In close collaboration with DBH leadership, the Trust continues to play a catalytic role in expanding access to supportive housing opportunities and long-term services and supports for Trust beneficiaries.[27] The Trust leadership has identified "housing and long-term services and supports" as a strategic focus area, and has promoting activities to increase a balanced continuum of supported housing options for beneficiaries, to develop and maintain stable behavioral health services, and to develop and maintain community-based long-term services and supports.[28] As part of these activities, the Trust has provided strategic investments in community-based supportive services linked with community-based rental housing, offering a "bridge" to sustainable funding. The Trust, in close collaboration with local partners, continues to play a leadership role in supporting the development of Housing First PSH projects targeting Trust beneficiaries throughout the state.

[27] Alaska Mental Health Trust beneficiaries: http://mhtrust.org/about/beneficiaries/
[28] Alaska Mental Health Trust Housing and Long-Term Services and Supports Focus Areaj: http://mhtrust.org/focus/housing-long-term-services-support/

Table 2: Medicaid Behavioral Health Services and Application to PSH

Service	Service Description	Application to PSH
Comprehensive Community Support Services (CCSS)	Improve the recipient's overall functioning; restore capacity for more effective daily functioning and reduce the likelihood of institutionalization or institution-based care; assist the recipient to develop, maintain, or improve specific self-care, self-direction, and social behaviors; and restore the behavioral, emotional, or intellectual skills necessary to live, learn, or work productively in the recipient's environment.	Skill development and coaching related to the roles of tenant, neighbor, and member of the community within which the recipient lives.
	CCSS may be delivered in the recipient's home or other appropriate community setting.	Assisting with the housing application, search, and recertification processes.
	Eligible CCSS activities include teaching skills to restore functioning, counseling focused on functional improvement, recovery, and relapse prevention; and encouraging and coaching.[29]	Helping to resolve conflicts with landlord or neighbors. Counseling on tenant role, rights, and responsibilities. Counseling and skill development related to lease compliance. Counseling and skill development to promote health and wellness, and illness/disability management.
Peer Support Services	Support transitions from an institution to the community, help the recipient to gain greater control and balance, enhance community living skills, and support independence.	Paired with CCSS, provide opportunities to practice new skills related to roles of tenant, neighbor, and community member.

[29] Behavioral Health Services Integrated Regulations, 7AAC 135.200

	These services are delivered by a peer, a person with similar lived experience who meets designated requirements for the role.	Activities to develop social skills and natural support.
	Peer support services are to be delivered to adults only in combination with CCSS. [30]	Helping the recipient become familiar with neighborhood and community resources.
Case Management	Provide and ensure service coordination, help recipient access needed and desired services, monitor whether all services are provided effectively and as agreed upon, and provide overall advocacy and support for the recipient's various needs. [31]	Advocating on issues related to Fair Housing and housing rights.
Short Term Crisis Stabilization Services	Stabilize, preventing harm and further relapse or deterioration resulting from an assessed short-term crisis impacting the individual's mental, emotional, and behavioral state. These services may be delivered by a qualified CBHS provider, substance use disorder counselor, or behavioral health clinical associate. Services may be provided in a recipient's home.[32]	Time-limited, home-based support during times of distress to allow recipient to remain in home.

[30] Behavioral Health Services Integrated Regulations, 7AAC 135.210
[31] Behavioral Health Services Integrated Regulations, 7 AAC 135.180
[32] Behavioral Health Services Integrated Regulations, 7 AAC 135.160, 7 AAC 135.170

Non-Medicaid Behavioral Health Services

In addition to the Medicaid-covered behavioral health services described above, DBH, in partnership with the Trust, released a competitive solicitation in October 2014 to meet the complex needs of chronically homeless individuals, including chronic inebriates. Two new levels of service, Assertive Community Treatment (ACT) and Intensive Case Management (ICM), are being implemented based on the intensity of services needed by homeless individuals. Both services are ideally suited to permanent supportive housing and use Housing First, a non-contingency based approach that minimizes barriers to getting and keeping housing (such as including sobriety or participation in treatment as eligibility criteria).[33] To ensure quality and achieve documented outcomes, ACT will be designed, implemented and monitored using a recognized fidelity tool. As these services are implemented, they could be billable to Medicaid, thus offsetting costs to the State.

Assertive Community Treatment (ACT): ACT is a widely researched and well-documented evidence-based practice. It is a client-centered, recovery-oriented service delivery model in which community-based comprehensive treatment, rehabilitation, and support services are delivered by a multidisciplinary team. Team members include behavioral health treatment professionals, peer specialists, skilled rehabilitation practitioners (including supported employment specialists), and case managers. ACT and a Housing First approach are proven strategies to end chronic homelessness, reduce hospitalization days and other high-cost emergency services, and promote housing stability and community tenure among very vulnerable individuals with complex behaviors.

Intensive Case Management (ICM): ICM is a client-centered, recovery-oriented service delivery model that promotes community integration, independence, and an improved quality of life. This is a flexible and intensive service model that includes both direct service provision and coordination and brokering with treatment providers, crisis intervention, employers, family, peer support specialists, and others as requested by the individual. Assertive outreach and engagement are critical components. As implemented in Alaska, ICM will emphasize intensive supportive housing and community integration. ICM is described in the Interim Program Standards as more than a brokerage function.[34] Case managers will develop strong therapeutic relationships with recipients to help them acquire and use an array of services to enable them to live in the least restrictive, most natural environment possible.[35]

V. Strategic Goals and Findings

TAC recommends seven strategic goals for DBH to accomplish over the next three years. These goals were formulated to support the expansion of permanent supportive housing opportunities for Alaskans with serious behavioral health issues and to guide action that will

[33] http://www.endhomelessness.org/pages/housing_first
[34] ICM Interim Program Standards (SOA/DHSS/DBH)
[35] ICM Interim Program Standards (SOA/DHSS/DBH)

facilitate system transformation towards recognition of housing as a foundational context within which services are provided to promote independence and community integration.

These goals and action steps were informed by discussions with state leadership from DBH, DSDS, the Trust, and AHFC. They also draw on input from key stakeholders, and a review of current housing resources and related community supportive services and supports.

GOAL ONE

Develop a policy framework to guide implementation of permanent supportive housing as an essential component of the DBH service system.

Health, wellbeing, and recovery occur within the context of life in the community. Access to safe, affordable, and preferred housing is the foundation that allows an individual to more consistently engage with services and treatment options, participate in social, employment, educational, and leisure opportunities, and develop a sense of identify and purpose beyond that of service recipient.

It is common in state systems for planning to occur in specific and separate systems, such as the homelessness system (Continuum of Care and state plans to end homelessness) or the criminal justice system (re-entry initiatives); or on a project-by-project basis. This can result in poor coordination, lost opportunities to maximize and leverage resources, or failure to target resources to meet the needs of the most vulnerable, high-service, and ultimately high-cost individuals. DHSS, in partnership with the Trust and AHFC, has made significant efforts to identify and address the housing and service needs of individuals who cross systems.

To strengthen these efforts, DBH should establish a PSH policy framework that crosses state agencies to create a unified approach to addressing the supportive housing needs of vulnerable Alaskans with behavioral health disorders. A unified framework will foster consistency, coordination, and communication across state agencies serving similar populations; minimize fragmentation; and reduce competition among different populations for limited resources.

To achieve this goal, the following action steps are recommended:

1a. Convene a DBH-led PSH Steering Committee to establish policies, identify priority populations, and coordinate access and services for those individuals who cross DHSS, the Department of Corrections, and Homelessness/Continuum of Care systems.

DBH should establish an inter-agency PSH Steering Committee to set policy and to monitor and evaluate implementation of the Strategic Supportive Housing Plan. Membership should include high-level leadership from DHSS, the Trust, AHFC, and the Department of Corrections (DOC). Other vital partners for inclusion are ANTHC, the Governor's Council on the Homeless, the Governor's Council on Disabilities and Special Education, the Alaska Coalition on Housing and Homelessness, the Alaska Commission on Aging, and the Office of the Long Term Care Ombudsman. Bringing together key policymaking and funding agencies will facilitate

coordinated planning and decision-making to address the housing and service needs of all Alaskans with disabilities. The PSH Steering Committee will align all current statewide housing planning efforts.

The PSH policy framework should articulate DBH's vision for a coordinated and consistent approach to providing PSH opportunities across the DBH system. In this policy, DBH should acknowledge housing as essential to individuals' recovery and well-being, and specify the types of housing models to be emphasized and developed.

Establishing a PSH policy framework will require DBH to define and prioritize eligible populations, preferred housing models, and approaches (e.g. Housing First) to guide new project design, service development, and funding decisions. Standardizing eligibility criteria and ensuring alignment with PSH principles and practices will minimize fragmentation, unify planning, and ensure that resources are targeted to the individuals who are most vulnerable and in greatest need.

This work is already underway. Alaska's recent HUD 811 PRA award requires to the state to establish an inter-agency agreement among the state Housing and Finance Corporation, Health and Social Services, and Medicaid. Grantees must plan and develop integrated supportive housing opportunities for individuals across disability populations. This program will create a model to form the basis for a statewide permanent supportive housing policy framework to extend beyond the HUD 811 PRA program.

1b. Develop and implement outcome/performance measures related to access, housing stability, tenancy, and community integration.

DBH should establish system-level goals and performance measures related to permanent supportive housing. Such measures might include number of new housing units developed, projected financial savings through maximizing federal financial participation for services, housing tenure, and reductions in days institutionalized and use of higher-cost emergency services.

DBH should include as part of the PSH policy framework the primary goals of ending homelessness, preventing unnecessary or prolonged institutionalization for individuals with disabilities, and promoting community integration. By achieving these goals, DBH will meet two of DHSS' priority objectives outlined as part of the 2014 Priorities:[36]

> 1.2.3 - Increase the number of Alaskans with disabilities who are living safely in the least restrictive environment.
> 1.2.4 – Increase the number of Alaskans with behavioral health issues who report improvement in key life domains.

[36] https://www.dhss.alaska.gov/Documents/Pulications/priorities.PDF

Additionally, individuals living in PSH settings receive services that facilitate health care outcomes aligned with a number of DHSS priorities. For example, PSH tenants receive assistance accessing and engaging regularly with health care practitioners (Priorities 1 & 2), seeking employment (Priority 3.1.1), and gaining competency in self-management of behavioral and physical health conditions (Priority 3.3.3).

1c. Create a structure and process within DBH to oversee and coordinate implementation of the PSH plan that includes timelines and accountability.

To carry out the varied tasks required for implementing the PSH Plan, the PSH Steering Committee should establish time-limited, task-specific workgroups. Having separate workgroups charged with completing specific actions uses human resources strategically, makes implementing a supportive housing plan manageable, and fosters sustained effort and ultimate success. Membership on workgroups should align with staff members' area of work within the system, subject matter expertise, and designated time to focus on the work. Specific areas of this plan that require this level of concentrated effort include: a Funders Collaborative for housing pipeline development; PSH workforce development; Medicaid services for individuals in PSH settings; housing and workforce issues unique to rural, remote, and frontier communities; and housing and community integration outcome and performance measures.

The DBH coordinator for the Office of Integrated Housing will play a vital coordinating role. This position is responsible for managing the different housing programs and initiatives. This position currently works in partnership with the similar role within the DSDS to plan for and implement the HUD 811 PRA award and redesign of GRA. It is likely these staff will be co-facilitators of one or more of the established workgroups.

1d. Align this plan with statewide housing planning efforts, including the Governor's Housing Summit, the Governor's Council on the Homeless, and the Governor's Council on Disabilities and Special Education.

Alaska has done much in the way of assessing the housing needs of its citizens. In 2014, AHFC conducted a housing assessment, prepared by the Cold Climate Housing Research Center. This report provides a statewide, regional, and community look at major factors affecting housing including affordability, overcrowding, and energy use, and compares Alaska with the rest of the United States in these areas. Among other findings, this report shows that nearly one in three households is cost-burdened (spending more than 30% of total income on housing costs), and that the rate of overcrowding is twice the national average.[37]

In 2015, the Governor's Council on Disabilities and Special Education published a report on housing barriers.[38] A shortage of desirable and affordable housing and lack of knowledge about housing resources were identified as primary barriers. Suggestions offered by focus groups and survey respondents included giving incentives to developers to increase use of universal design

[37] 2014 Alaska Housing Assessment, April 1, 2014. Alaska Housing Finance Corporation
[38] Housing Barriers Report 2015. Alaska Governor's Council on Disabilities and Special Education

features, training and education for landlords and property managers on Fair Housing and reasonable accommodations, expanding transportation services, and establishing Housing First programs for homeless individuals.[39]

In October 2015, Governor Walker announced plans for a Housing Summit to examine and address the lack of available housing faced by many Alaskans. The summit will address planning for the affordable housing needs of vulnerable Alaskans living on extremely low incomes. The HUD 811 PRA program in particular can serve as a model for integrating deeply subsidized housing into existing and new development.

GOAL TWO

Establish a coordinated and consistent approach to housing and housing-related services across all DHSS divisions.

The need for safe, decent, affordable housing is consistently identified as one of the primary challenges faced by individuals with moderate to low incomes. This need is even greater for individuals with extremely low incomes[40]who have serious behavioral health conditions or intellectual and developmental disabilities, as well as for transition-aged youth and individuals leaving hospitals, nursing homes, prisons, or jails. In addition to having little to no income, many of these individuals require assistance and supportive services to live successfully in the community.

Individuals who are most vulnerable and in need of PSH and specialized residential services are also those who most often cross systems. Of particular concern are transition-aged youth and individuals with serious behavioral health conditions who are exiting institutions like hospitals, jails and prisons; who are experiencing chronic homelessness; who have intellectual or developmental disabilities; or who are aging and exhibiting symptoms of dementia or Alzheimer's disease. Often the needs of these subpopulations are dealt with in separate systems, and especially by the primary system with which an individual is currently engaged. This can be ineffective and create unnecessary competition for limited resources.

To address the housing and service needs of individuals who cross systems, often at great expense, DHSS should establish a coordinated and consistent approach to housing planning and policy.

The vast majority of individuals served by DHSS can live in independent settings with the appropriate wraparound services to support them. However, some individuals with more pronounced and complex conditions may require, and prefer, service-enriched and supervised residential options. Having a full continuum of housing and residential options available allows systems to meet varied needs. However, a continuum of housing and residential options is most effective when operated strategically to foster individual choice and preference, targeted use,

[39] https://www.dhss.alaska.gov/gcdse/Documents/Publications/HousingBarriers2015.pdf
[40] Defined by HUD as a household with income at or below 40% of the area median income (AMI).

and flow from restrictive and transitional settings to independent and permanent housing options.

To establish a DHSS-wide housing policy, the following actions steps are recommended:

2a. Convene a standing DHSS Housing Committee to coordinate policy, practice, and services related to DHSS-supported housing and residential programs.

TAC was engaged by DBH specifically to create a plan to expand permanent supportive housing opportunities for individuals with serious behavioral health conditions, but many focus group participants and key informants are also concerned with services for individuals served by DSDS. Because individuals most vulnerable and in need tend to cross systems, it is essential for DHSS to coordinate policy, practices (such as referral and eligibility), and services provided in housing and residential programs. A coordinated housing policy and approach will enable DHSS to identify priority populations, centralize access to existing and new PSH opportunities and other specialized residential services, and leverage and target resources across the department.

Two initiatives underway establish a framework for this recommendation. The HUD 811 PRA program encourages a cross-disability approach, and DBH and DSDS are already partnering with AHFC to implement the program and its evaluation. Meanwhile, DSDS is leading the planning for a redesign of the General Relief Assistance program. As discussed in 1c, DBH and DSDS are already partnering to coordinate shared housing programs including the HUD 811 and GRA programs. Each division has a coordinator tasked with overseeing these programs, whose staff meet on a regular basis with representatives from DBH, DSDS, the Trust, and the Alaska Coalition on Housing and Homelessness.

DHSS can strengthen these efforts even further by establishing a standing housing committee that also includes representatives from the DHSS Commissioner's Office, the Division of Children's Services, and DOC. This committee could consolidate the various planning initiatives underway that involve housing. This would minimize fragmentation and avoid the confusion created by multiple similar initiatives being simultaneously rolled out, while ensuring that those Alaskans with the greatest need have priority access to scarce yet critical resources.

2b. Conduct a DHSS-wide assessment to estimate the need for PSH and other residential service options for vulnerable Alaskans served across all DHSS divisions.

DHSS should conduct a comprehensive review of all current housing and residential service programs funded or administered by DHSS. Areas for review should include: eligibility criteria, level of services available, staffing patterns, referral and admission criteria and practices, operational costs to DHSS, length of stays, and performance measures. This assessment will allow DHSS to gain a deeper understanding of existing resources and how they are being accessed and used. DHSS should add to its initial intake and assessment protocols an assessment of an individual's housing needs and preferences. Having a thorough inventory of

existing resources and needs and preferences of individuals served will help DHSS determine what types of housing or residential settings need to be developed, and what settings or programs can be repurposed to meet an identified priority population.

2c. Conduct an assessment of all currently enrolled GRA recipients and develop individualized housing plans based on level of care/service needs, housing needs, and preferences.

The General Relief Assistance program is currently facing a crisis. Current use and projected need are fiscally unsustainable based upon how the program is presently operated. A number of individuals receiving GRA funding and living in assisted living homes (ALH) may not need this level of support, while others may not be receiving the level of support needed to accommodate various health- and disability-related challenges. DSDS is currently leading the effort to conduct a comprehensive review of the GRA program, including an assessment of needs of individuals receiving GRA funds.

The tier 1 priority population targeted for the HUD PRA 811 program is individuals currently residing in assisted living homes. To facilitate timely access to these housing opportunities as they become available, maintaining a ready pool of applicants will be critical. Conducting a housing needs and preferences assessment to identify interested and eligible individuals will serve to establish this pool of applicants. This assessment process will also help DSDS and DBH identify current ALH residents who require increased services and support in order to remain living in the community. As these individuals and their needs become better understood, DHSS can work with interested and competent ALH operators to plan for possible repurposing or redesigning of the program and/or setting.

GOAL THREE

Establish a PSH pipeline to create between 465 and 615 PSH opportunities over the next five years.

TAC recommends that DBH work collaboratively with AHFC, the two CoCs, DSDS, and other stakeholders to establish goals for creating a sustained level of new PSH opportunities over the next five years. TAC estimates that by drawing on several different strategies, this partnership could create between 465 and 615 new PSH housing opportunities statewide over this period.

Below is a breakdown of new PSH opportunities to be created based on the following housing resource strategies:

Housing Resource Strategies	Range of Supportive Housing opportunities to be created during next five years
AK's Section 811 PRA Program — Integrated Supportive Housing	200
AHFC's GOAL Program — Integrated Supportive Housing	45–90
AHFC's SNHG Program — PSH Development	160–225
HUD's CoC program — new PSH opportunities	60–100
Total:	**465–615**

The estimate of 200 units to be produced through PRA assumes full implementation of AHFC's current initiative awarded in March 2015. TAC strongly recommends that AHFC, DBH, and DSDS continue to partner on this initiative with the goal of further expansion over the next five years. TAC recommends that AHFC pursue all future funding opportunities through HUD's Section 811 PRA program over this period. TAC's PSH projection for the GOAL program is based upon a range of five to ten percent of the average multi-family rental production over the next five years. Leveraging new resources from the National Housing Trust Fund, potential SNHG resources gained through a review, and continued resource collaboration through the PSH Funders Collaborative (discussed below), TAC estimates that SNHG will be able to create one new PSH project each year with 32 to 45 units (on average). The projection for the CoC program is based on the FY 2015 CoC appropriation level with the expectation that the two CoCs will be able to create new PSH opportunities in three of these years (low end) or all five years (high end).

3a. Establish a PSH Funders Collaborative to align and leverage resources to encourage the production of permanent supportive housing.

TAC recommends that AHFC and DBH work closely with other key funders/stakeholders to establish and organize a PSH Funders Collaborative. TAC recommends that membership in the collaborative include AHFC (representatives from both multi-family and public housing), DBH, DSDS, the Trust, and the Municipality of Anchorage.

The Collaborative's purpose would be to develop a predictable annual funding mechanism to pool all available funding for PSH development, operation, and supportive services. The collaborative would offer an efficient process for PSH developers to propose projects, reducing

the cost of assembling applications. The Collaborative would also be able to align funding streams to maximize the efficient use of limited housing and support services resources. As a possible approach, there may be an opportunity to adapt and enhance the existing SNHG application process and timing, integrating additional funding partners into this existing platform.

As part of its funding process, the Collaborative would conduct a joint review of project applications and make collective funding recommendations to better align and leverage existing resources. TAC recommends that each Collaborative member's skills and competencies be leveraged in the review of applications. For example, DBH and DSDS staff could play an important role in the review of proposed supportive service plans and financing strategies to ensure a PSH proposal fully leverages existing community-based services and Medicaid funding. AHFC staff should continue to provide expertise and take the lead on the financial underwriting of each PSH proposal.

3b. Through the Funders Collaborative, oversee and review progress on meeting PSH production goals.

As part of fully developing the role of the PSH Funders Collaborative, TAC recommends that this group play a role in periodically reviewing progress toward the PSH development goals — assessing progress, identifying and addressing barriers in meeting production benchmarks within each resource strategy, reviewing plans for future Collaborative funding rounds, and collectively leveraging future funding opportunities. TAC also recommends that the PSH Steering Committee (discussed above in recommendation 1a) oversee the planning of the Funders Collaborative and provide leadership to support its ongoing efforts.

3c. Conduct a comprehensive review of the Special Needs Housing Grant program in order to enhance and sustain its role as a significant driver of PSH production.

Based on AHFC staff analysis of both future SNHG funding levels and the renewal demand from existing PSH projects for continued operating and support services funding, AHFC will not be expected to release future SNHG solicitations for new PSH development during FY 2016. Given this challenging circumstance and the resulting need to free up SNHG funding for future PSH development, TAC recommends that AHFC conduct a comprehensive review of the SNHG program to identify potential savings and efficiencies. Specifically, TAC recommends that AHFC review all existing operating assistance and supportive services funding commitments that are expected to seek renewal funding during the next three fiscal years. As part of the operating costs review, TAC recommends AHFC consider a strategy to transition selected existing PSH projects from SNHG-funded operating assistance to Section 8 Housing Choice voucher assistance (either sponsor- or project-based). As part of the supportive services review, TAC recommends that AHFC partner with DBH and DSDS staff to ensure that each existing PSH project is leveraging all community-based support services and maximizing the use of Medicaid financing. DBH and DSDS staff could also play a role in providing specialized technical assistance to support agency efforts and capacity-building in order to become approved to bill for Medicaid-funded support services. These strategies would free up SNHG resources for new development for future funding rounds over three next three to five years.

In addition, TAC recommends that AHFC conduct a comprehensive review of previous SNHG Notice of Funding Availability (NOFA) requirements and evaluation criteria, with a focus on eliminating requirements or incentives that significantly increase project costs and the need for SNHG capital financing. In this challenging funding environment at both the federal and state levels, TAC recommends an assessment of the cost benefit of each NOFA requirement and incentive and the potential elimination of certain requirements in order to reduce the overall need for SNHG capital financing, freeing up additional resources for new PSH development. For example, the SNHG NOFA requirements/incentives to use solar energy enhancements may not deliver the energy savings payback to justify the up-front capital costs, especially in an environment of limited capital resources available and high demand for additional PSH opportunities.

3d. Adopt further enhancements to the current special needs set-aside within the Low Income Housing Tax Credit program to encourage the creation of integrated PSH.

TAC applauds AHFC's efforts to establish the special needs set-aside requiring all LIHTC-financed projects over 20 units to set aside five percent of those units for a "special needs" population. Within its Qualified Allocation Plan which outlines the rating and award criteria for Alaska's LIHTC program, special needs populations are defined as persons with mental or physical disabilities, households with incomes less than or equal to 30% of area median income, and homeless persons (this may include people who are "overcrowded" as defined by AHFC). The allocation plan offers an incentive of up to eight points for committing additional units for special needs populations (up to 50% of the residential units in the project).[41] The project's property owner, often through a property management company, is responsible for outreach and marketing efforts to identify potential tenants for the special needs set-aside units.

To maximize the benefit of this effort, TAC recommends that AHFC adopt a series of enhancements to the set-aside requirement/incentive approach in order to evolve to an integrated PSH set-aside approach. This approach will align with the PSH Framework which includes the identification of priority populations discussed in recommendation 1 above.

- Refine the eligible special needs populations to align with the PSH priority populations identified in the state's PSH Framework.
- Provide owners with timely referrals of PSH priority consumers from the state-sponsored PSH Clearinghouse (discussed in recommendation 4 below) at both initial occupancy and turn-over of the new set-aside units (In addition to referral, the PSH Clearinghouse will be responsible for the coordination of supportive services and tenant liaison services.)
- Offer the referral service of the PSH Clearinghouse as an optional benefit for special needs units in existing LIHTC-financed properties upon turnover of these units;
- Offer the benefit of Section 811 PRA rental assistance to support the provision of deep affordability for these set-aside units; and

[41] Alaska's GOAL Program Rating and Award Criteria Plan (QAP), May 14, 2014, p. 28.

- Consider establishing a ceiling of 25% for the PSH units set-aside to ensure consistency with the Section 811 PRA program guidance and integrated PSH best practices.

3e. Commit Section 8 Housing Choice Voucher rental assistance from AHFC to support the operation and development of PSH.

Using its regulatory flexibility as a Moving to Work agency, TAC recommends that AHFC's public housing authority consider the strategic use of either project-based or sponsor-based Section 8 rental assistance to support PSH development and/or to replace SNHG-funded operating assistance (discussed earlier). From a planning perspective, AHFC may want to consider a modest number of Section 8 subsidies each year for this purpose to be utilized by the PSH Funders Collaborative. It is important to note that AHFC has enjoyed success with the targeted use project-based or sponsor-based rental assistance approach with Section 8 vouchers to support Loussac Place, a mix-income rental housing project and Karluk Manor, the Housing First PSH project, both located in Anchorage.

3f. Leverage future federal funding opportunities through the National Housing Trust Fund and Section 811 PRA to support the creation of new PSH development.

On December 16, 2015, Congress announced the FY 2016 Omnibus Spending bill. The HUD portion of the bill funded the HOME Investment Partnership Program at $950 million, an increase of $50 million from the FY15 level. The funding for the HOME Program comes entirely from new appropriations, leaving the funding stream for the NHTF intact. As of this writing, both chambers of the Congress are expected to pass the bill. Based on this information, TAC expects Alaska to receive a $3 million allocation from the National Housing Trust Fund in FY 2016.

In April of 2015, TAC released *Creating New Integrated Permanent Supportive Housing Opportunities For ELI Households: A Vision for the Future of the National Housing Trust Fund* [42] which outlines a vision for states to use NHTF resources as a catalyst to expand integrated PSH opportunities. This report highlights three successful state financing models (Pennsylvania, North Carolina, and Illinois) that could be adapted for NHTF capital and operating subsidy funding to assist with closing the gap in PSH supply.

In the *Creating New PSH Opportunities* report, TAC recommends that states follow a few key principles to help guide NHTF policy decisions:

- The NHTF program must be targeted to address the full spectrum of ELI needs, including vulnerable households with disabilities in need of PSH.

- The federal LIHTC program should be used as a platform for the NHTF to expand ELI and PSH units. When combined with other sources of capital financing, the LIHTC program can produce much lower rents for a subset of units in a property — as low as

[42] The complete TAC report is located at http://www.tacinc.org/media/51527/Creating%20New%20Integrated%20PSH%20Opportunities%20For%20ELI%20Households.pdf

30 percent of area median income in some housing markets. When lower rents are achieved, the cost of adding an additional ELI subsidy — such as the NHTF operating subsidy — will be much less than the cost of an FMR-based subsidy. Pennsylvania and Illinois both utilize the LIHTC program for this purpose, and illustrate the relatively low cost — and transparency — associated with this ELI approach.

- NHTF strategies should include a focus on mixed-income approaches that create a subset of ELI units in properties that also provide housing for higher income households. The mixed-income model can reduce the community resistance often encountered for projects that are either 100 percent ELI or 100 percent PSH and may provide opportunities to cross-subsidize PSH rents. Equally important for PSH policy, a mixed-income approach also maximizes the level of community integration which can be achieved for PSH tenants. All three of the highlighted states use this mixed-income approach to expand the supply of integrated PSH units.

- Use NHTF resources to develop the most cost-effective, transparent and long-term ELI subsidy approach possible. ELI units cost more to develop, but realistic cost-conscious policies are essential to the future of ELI housing policy.

- NHTF resources must be used in combination with other existing affordable housing programs, rather than supplanting funding from these programs. For example, NHTF capital should not be used to replace HOME funds that are being used systematically to lower rents in LIHTC properties. Instead, NHTF resources can be used to augment LIHTC/HOME-financed models to achieve deeper levels of affordability.[43]

Guided by these principles, TAC recommends that AHFC target the state's NHTF resources as core sustaining capital and operating resources to support the creation of new PSH development over the next five years. As AHFC prepares its NHTF Allocation Plan (due to HUD in the first half of 2016), TAC suggests assessing the state financial models presented in TAC's *Creating New PSH Opportunities* report and developing capital and operating assistance strategies to efficiently deploy NHTF resources to support PSH development through the Funders Collaborative (see recommendation 3a) and the GOAL program.

In addition to maximizing NHTF to support future PSH development, TAC recommends that AHFC pursue all future opportunities for accessing additional targeted rental assistance through the Section 811 PRA program. TAC recommends that AHFC, in partnership with DBH and DSDS, work to ensure implementation of the Section 811 PRA program in 2016. TAC further recommends that the AHFC/DBH/DSDS team make every effort to reach key implementation benchmarks in 2016 including (1) establishing policies and procedures for targeting, referral, and the coordination of supportive services and (2) exceeding the program year one goal for the number of PRA units under contract. Achieving these key implementation benchmarks for PRA

[43] *Creating New Integrated Permanent Supportive Housing Opportunities For ELI Households: A Vision for the Future of the National Housing Trust Fund,* Technical Assistance Collaborative, pp. 17-18.

in 2016 will set the conditions for AHFC to compete for additional Section 811 PRA resources when they become available in FY 2017.

3g. Leverage all available resources and encourage the replication of innovative financing models to create PSH.

TAC commends AHFC's creativity and success in leveraging a broad range of housing resources to create sustainable permanent supportive housing. Specifically, TAC wants to highlight AHFC's recent efforts to utilize four percent low income housing tax credits (non-competitive) as a funding resource offered in the recent SNHG NOFA round. State Housing Finance Agencies typically do not utilize four percent LIHTC as a capital source to support PSH development. TAC recommends sustaining this practice of leveraging all available resources for PSH development, especially four percent LIHTC. TAC further recommends that AHFC work with other developers to replicate this innovative financing model in other Alaskan communities.

GOAL FOUR

Establish a PSH clearinghouse to coordinate the timely referral of eligible households for PSH opportunities.

4a. Create a PSH Clearinghouse to coordinate the referral and supportive service provision of households eligible for PSH opportunities.

TAC recommends that DBH in coordination with its PSH Steering Committee partners establish a PSH Clearinghouse to efficiently assess and provide timely referrals of priority consumers to all PSH opportunities which become available upon either initial lease-up or vacancy. As part of its PSH Framework (discussed above), the state should develop prioritization criteria to define the specific target populations for all PSH opportunities developed and supported by the state. The PSH Clearinghouse should conduct focused outreach and engagement to identify and prepare a pool of disabled/homeless households for timely referral.

The PSH Clearinghouse will serve the following functions: create a comprehensive portfolio on PSH opportunities/units throughout the state that will accept referrals over time; offer a community-based, accessible, single-access process for disabled/homeless households to the PSH Clearinghouse; provide timely referral of PSH priority households to PSH opportunities; and reduce access barriers at the time of application/referral.

TAC recommends that the PSH Clearinghouse provide the access/referral point for all state-funded PSH opportunities (both PSH tenant-based options and PSH projects) over time including existing and new PSH opportunities supported by the Section 811 PRA, Moving Home, SNHG-funded PSH projects, GOAL-financed multi-family rental projects, and future PSH development created through the Funders Collaborative.

TAC suggests that the DBH and its partners consider the following design elements in developing the structure of the PSH Clearinghouse:

Purpose: Provide a mechanism to ensure timely referral of eligible disabled households (as defined by the PSH Framework) to PSH units or opportunities upon lease up or turnover.

Key Roles and Responsibilities: Initial responsibilities may include: conducting eligibility determination and housing assessment; conducting possible initial criminal background screening and housing choice survey (with the purpose of better informing referrals and a good housing match); coordinating access to needed supportive services for disabled households; managing a ready pool or wait list of eligible disabled households; offering timely referral of households to PSH units made available, which also may include application assistance and move-in assistance; developing relationships with property managers and offering reasonable accommodation training to reduce barriers to access; and establishing tenant liaison services, providing a single point of contact for the property owner.

Responsible Party: Take advantage of existing staff and infrastructure to carry out the activities of the PSH Clearinghouse.

Regional Coverage: Initially align with the four regions identified by AK Section 811 PRA Demo Program: Anchorage, Juneau, Fairbanks, and the Matanuska-Susitna Valley. Consider expansion of PSH Clearinghouse coverage later in the implementation of the PSH pipeline and as the need exists.

Regulatory Structure: Establish the requirement to accept priority referrals to the PSH units at initial occupancy and turnover in the land use regulatory agreement for new PSH development. Consider establishing and implementing a memorandum of understanding (MOU) between the PSH Clearinghouse, the owner, and the property manager to outline roles and responsibilities of each party in providing timely referral to PSH units. The MOU would be signed and reviewed by all parties prior to initial marketing and lease up.
Data and Tracking: Through the experience of the Section 811 implementation, select a data system to support the wait list management and referral process.

Implementation Plan: Develop a phased implementation plan initially focusing Clearinghouse activities on the PSH opportunities supported by HUD Section 811 PRA and Moving Home programs. As a second stage of implementation, TAC suggests expanding to cover and support PSH opportunities in both the LIHTC multi-family housing portfolio and PSH developments supported by the SNHG program. This second stage of implementation might include offering the PSH Clearinghouse as an optional service to existing PSH opportunities. This part of the implementation should also respect and take into consideration rights of disabled persons on site-based waiting lists for existing PSH resources.

4b. Coordinate design and implementation efforts with the two CoCs' work on coordinated entry.

TAC recommends that DBH and its PSH Steering Committee partners align the PSH Clearinghouse and the coordinated entry systems currently being designed by the two CoC programs. Given the fact that the two systems have significant overlap, TAC recommends potentially moving toward a "no wrong door" approach, so that both systems could serve as access points for PSH opportunities. This unified approach would require detailed policies and procedures including protocols to share information between entities. The benefit would be offering one streamlined engagement and assessment process for homeless individuals and families throughout the state, providing access to both state- and CoC-funded PSH opportunities as they become available.

4c. Align the access and referral policies and procedures for the Moving Home program with the proposed PSH Clearinghouse and the CoCs' coordinated entry system.

The state's Moving Home program and the two CoCs both prioritize disabled, homeless individuals and families for access. Given these programs' mutual goals, there is an opportunity to align and streamline access to both of these PSH opportunities. TAC recommends that AHFC and DBH work closely with the two CoCs as they work to establish a coordinated entry system. At a minimum, TAC recommends developing specific protocols to share referrals between the two entry points to streamline access. Over the longer term, TAC recommends that DBH and the CoCs consider a "no wrong door" approach for these two programs allowing homeless households to apply and gain access via Coordinated Entry and the PSH Clearinghouse (also discussed above).

4d. Provide PSH property owners and managers with sustained training opportunities to build understanding of their obligation under the Federal Fair Housing Act and the Americans with Disabilities Act, with the goal of eliminating barriers to access and reducing stigma.

In our discussions, several stakeholders identified barriers to accessing many affordable multi-family rental housing properties. Stakeholders noted that property managers of these rental housing properties often lack a full operational understanding of their obligations under the Federal Fair Housing Act and the Americans with Disability Act. In addition, frontline property management staff often struggle with a basic understanding of how to accept and fairly review a request for a reasonable accommodation or reasonable modification from a disabled household either at time of application or during occupancy. Many homeless and disabled households with a criminal justice-involved background may also face discriminatory access and eligibility barriers in their applications for rental housing. In fact, HUD recently provided guidance to Public Housing Authorities and owners of federally assisted multi-family properties on excluding the use of arrest records in making housing decisions.[44] Finally, there is a lack of understanding about homeless and disabled households and a general stigma or fear of renting to such

[44] See HUD's PIH Notice at http://portal.hud.gov/hudportal/documents/huddoc?id=PIH2015-19.pdf

households. Some states, including Massachusetts (through efforts by MassHousing) and Maryland (through the efforts of the Maryland Partnership for Affordable Housing), have implemented education efforts for frontline property managers and supportive service providers on fair housing obligations and reasonable accommodation to reduce such barriers to access.

As a result of these efforts, these states have recorded significant fewer complaints, and better access to affordable rental properties.

TAC recommends that the PSH Clearinghouse engage in the coordination of a sustained training effort targeted initially to frontline property managers on a range of topics to decrease access barriers to both market and affordable rental housing properties. The range of training topics should include: obligations under the Fair Housing Act and the Americans with Disabilities Act, reasonable accommodation training, and strategies and skills to engage and work with homeless, disabled, or justice-involved households. This effort should leverage existing training resources and capacity throughout Alaska. Specifically, TAC recommends partnering with Alaska Legal Services Corporation's Fair Housing Enforcement Project[45] which is funded by HUD in part to provide trainings on fair housing and reasonable accommodation.

GOAL FIVE

Establish a funding source for services delivered in supportive housing settings that is sustainable and tailored to the needs of individuals.

The current patchwork of funding through DHSS, DBH, the Trust, and Medicaid relies too much on state funds and is not designed to support a system of flexible, responsive services in integrated, supported housing settings. The current services available are not well organized or funded to meet the needs of individuals who can benefit from supported housing in integrated settings. The overuse of the GRA program has resulted in a reliance on assisted living homes, and there has been little funding for more integrated services.

A major objective of this process is to establish steps the state can take to identify the types of services needed to support individuals in PSH and to organize and maximize resources to pay for these services.

5a. Assign responsibility to a new Medicaid task force to improve Medicaid coverage of services in supportive housing.

In order to develop, finance, and implement the services needed to support individuals in supported housing, there must be coordinated planning among key agencies, including DBH, DSDS, Medicaid, and the Trust. A "steering committee" composed of leaders from DHSS, DOC, the Trust, and AHFC has been involved in this strategic planning process; however, DHSS should establish a new Medicaid task force or formalize an existing workgroup within DHSS to

[45] See additional information regarding the AK Fair Housing Enforcement Project at http://www.fairhousingalaska.org/know-your-rights-fair-housing-overview/

focus on the role of Medicaid in services in PSH settings. The responsibility to oversee and coordinate modifications to existing and new Medicaid state plan services for individuals in PSH settings should rest with this task force. While this task force should be led by Medicaid, its work should be informed by DBH, the Trust, DOC, and related agencies.

5b. Improve DHSS leverage of existing Medicaid services (CCSS, Case Management, and RSS).

While TAC did not perform data analysis on spending or utilization of Medicaid services for adults with mental illness, our interviews with state staff and key stakeholders suggest that better use could be made of RSS, CCSS, peer support services, and case management to assist individuals in PSH. CCSS, peer support, and case management are Medicaid services that can be delivered effectively in PSH but are for now largely supported by state funds to providers.

DHSS should conduct an analysis of Medicaid claims to understand who is receiving these services and at what level. DHSS can also survey providers to learn who is receiving services that are not being billed to Medicaid for various reasons (e.g. ineligible, rates too low, etc). For CSS, peer support, and case management services that are eligible for Medicaid reimbursement, DHSS should require providers to submit claims to Medicaid.

Because providers can bill for these services onsite at their offices, there is little incentive to provide them in individuals' homes. However, the target populations for PSH often need home-based tenancy support services to maintain housing, and may struggle to attend appointments at community-based facilities due to lack of transportation or the unavailability of appointments after normal business hours. DHSS should examine ways to ensure that CCSS and peer support services are delivered in community-based settings such as people's homes. Increasing reimbursement rates for in-home services is one possible way to encourage providers to do this.

5c. Engage CMS to maximize coverage of services in supportive housing.

DHSS should seek to increase federal financial participation by submitting a 1915(i) Medicaid State Plan Amendment and refinements to existing rehabilitation option services as part of current Medicaid reform and expansion efforts.

Alaska should consider Medicaid options to pay for the types of services Medicaid beneficiaries need to succeed in PSH. The Medicaid task force proposed above should determine the types of services that should be offered in PSH, and design the best Medicaid approach to accomplish this. CMS should be engaged in this process to work with DHSS on the types of services the state seeks to cover and to determine the most appropriate Medicaid vehicle to use. Among the approaches to consider is submission of a 1915(i) and/or a Health Homes state plan amendment to CMS, as well as refinements to or consolidation of the existing CCSS and peer support functions.

In addition to the types of services needed in PSH, we found that there were gaps in other critical systems like crisis response. Safety net programs provide important support for individuals in community-based settings, however there is no mobile response capacity and no after-hours crisis response system. Crisis response services should be oriented to mitigating the crisis in the community and preventing unnecessary hospitalization. DHSS should consider building crisis response services into any Medicaid state plan changes.

5d. Determine rates for services that reflect accurate costs of providing flexible home- and community-based services.

Medicaid rates must reflect the costs of providing services to individuals in PSH. Establishing new rates or modifying existing rates will depend on the approach DHSS decides to take in Goal 4c. Services that are necessary but are ineligible for Medicaid reimbursement should be reimbursed by DBH or other funding sources (e.g. block grants, local funds). While we did not conduct an analysis of provider costs and Medicaid rates, providers asserted that rates are low and one of the main reasons why there is limited service availability off-site. Depending on decisions about new or modified Medicaid state plan services, DHSS should establish reasonable rates to ensure that the desired services are provided.

Recently, DHSS retained a consultant to work with the state to contemplate rate changes for individuals living in ALH based on the level of support they require. ALH providers, the Trust, DSDS staff, representatives from the Office of Rate Review, DBH staff, and staff from Licensing met on July 14, 2015 to discuss various options and potential impacts. This is a positive step and should be supported.

5e. Budget state funds to pay for important supportive housing services that are not covered by Medicaid.

Not all of the services needed to support individuals in PSH are covered by Medicaid. One reason is that there are many individuals who are served by DHSS who could benefit from PSH, but are currently ineligible for Medicaid in Alaska. The other reason is that some services provided to Medicaid-eligible individuals will not be covered by Medicaid. Nevertheless, these services are important to help people succeed in integrated settings.

DHSS should estimate the number of individuals who are not eligible for Medicaid but who are clinically eligible for designated supportive housing programs and services (HUD 811, Moving Home, Special Needs Housing Grants, Housing First, CoC programs) and budget state funds for this group. If Alaska does implement Medicaid expansion through the ACA, the costs to serve this group will likely be offset by additional Medicaid funding for some individuals. DHSS should also estimate the cost of services not covered by Medicaid reimbursement and budget accordingly. These funds could be distributed to providers through contracts with specific requirements.

5f. Work with the Trust to use funds for services in strategic and targeted ways.

The Mental Health Trust Authority is a resource unique to Alaska, and offers a range of opportunities to expand PSH in the state. Building on Goal 4e, the Trust should consider the following three strategies to support PSH in Alaska:

- "Bridge Funding": Trust funds could be used to jumpstart the implementation of services in PSH until sustainable sources of funding become available. For example, Oregon uses 100 percent state funds to start new ACT teams until the teams achieve program fidelity and are able to bill Medicaid. At that point, the state funds are repurposed to start new teams or services elsewhere. The funds are used as a time-limited "bridge" to Medicaid.

- Flexible funding for program innovation: Trust funds could be used to implement evidence-based, emerging, or innovative programs consistent with PSH. As these services are tested, they can be moved to scale throughout the state, and should include a plan for long-term financial sustainability beyond Trust funds (e.g. Medicaid);

- Ongoing Support: Some services may not be eligible for Medicaid reimbursement or have a sustainable source of funds, but are important nevertheless. Trust funds could be used to pay for these specific services (e.g. building security in single site settings).

5g. Plan ahead to restructure provider agreements and contracts when additional Medicaid revenue is expected.

As the state takes advantage of Medicaid funding opportunities, state resources to providers will be offset by Medicaid revenues. DHSS should begin to estimate this revenue in FY16 based on the number of Medicaid-eligible individuals in PSH, the types of services that are reimbursable (based on anticipated Medicaid state plan changes), and the units of service that are provided. This will require DHSS to work with providers to estimate figures. State funds in contracts will need to be repurposed or reduced accordingly. State funds could be used to pay for important services that are not Medicaid reimbursable, or to expand PSH to additional individuals who are coming out of Alaska Psychiatric Institute, homeless, or otherwise in need of PSH.

5h. Continue to pursue Medicaid expansion through the ACA to provide more Alaskans with health insurance coverage and to and maximize federal financial participation.

Adopting Medicaid expansion will provide more Alaskans with health insurance, offering greater opportunities to access health care, reducing costs to the state, and reducing uncompensated expenses for providers. Many people are currently receiving services from DHSS and other agencies at 100% state expense. Others are not accessing services, but are still likely costing the state money through uncompensated hospital emergency department visits or incarceration. Medicaid expansion will also improve access to mental health and substance use treatment and to services for people with behavioral health conditions. The package of services for the Medicaid expansion population previously served by DBH or other state agencies should

include home- and community-based services and tenancy support services to support successful community living. Despite Alaska's fiscal constraints, TAC cautions that increased federal revenue should not result in cuts to state or local funds currently supporting the housing and service needs of disabled and homeless individuals. Medicaid is not a total solution, and TAC strongly recommends that state and other non-federal funds continue to be applied to the housing and community support needs of individuals.

GOAL SIX

Expand service delivery in home- and community-based settings to promote housing stability and community integration.

DBH, in partnership with the Trust and AHFC, provides a variety of programs and services that support individuals living in community settings. A number of Medicaid behavioral health services can be delivered in recipients' homes and other community settings. AHFC's Special Needs Housing Grant (SNHG) funds include services to tenants. And the Trust recently funded the creation of Alaska's first ACT and ICM teams. These and the PRA 811 program are opportunities to expand and strengthen services delivered in an individual's home. As new PSH opportunities become available, DBH will need to expand services and service delivery in community settings and in more independent, integrated housing settings.

However, many individuals with serious behavioral health conditions currently live in congregate settings such as ALH or shared housing programs (e.g. SNHG, substance use disorder residential treatment, or Continuum of Care housing programs) where staff are on-site 24/7 or at regularly scheduled times. While each recipient has an individual services plan, congregate and shared living settings naturally promote an approach that meets the needs of a group. Activities are scheduled at set times, and meals are usually planned and prepared on a group basis. Privacy is limited and house rules or guidelines are established to promote harmonious group living that can restrict individual choice.

Conducting a housing needs and preference assessment as discussed in 2c will allow DHSS to identify who needs and prefers this level of service and type of housing, and who can be transitioned to PSH. As beds in congregate supervised residential settings are vacated, DHSS can evaluate whether these beds should be taken off line and funds reallocated or if the setting can be repurposed to meet the needs of an identified priority subpopulation. To further develop PSH opportunities, reallocated funds can be used to expand the Moving Home voucher program or to fund housing support services that are not eligible for Medicaid reimbursement, such as moving-in expenses.

6a. Design services to be provided in home and community settings that will promote housing stability and community integration.

As discussed in Section 4, certain Medicaid behavioral health services are compatible with the needs of individuals living in PSH settings and are eligible to be delivered in home and community settings. Typical housing and tenancy support service activities appear eligible

within the current service definitions for CCSS, peer support services, case management, and short-term crisis stabilization. These include helping individuals to identify their housing needs and preferences; completing housing applications; obtaining benefits and entitlements (e.g. Medicaid, Social Security, food stamps, utility assistance); teaching skills required for successful tenancy; arranging to move; accessing and health care practitioners; training in illness self-management, relapse prevention skills, and coping; training in tenant rights and responsibilities; teaching social skills to interact with neighbors, landlords, and the community; daily living and household management skill development; and helping to access community resources.

While it is possible to provide current services in individuals' homes and other community settings, for now service delivery is primarily facility-based. Stakeholders frequently expressed concerns that most individuals with serious behavioral health issues require on-site supervision for safety and success. Concern for these individuals' safety, behaviors that jeopardize relationships with landlords, and community complaints were frequently cited as reasons why many people with serious behavioral health conditions need to live in structured and supervised settings. These are common concerns expressed by providers as systems shift service delivery to home- and community-based settings from clinic-or facility-based settings. However, it is well documented that with access to an array of flexible and responsive wraparound supportive services, most individuals with serious behavioral health conditions can live successfully in the community in less restrictive or supervised settings.

DBH can address these concerns and increase individualized housing-based services by continuing to review and refine existing service definitions and by designing new services as part of any Medicaid State Plan Amendment to include tenancy support. Service design should include a flexible, individualized approach, and emphasize home- and community-based settings as preferred service delivery locations. The service authorization process should be responsive, allowing for more units during times of need. As part of the Medicaid reform and expansion efforts, current rates and payment structures should be reviewed and revised to provide incentives and to accurately reflect the cost of delivering home-based services to individuals living in remote and widespread geographic areas.

6b. Increase the use of evidence-based best practices that lead to the attainment of valued life roles including tenant, worker, community member, and family/friend/partner.

Since 2006, DBH has placed a stronger emphasis on funding projects that can demonstrate an evidence base, and has included for consideration approaches that are emerging as promising and value-based practices. This approach to funding ensures that public funds are used most effectively and efficiently. TAC recommends extending this requirement to all publicly funded services and programs.

Evidence-based and promising practices most often provided to individuals living in PSH settings include ACT, Motivational Enhancement, Illness Management and Recovery, Supported Employment, Psychiatric Rehabilitation (particularly the model commonly referred to as "Choose-Get-Keep"), formal skills teaching, cognitive-behavioral and behavior management

techniques, and harm reduction strategies. A Housing First approach to eligibility and admissions criteria is also applied to reduce barriers to accessing and keeping housing. A Housing First approach can be implemented on a specific program basis (such as Karluk House), or as an overarching approach to available housing programs where no expectations for sobriety or treatment participation are included as eligibility criteria.

6c. Increase the availability of community-based crisis services.

One concern frequently expressed by focus group participants was that many individuals cannot live in more independent housing because problematic behaviors (symptoms of psychiatric illness and substance use disorders were most commonly cited) jeopardize housing, damage relationships with landlords, and generate community complaints. Providers described police involvement as a common intervention when an individual is experiencing difficulty in the community. As more individuals live in integrated housing in their communities, systems require adequate and responsive community-based crisis services. Systems expanding PSH also seek to expand programs such as mobile crisis services and crisis diversion or respite beds.

DBH provides crisis services as an integral part of its system. Careline is Alaska's suicide prevention and crisis intervention hotline. Short-term crisis stabilization services can be provided in a facility designated for crisis respite or in a person's residence. DBH should ensure that at least one member of each ACT and ICM team, and all providers who deliver home-based CCSS, are able to provide this service. These teams should have agreements with the CBHS provider to deliver this service as needed when qualified team members are not available. If qualified, each resident in a supportive housing setting should have as part of their individual service plan a crisis prevention and intervention plan that identifies known triggers, proven and desired responses, and actions that will ensure safety and preserve housing while the crisis is being resolved.

A number of states have expanded peer services to support individuals living in the community and intervene during times of distress. Service models include warm lines for people to call when feeling anxious, lonely, or distressed as a preventive approach to intervene before the situation escalates. Additionally, peer-run drop-in centers available evenings and weekends offer support and a place for individuals to go to socialize and combat feelings of loneliness or boredom, common triggers for anxiety and depression.

6d. Develop a community-based residential crisis stabilization and behavior training program.

DHSS has established a Complex Behaviors Collaborative to provide expert consultation to providers serving individuals with challenging behaviors, identify gaps in services, and make recommendations. This group has identified the need for a short-term crisis stabilization program (up to 30 days) to treat and stabilize challenging behaviors in a contained environment that can implement consistently applied behavior management interventions. This type of resource could be a valuable addition to the service system.

To ensure appropriate use and flow through such a program, eligibility and discharge criteria should be clearly established, including a place to return to after stabilization. Otherwise, this program could become a longer-than-desired placement for individuals who are challenging to house in the community post-discharge. Transition planning, training, and consultation should be provided to community providers to ensure continuity of approach for sustained results.

6e. Improve provider performance in supporting individuals to achieve housing stability and community integration.

DHSS should identify housing-related outcomes to track and incorporate as part of provider data collection and reporting requirements to direct the shift to a home- and community-based approach to service delivery. Provider agreements and contracts can be restructured to include identified outcomes and performance measures, with payment and contract renewal tied to performance. To establish outcomes, DBH should appoint a time-limited workgroup to identify possible outcomes for DHSS to consider and approve. These might include housing tenure, time from housing application to lease up, and the addition of a housing goal as a required component of individual service plans that include housing preferences. The workgroup should include providers, service recipients, families, and other key stakeholders.

6f. Adapt home- and community-based services and delivery of services to meet the needs of individuals living in rural and remote Hub and village communities.

Individuals who need PSH and live in hub and village communities or remote and frontier areas pose a unique challenge. Housing is extremely limited. AHFC does not have offices or programs in certain areas. Housing options in some areas may meet a need for shelter yet not meet HUD's standards for quality, such as cabins and other structures that do not have indoor plumbing, and as such, making them ineligible for certain federal assistance.

Hub villages and their surrounding areas have access to Comprehensive Community Behavioral Health Centers and an array of Medicaid behavioral health services compatible with PSH (CCSS, peer support, etc.) However, these centers may not have adequate staffing or financial resources to provide home-based services at the needed frequency or intensity. DBH should explore partnering with the Behavioral Health Aide (BHA) program operated by the ANTHC. Any PSH training developed can be made available to the BHA program and this model can be examined to see how it might be adapted to individuals living in PSH settings.

GOAL SEVEN

Strengthen community provider workforce capacity to deliver home- and community-based housing services that promote wellness, recovery, and community integration.

Home-based tenancy support services require a unique knowledge base and set of skills. Staff must be experienced with housing systems and with providing services and interventions that help individuals to be good tenants, neighbors, and community members. Understanding the complexities of subsidized and affordable housing eligibility as well as application and recertification processes is essential to support individuals in accessing and keeping housing. Service activities and interventions must result in improved competence specific to the roles of tenant and member of the community where the individual resides. Services are delivered in a person's home, requiring sensitivity and awareness of environmental factors that may contribute to behavior or safety concerns. While home- and community-based services are becoming the foundation of most human and social service systems, how to provide services in these settings has yet to become embedded in academic training and education. This leaves the responsibility for workforce training and development to the behavioral health system.

Two action steps can help DBH strengthen its workforce capacity to deliver home-based tenancy support services.

7a. Develop a PSH certification requirement for providers receiving state, federal, or Trust funds to deliver services in PRA, Moving Home, HUD CoC programs, and settings receiving GRA funds.

Certification:
To ensure that staff who support individuals in PSH settings are knowledgeable about the different housing programs and requirements and the housing-related needs of PSH tenants, DBH should develop and implement a certification process. All staff delivering services to individuals in PSH settings would be required to participate in a half- to full-day PSH overview training. This would provide an introduction to the model, an explanation of the requirements of the relevant housing programs (eligibility, recertification process, etc.), a review of common tenancy support services provided to individuals, and a description of provider roles and responsibilities pertaining to housing.

Louisiana has implemented such a process. Its state PSH program office is housed within the Department of Health and Hospitals (DHH), Office of Aging and Adult Services. The PSH program is operated in partnership with the Louisiana Housing Authority, a subsidiary of the Louisiana Housing Corporation. Service providers delivering certain Medicaid 1915i and waiver services to individuals in PSH units are first credentialed as Medicaid providers, and then certified by DHH to deliver these services to individuals in a PSH unit. Providers delivering services to Medicaid-ineligible individuals must also become certified by the DHH. Only providers who are delivering services to individuals in the state PSH program are required to become certified. DHH provides a five-hour PSH 101 training on a quarterly basis, and providers are required to send all new staff to this training. This requirement assures the Louisiana Housing Corporation that providers understand what is expected of them in terms of supporting someone in a PSH unit, and DHH is assured that providers understand the supportive services needs of PSH tenants.

PSH Curriculum and Training:
Beyond the basic certification described above, DBH should convene a time-limited PSH workforce committee charged with the guiding the development of a PSH training curriculum. Development of the curriculum and actual training could be provided by a contractor and procured competitively. The training should incorporate various mediums to allow access across the state, including virtual, distance, and in-person training options. Implementation of a training curriculum can take place in stages, beginning with the ACT and ICM teams and service providers supporting individuals accessing the new HUD 811 units. A basic core curriculum should then be offered regularly to meet the needs of an ever-changing workforce.

Many staff providing behavioral health services have academic backgrounds or general training in mental illness and substance use disorders. This often includes training in signs and symptoms, common treatment approaches, and crisis intervention strategies. With the advent of evidence-based practices, many staff may also have received training in topics such as motivational interviewing, cultural competence, and trauma-informed care. However, very few service providers receive specific training in how to deliver services in a way that promotes housing stability. Such training should include both how to help an individual to access and keep housing, but also how to interact and intervene with landlords as vital partners in supportive housing.

As DBH expands supportive housing opportunities and shifts service delivery to home and community settings, staff need to gain knowledge and skills specific to helping individuals successfully accomplish tasks and responsibilities related to pre-tenancy, moving into a PSH setting, and ongoing tenancy; community integration as a civil right and federal mandate; roles, rights and responsibilities of tenancy; partnering with landlords; and the Housing First approach. SAMHSA is in the process of updating its PSH Toolkit which can also serve as a valuable resource for providers.

7b. Identify providers who excel in delivering services aligned with the principles and practices of PSH and community integration to serve as role models, system champions, and peer provider coaches to other providers.

Systems change requires champions. DBH should identify providers who currently excel in delivering services that support individuals with complex issues to live independently in the community. In addition to identifying providers, DBH should work with peer providers to identify service recipients who are successful. These individuals can best speak to what is most helpful and how they manage complex behavioral health conditions while living in the community. Service recipients with lengthy stays in the Alaska Psychiatric Institute or who have been incarcerated can best show providers and other consumers what is possible. These systems champions can be included in developing the PSH curriculum, delivering training, and providing coaching to agencies and programs on best practices and strategies in delivering services and supports to individuals living in PSH settings.

VI. Conclusion

This report presents a series of strategic recommendations for the Alaska Division of Behavioral Health and related state agencies to increase access to permanent supportive housing, an evidence-based approach to meeting the community-living needs of people with mental illness and other disabilities and of people who are homeless. The recommendations in this report were developed based on research and national best practices, an analysis of Alaska's current programs and services, and meetings and interviews with key stakeholders, including state agency staff, providers, consumers, and other interested individuals. This report presents Alaska with a strategic, action-oriented framework for improving the lives of individuals served by state agencies in a cost-efficient manner, and it will be important for DBH and its sister agencies to demonstrate the leadership needed to take action on these recommendations. Currently, too many Alaskans live in segregated settings or are homeless, have limited access to health care and employment, and place an undue financial burden on the state. If the State takes action on these recommendations, many more Alaskans will live in integrated, affordable housing and receive evidence-based services, fewer individuals will be living in segregated settings

Alaska Supportive Housing Plan Appendices

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Table of Contents

A. Alaska DHSS – Division of Behavioral Health Strategic Plan for Permanent Supportive Housing for Vulnerable Alaskans – 2015

Goal	Recommended Action Steps
Goal 1 **Develop a policy framework to guide implementation of PSH as an essential component of DBH's service system**	1a. Convene a DBH-led PSH Steering Committee to establish policies, identify priority populations, and coordinate access and services for those individuals who cross DHSS, the Department of Corrections, and Homelessness/Continuum of Care systems.
	1b. Develop and implement outcome/performance measures related to access, housing stability, tenancy, and community integration.
	1c. Create a structure and process within DBH to oversee and coordinate implementation of the PSH plan that includes timelines and accountability.
	1d. Align this plan with statewide housing planning efforts, including the Governor's Housing Summit, the Governor's Councils on the Homeless, and the Governor's Council on Disabilities and Special Education.
Goal 2 **Establish a coordinated and consistent approach to housing and housing related services across all DHSS Divisions**	2a. Convene a standing DHSS Housing Committee to coordinate policy, practice, and services related to DHSS-supported housing and residential programs.
	2b. Conduct a DHSS-wide assessment to estimate the need for PSH and other residential service options for vulnerable Alaskans served across all DHSS divisions.

	2c. Conduct an assessment of all currently enrolled GRA recipients and develop individualized housing plans based on level of care/service needs, housing needs, and preferences.
Goal 3 **Establish a PSH pipeline to create between 465 and 615 PSH opportunities over the next five years**	3a. Establish a PSH Funders Collaborative to align and leverage resources to encourage the production of permanent supportive housing.
	3b. Through the Funders Collaborative, oversee and review progress on meeting PSH production goals.
	3c. Conduct a comprehensive review of the Special Needs Housing Grant program in order to enhance and sustain its role as a significant driver of PSH production.
	3d. Adopt further enhancements to the current special needs set-aside within the Low Income Housing Tax Credit program to encourage the creation of integrated PSH.
	3e. Commit Section 8 Housing Choice Voucher rental assistance from AHFC to support the operation and development of PSH.
	3f. Leverage future federal funding opportunities through the National Housing Trust Fund and Section 811 PRA to support the creation of new PSH development.
	3g. Leverage all available resources and encourage the replication of innovative financing models to create PSH.

Goal 4 **Establish a PSH Clearinghouse to coordinate the timely referral of eligible households for PSH opportunities**	4a. Develop and implement a PSH Clearinghouse to coordinate the referral and supportive service provision of eligible households for PSH opportunities.
	4b. Coordinate design and implementation efforts with the two CoCs' work on coordinated entry.
	4c. Align the access and referral policies and procedures for the Moving Home program with the proposed PSH Clearinghouse and the CoCs' coordinated entry system.
	4d. Provide PSH property owners and managers with sustained training opportunities to build understanding of their obligation under the Federal Fair Housing Act and the Americans with Disabilities Act, with the goal of eliminating barriers to access and reducing stigma.
Goal 5 **Establish a funding source for services delivered in supportive housing settings that is sustainable and tailored to the needs of individuals**	5a. Assign responsibility to a new Medicaid task force to improve Medicaid coverage of services in supportive housing.
	5b. Improve DHSS leverage of existing Medicaid services (CCSS, Case Management, and RSS).
	5c. Engage CMS to maximize coverage of services in supportive housing.

	5d. Determine rates for services that reflect accurate costs of providing flexible home- and community-based services.
	5e. Budget state funds to pay for important supportive housing services that are not covered by Medicaid.
	5f. Work with the Trust to use funds for services in strategic and targeted ways.
	5g. Plan ahead to restructure provider agreements and contracts when additional Medicaid revenue is expected.
	5h. Continue to pursue Medicaid expansion through the ACA to provide more Alaskans with health insurance coverage and to and maximize federal financial participation.
Goal 6 **Expand service delivery in home- and community-based settings to promote housing stability and community integration**	6a. Design services to be provided in home and community settings that will promote housing stability and community integration.
	6b. Increase the use of evidence-based best practices that lead to the attainment of valued life roles including tenant, worker, community member, and family/friend/partner.
	6c. Increase the availability of community-based crisis services.

	6d. Develop a community-based residential crisis stabilization and behavior training program.
	6e. Improve provider performance in supporting individuals to achieve housing stability and community integration.
	6f. Adapt home- and community-based services and delivery of services to meet the needs of individuals living in rural and remote Hub and village communities.
Goal 7 **Strengthen community provider workforce capacity to delivery home- and community-based housing services that promote wellness, recovery, and community integration**	7a. Develop a PSH certification requirement for providers receiving state, federal, or Trust funds to deliver services in PRA, Moving Home, HUD CoC programs, and settings receiving GRA funds.
	7b. Identify providers who excel in delivering services aligned with the principles and practices of PSH and community integration to serve as role models, system champions, and peer provider coaches to other providers.

B. Interviews and Meetings with Key Informants

AGENCY	NAME
PUBLIC/TRIBAL AGENCIES	
AHFC	Carrie Collins
AHFC	Mark Romick
AHFC	Mike Courtney
AHFC	Daniel Delfino
AHFC	Cathy Stone
AVCP RHA	Ronald Hoffman
AVCP RHA	Mark Charlie
HUD	Carma Reed
Municipality of Anchorage	Erika McConnell
Municipality of Anchorage	Melinda Freemon
Municipality of Anchorage	Steve Ashman
CIHA	Patrick Lawlor
DBH	Sherrie Hinshaw
DBH	Terry Hamm
DSDS	Kelda Barsted
Developmental Disability Services (Bethel)	Jeanne Evans
PHILANTHROPY/PLANNERS	

Alaska MH Trust	Nancy Burke
Balance of State CoC	Scott Ciambor
Rasmuson Foundation	Chris Perez
United Way of Anchorage	Jane Straight
Foraker Group	Chris Kowalczewski
ANTHC	Xio Owens
Bethel Community Services Foundation	Michelle Dewitt
HOUSING DEVELOPERS/HOUSING PROVIDERS	
Development Consultant	Glenn Gellert
Rural CAP	Corinne O'Neill
VOA/Alaska	Elaine Dalgren
Valley Residential	John Weaver
KBHI	Steve Rouse
SERVICE PROVIDERS/ADVOCATES	
Alaska Legal Services Corp.	Nikole Nelson
Association of Alaska Housing Authorities	Colleen Dushkin
ALSC	Jeremy Baker
AK Council on Aging	Denise Daniello
Long Term Care Ombudsman	Theresa Holt
Tundra Women's Coalition	Eileen Arnold
Bethel Cultural Center	Eva Malvich
YKHC	Rick Robb

TAC also met with the following groups:

- Focus Group with representation from DSDS provider network as identified and invited by DSDS staff
- Focus Group with representation from assisted living home operators
- Meeting with the Complex Behavioral Solutions group
- Meeting with Patrick Reinhart and staff from the Governor's Council on Disabilities and Special Education
- Phone meeting with members of the ANTHC Behavioral Health Directors
- Presentation and phone conference with the Board of the Association of Alaska Housing Authorities
- Meeting with AVCP Housing (Bethel)
- Meetings with SH Planning Leadership Group

Tours were conducted at the following sites:

Anchorage, AK:

- Karluk House Housing First Project
- Anchor House ALH

Bethel, AK:

- Morgan House and Bautista House managed by YKHC and housing managed by the Tundra Women's Coalition.

Presentation of Alaska Housing Resources

Presented by: Technical Assistance Collaborative, Inc.

March 9, 2015

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Agenda

- Welcome and Introductions
- Background and Purpose
- Housing Inventory
  - Capital Resources
  - Operating and Rental Assistance Resources
  - Strengths and Challenges
  - Opportunities
- Housing Access Points
- Next Steps

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Welcome and Introductions

TAC's core mission focuses at the intersection of affordable housing, health care, and human services policy and systems development.

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BACKGROUND AND PURPOSE: STRATEGIC SUPPORTIVE HOUSING PLAN

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Housing Utilization and Maximization Workgroup

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Workgroup Charge

- Stakeholder workgroups will help inform recommendations to consider for inclusion in plan
- This workgroup will meet to discuss and recommend:
  - Review and comment on housing inventories and pathways
  - Identify strategies to determine unmet supportive housing needs within the state
  - Develop and recommend strategic options to meet unmet supportive housing needs for the defined target populations
  - Explore and recommend implementation of action steps and performance and housing targets

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Capital Resources

- HOME
  - FY14: $3.6 million
- CDBG
  - FY14: $4.1 million
- LIHTC
  - FY14: $2.6 million allocation
- Continuum of Care resources
  - FY14: All renewal projects were funded
  - Potential for new projects subject to annual HUD NOFAs

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Capital Resources

- AHFC
  - Operating Expense Assistance Program (OEA)
  - Greater Opportunities for Affordable Living (GOAL) program awarded funds to six projects totaling more than 180 units to be developed and upgraded
  - LIHTC projects with 20 or more units must set aside 5% of total units for a special needs population
  - Special Needs Housing Grant (SNHG) provides funding to nonprofit service providers and housing developers for construction of housing for special needs populations

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Capital Resources

- AHFC
  - Multi-Family Congregate and Special Needs Program provides financing to construct or purchase and renovate housing projects characterized as multi-family housing, senior housing, housing utilized by individuals with physical or developmental disabilities, emergency shelter, transitional housing, or congregate housing
  - From 2011-2013, 79 new projects were funded and closed under this program, including 113 supportive housing units

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Old Section 811 Program

- Prior to FY12, the program provided both capital funding and project-based rental assistance to develop new PSH for persons with disabilities
- From FY2005-2011, Alaska was awarded over $6 million to develop 26 units of supportive housing

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Today's Section 811 Program

- In January 2011, President Obama signed into law the Frank Melville Supportive Housing Investment Act
- In FY12, FY13, and FY14 appropriations, all funding for the new Section 811 units is provided solely through project-based rental assistance
- Properties must limit the total number of units with PSH to 25% or less
- Alaska recently received $7.7 million to develop 200 units of supportive housing

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Section 202

- This program expands the supply of affordable housing with supportive services for elderly persons (age 62 and over)
- Provides capital advances to finance the construction and rehab of structures and provides rental subsidies for the projects
- From FY2005-2011, Alaska received funding for 30 new units of supportive housing

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Operating and Rental Assistance Resources

- AHFC:
  - Housing Choice Voucher Program
    - 4,672 vouchers- 25% utilization rate by non-elderly disabled individuals
  - Public Housing Units
    - 1,263 units, none designated for people with disabilities
  - Non-Elderly Persons with Disabilities Vouchers
    - 45 rental subsidies
  - VASH
    - 210 vouchers
  - Tenant-based rental assistance
  - Basic Homeless Assistance Program (BHAP) awards grants aimed toward reducing homelessness through shelter, transitional housing and/or related supportive services

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Operating and Rental Assistance Resources

- Division of Behavioral Health
  - Moving Home Voucher Program, in partnership with AHFC, allows for approximately 150 rental subsidies for individuals receiving DHSS-funded services

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Operating and Rental Assistance Resources

- Anchorage & Alaska Balance of State CoCs
  - Rental assistance and leasing funding for PSH

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Provider Managed Housing

- PSH for individuals- approximately 300 units (CoC inventory)
- Neighborworks Anchorage- 1,038 units
- Fairbanks Neighborhood Housing Services- 38 units
- Rural Alaska Community Action Program- 128 units
- Valley Residential Services- 178 units

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STRENGTHS

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CHALLENGES

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OPPORTUNITIES

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Supportive Housing Eligibility and Allocation Workgroup

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Workgroup Charge

- Stakeholder workgroups will help inform recommendations for inclusion in plan
- This workgroup will discuss and recommend:
  - Processes and standardized level of care assessment tools for assessing housing and service needs
  - Factors to consider in establishing person-centered eligibility criteria for supportive housing that builds upon a standardized level of care assessment
  - Criteria for establishing an equitable allocation methodology for prioritizing access to supportive housing for eligible individuals

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Best Practice- Permanent Supportive Housing

- PSH is an evidence-based, cost effective model that combines permanent, affordable rental housing with voluntary, flexible and individualized services to maximize independent living
- SAMHSA's PSH Evidence-Based Practice Toolkit defines key elements of the model:
  - Integrated, community-based permanent housing that is safe and secure
  - Housing that is affordable with tenants paying no more than 30% of their income towards rent and utilities
  - Leases that are consistent with local landlord-tenant laws and held by tenants without limits on length of stay as long as the tenant complies with lease requirements
  - Individually tailored and flexible supportive services that are voluntary, accessible to where the tenant lives, available 24 hours a day/7 days a week and are not a condition of ongoing tenancy
  - Ongoing collaboration between service providers, property managers & tenants to preserve tenancy and resolve crisis situations that may arise

Populations of Focus

- Homeless consumers with a serious mental illness
- Consumers who are moving to a less restrictive environment
- Extremely low-income disabled households with at least one person in the household, between the ages of 18 and 62, who is eligible for community-based services as provided through Medicaid or grant-funded services

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Coordinated Entry

- According to FY13 CoC application to HUD:
  - Anchorage CoC is currently operating a coordinated entry system
    - How does coordinated entry factor into housing access in your system?
  - Alaska Balance of State CoC was not operating a coordinated entry system
    - What are updates or next steps for design and implementation?

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Housing Access Points: Division of Behavioral Health

- To be eligible for Moving Home program, a person must meet the following three criteria:
  - Meet the U.S. Department of Housing and Urban Development's definition of a disabled family (24 CFR 5.403) or be an Alaska Mental Health Trust Authority beneficiary; AND
  - Demonstrate qualification as low-income, defined as less than 50 percent of Area Median Income; AND
  - Be eligible for community-based, long-term services as provided through Medicaid waivers, Medicaid state plan options, state funded services, or other appropriate services related to the target population {i.e. Division of Behavioral Health (DBH) funded Community Behavioral Health Services Provider, or Senior and Disabilities Services (SDS) funded provider}.

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Housing Access Points: Division of Behavioral Health

- Moving Home Program eligible populations have been placed into two tiers for prioritization of vouchers:
- Tier 1 - A person who:
  - Scores 10 or higher on the Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT); AND
  - Is currently homeless, has had one or more episodes of homelessness in the past year, or is at imminent risk of homelessness.
- Tier 2 - A person who:
  - Has a need for housing due to transitioning from an institutional setting (e.g., DOC, RPTC, nursing home or other long-term care facility, out-of-state placement); or
  - Has been living in an unnecessarily restricted and segregated environment; AND
  - Has been identified as needing level three (high intensity community based services) or level four (medically monitored non-residential services) level of care through the LOCUS assessment tool.

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Housing Access Points: Section 811

- Outreach and referral will be conducted primarily through community-based service providers who are grantees of the State of Alaska, Division of Behavioral Health, and Senior and Disabilities Services
- Community-based service providers and Community Mental Health Centers serving the target population will be notified regarding program availability

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Housing Access Points: Section 811

- Two priority populations identified:
  - Tier 1: Individuals that meet the HUD 811 program criteria who are currently in Assisted Living Homes, on state General Relief and supported by state general funds, and are appropriate candidates for independent supportive housing
  - Tier 2: Individuals that meet the HUD 811 program criteria who are re-entering the community from institutional care
  - Tier 2 would only be utilized if an insufficient number of potential participants will be identified from Tier 1

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Housing Access Points: CoC Program

- To be eligible for assistance in the CoC Program, an individual or family must be homeless and meet any additional eligibility criteria set by annual HUD NOFAs
  - CoC Program-funded PSH can only be provided to individuals with disabilities and families in which one adult OR child has a disability

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Housing Access Points: AHFC's Tenant-Based Rental Assistance

- The TBRA Program is a referral-based, transitional, rental assistance program for eligible low-income families.
- Families must be referred from the State of Alaska Department of Corrections or the State of Alaska Department of Health and Human Services Office of Children's Services.

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Housing Access Points: Provider Operated/Managed Housing

- Consumers may access housing resources that local providers operate and manage access to
- Providers may offer a range of options of housing

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STRENGTHS

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CHALLENGES

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OPPORTUNITIES

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DBH Strategic Supportive Housing Plan
Service Needs & Realignment Workgroup

Kevin Martone & Patti Holland
Technical Assistance Collaborative, Inc.
March 10, 2015

Background and Purpose

DBH is committed to development of a Strategic Supportive Housing Plan to provide increased supportive housing opportunities for consumers & to identify the best use of available resources to achieve this goal.

Workgroup Charge

- Stakeholder workgroups will help inform recommendations for DBH to consider for inclusion in the Plan.
- This Workgroup will meet 2-3 times to:
  - Evaluate services provided in the housing and residential continuum & identify duplication, gaps or the need for modifications to services to meet the needs of consumers to be served in residential programs & supported housing.
  - Suggest feasible mechanisms for linking person-driven, wraparound community services & supports for people before, during & after tenancy in supported housing.
  - Make recommendations regarding best practice housing models, rebalancing & reallocation of resources & considerations for transitioning to supported housing.
  - Make recommendations regarding provider accountability & desired outcomes to ensure individuals are receiving high quality, person-centered & recovery-oriented services to facilitate community integration and independence.
  - Suggest strategies to incorporate Peer Specialists into the delivery of services within DBH housing support services.

Evidence Based Practice: Permanent Supportive Housing

- PSH is an evidence-based, cost effective model that combines permanent affordable rental housing with voluntary, flexible & individualized services to maximize independent living.
- SAMHSA's PSH Evidence-Based Practice Toolkit defines key elements of the model:
  - Integrated, community-based permanent housing that that is safe & secure;
  - Housing that is affordable with tenants paying no more than 30% of their income toward rent & utilities;
  - Leases that are consistent with local landlord-tenant law & held by the tenants without limits on length of stay as long as the tenant complies with lease requirements;
  - Individually tailored & flexible supportive services that are voluntary, accessible where the tenant lives, available 24 hours a day/7 days a week & are not a condition of ongoing tenancy; and
  - Ongoing collaboration between service providers, property managers & tenants to preserve tenancy & resolve crisis situations that may arise.

The Mandate for Community Integration

- In the landmark *Olmstead v. L.C.* decision (1999), the U.S. Supreme Court held that states have an affirmative obligation to ensure that individuals with disabilities live in the least restrictive, most integrated settings possible.

- The regulations implementing Title II define an integrated setting as one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible."

  - 28 C.F.R. § 35.130(d)
  - 28 C.F.R. § Pt. 35, App. A (2010) (addressing § 35.130)

Community Integration Defined

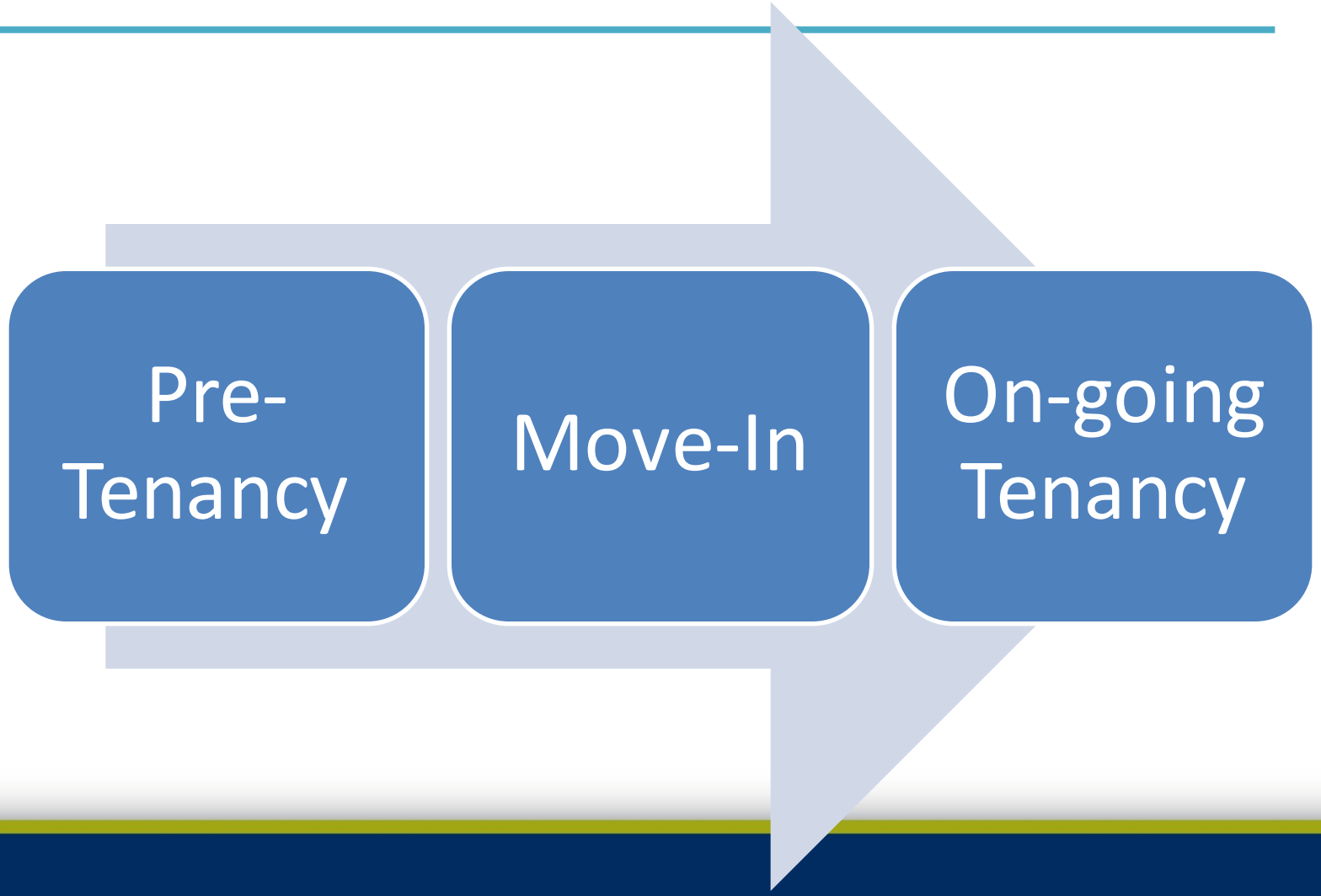
- Integrated settings are located in mainstream society;
- Offer access to community activities and opportunities at times, frequencies and with persons of an individual's choosing;
- Afford individuals choice in their daily life activities; and
- Provide individuals with disabilities the opportunity to interact with non-disabled persons to the fullest extent possible.
- Evidence-based practices that provide scattered-site housing with supportive services are examples of integrated settings.

Community Integration Defined

- By contrast, segregated settings often have qualities of an institutional nature. Segregated settings include, but are not limited to:
  1. congregate settings populated exclusively or primarily with individuals with disabilities;
  2. congregate settings characterized by regimentation in daily activities, lack of privacy or autonomy, policies limiting visitors, or limits on individuals' ability to engage freely in community activities and to manage their own activities of daily living; or
  3. settings that provide for daytime activities primarily with other individuals with disabilities.

SERVICES & ACTIVITIES THAT PROMOTE SUCCESSFUL TENANCY

Phases of PSH



Pre-Tenancy Services

- Engagement, relationship building with emphasis on housing support needs and preferences.

- Begins with assessment of housing and service needs and ends when housing unit is selected and ready for move in.

Key Tasks Of Pre-tenancy

- ✓ Developing rapport and partnership
- ✓ Understanding/assisting with PSH housing subsidy/ voucher and service program eligibility as needed
- ✓ Understanding the role and responsibilities of being a tenant
- ✓ Developing the initial Housing Plan

Key Tasks of Pre-Tenancy

- ✓ Assessing strengths, preferences, housing and tenant barriers
- ✓ Planning for support and service needs
- ✓ Conducting housing ‘search’ and selecting a unit
- ✓ Completing housing applications and awaiting approval

Common Challenges Pre-Tenancy

- Difficulty in locating or staying engaged with the individual
- Lack of essential documentation needed for housing application
- Trouble selecting a unit or does not want unit that is available

Move-in Phase

- Develop Move-in objective on the Housing Plan and update Assessment to address key tasks of this phase

- Develop Crisis Prevention and Intervention Plan for initial adjustment time period (to be updated once the individual has settled in).

Move-in Phase

- Many details to be arranged and attended to:
  - Making sure the individual has funds for security deposits, utilities turned on, furniture and household set up
  - Arranging for, or assisting with the actual move
  - Assisting the person to pack and unpack belongings
  - Lease signing
  - Supporting the person through the move and initial adjustment
  - Anticipating need for increased support

Key Tasks of Move-in Phase

- ✓ Arranging and/or assisting with actual move into the PSH unit
- ✓ Assisting with packing and unpacking belongings
- ✓ Orienting to new neighborhood
- ✓ Providing increased support during move and initial adjustment period
- ✓ Develop initial Crisis Prevention and Intervention Plan

Common Challenges
Move-In

- Last minute glitches with move in
- Disengagement

On-Going Tenancy

- Fostering community integration & inclusion
  - community participation, good neighbor, citizenship
- Developing natural support networks
  - Building friendships, peer support, reduced reliance on staff for social needs

On-Going Tenancy

- Providing services in a flexible manner that responds to the individual's changing needs
  - Adjusting frequency and intensity of services
  - Avoiding 'drive by' case management
- Moving from housing stabilization to thriving in the community
  - Employment, education, and meaningful activity
  - Personal enrichment goals

Key Tasks of On-Going Tenancy

- ✓ Accessing social and recreational opportunities
- ✓ Pursuing employment or education goals
- ✓ Engagement with existing and/or creating new support networks
- ✓ Intervening early in housing and landlord issues

Key Tasks of On-Going Tenancy

- ✓ Updating assessment and service and crisis support plans to reflect current needs and interests
- ✓ Skill building to promote competence and self sufficiency in managing apartment
- ✓ Service linkage and coordination
- ✓ Assistance with treatment for health and behavioral health conditions

Common Challenges
On-Going Tenancy

- Buyer's remorse
- Housing is jeopardized
- "Failure to thrive"

Life After PSH

- For many, PSH is not the “end of the road”
- Services must emphasize education, employment and other goals that increase income.

Funding Sources For Services

- Medicaid Behavioral Health Services
- Grant funded services
- HUD funded services
- Other?

Review Of Current Services

Strengths - Challenges - Opportunities

- Home & Community Based vs. Facility Based?
- Emphasis on housing & tenancy?
- Facilitating individual choice in preferred housing?
- Funding sources?

Contact Us

Technical Assistance Collaborative, Inc. – TAC

@TACIncBoston

Visit us on the web:
www.tacinc.org

Alaska DBH Strategic Supportive Housing Plan
Workforce & Training Workgroup

Kevin Martone & Patti Holland
Technical Assistance Collaborative, Inc.
March 10, 2015

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Workgroup Charge

- Stakeholder workgroups will help inform recommendations for DBH to consider for inclusion in the Strategic Supportive Housing Plan (SSHP).
- This Workgroup will meet 2-3 times to:
  - Evaluate workforce issues related to supportive housing and residential services that should be addressed in the SSHP;
  - The redevelopment and redeployment of existing residential program staff by developing competencies necessary in supportive housing;
  - The training of new staff in skills associated with the successful delivery of supportive housing services;
  - Suggest strategies to enhance/expand utilization of Peer Specialists in supportive housing settings; and

REVIEW OF PHASES OF PSH AND KEY SERVICE NEEDS AND TASKS

Review Of Current Workforce & Training Needs

- Strengths
- Challenges
- Opportunties

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SUPPORTIVE HOUSING THE BUSINESS CASE AND THE PROMISE OF COMMUNITY INTEGRATION

Kevin Martone & Patti Holland
Technical Assistance Collaborative, Inc.
March 11, 2015

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THE BUSINESS CASE

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Permanent Supportive Housing

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  - Individually tailored & flexible supportive services that are voluntary, accessible where the tenant lives, available 24 hours a day/7 days a week & are not a condition of ongoing tenancy; and
  - Ongoing collaboration between service providers, property managers & tenants to preserve tenancy & resolve crisis situations that may arise.

The Evidence and Outcomes

- Seminal Study: Pathways to Housing, NYC
  - Evidence in support of: SH, Housing First approach and ACT or ACT like services
  - 5,000 literally homeless individuals (living on street or in shelter), SMI w/wo co-occurring SA

Healthcare Outcomes

- Improved health status
- Better mental health outcomes
- Reduced substance use
- Higher survival rates for individuals living with HIV/AIDS

Impact on Healthcare Utilization and Costs

- When SH is linked with care management:
  - Reduction in ED use
    - Chicago Housing for Health Partnership
    - 200 homeless individuals used 24% less ED services than randomized control group over 18 months.
  - Decreases in inpatient admissions and hospital days
    - California Frequent User Initiative reported a 27% reduction in hospital admissions and inpatient days
    - Chicago Housing for Health Partnership reported 29% fewer hospital admissions and hospital days.
  - Reductions in detox utilization and psychiatric inpatient admissions
    - Seattle East Lake project: 87% decrease in use of detox services
    - Maine: 38% reduction in psychiatric admissions

Reductions in Medicaid Costs

- Massachusetts
  - Decreases in acute care utilization translated into a 67% decrease in average Medicaid costs ($26,124 to $8,499).
- Seattle
  - Reported 42% lower Medicaid cost for residents after one year of SH.

Medicaid As A More Sustainable Funding Source For Services

- Services to tenants often funded through a patchwork quilt of state or local resources, federal block grants, philanthropic grants, special appropriations, agency fundraising, etc.
- Crosswalk analysis of tenancy support services eligible for Medicaid.
- Use non-Medicaid dollars to cover those services clearly not eligible for Medicaid, or for those individuals not eligible for Medicaid.

Opportunities For Integrating Medicaid & Supportive Housing

- The Health Home State Plan Option
  - Established under the ACA
  - Medicaid enrollees with at least two chronic conditions (can include SA), one condition and risk of developing another, or at least one SMI condition.
  - Provides states with 90% federal match for eight quarters
  - E.g. NYS' Chronic Illness Demonstration Project found addressing housing issues integral to meeting health care needs. Now requires all Health Home providers to have direct partnerships with housing agencies.

Opportunities For Integrating Medicaid & Supportive Housing

- Home and Community Based State Plan Options [1915(i)].
  - Allows option to offer HCBS to individuals who do not meet the institutional level of care eligibility criteria required in 1915 (c) HCBS waiver.
  - Not subject to budget neutrality requirements provides mechanism to extend HCBS to people with SMI and SA who generally would not meet these requirements.
  - States set functional criterial for eligibility.
  - Gives states ability to target specific populations and provide various services to different populations.

Opportunities For Integrating Medicaid & Supportive Housing

- Medicaid Rehabilitation and Targeted Case Management Service
  - Need to consider current Plan and how SH strategies can be integrated into it.
- Working with Medicaid MCO
  - Provide care management to high risk, high user populations.

Why develop a Strategic Supportive Housing Plan?

- Communicate PSH as a policy priority
- Use as a system change document; signal change
- Actively solicit stakeholder feedback
- Consensus building for stakeholders, state agencies and staff, housing community
- Establish an actionable work plan
- Guides budget development
- Basis for Olmstead Plan

THE PROMISE OF COMMUNITY INTEGRATION

...and The ABC's of Olmstead Planning

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The Mandate for Community Integration

- In the landmark *Olmstead v. L.C.* decision (1999), the U.S. Supreme Court held that states have an affirmative obligation to ensure that individuals with disabilities live in the least restrictive, most integrated settings possible.

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U.S. Department of Justice. *Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C.*

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Implementing Olmstead

- In its decision, the Supreme Court stated that if a state had a, "….**comprehensive, effectively working plan** for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the state's endeavors to keep its institutions fully populated, the reasonable modification standard [of the ADA] would be met."

- For an *Olmstead* Plan to serve as a reasonable defense against legal action it must include, "…concrete and reliable commitments to expand integrated opportunities….and there must be funding to support the plan."

Approaches to Community Integration and Olmstead

- Proactive planning and implementation
- Reactive planning and implementation
- Planning with some implementation activity
- Litigation/Settlement Agreements
- No Planning

Critical Areas for System Planning and Implementation

- Role and Focus of Leadership
- Key Relationships To Establish
- Inter-departmental Collaboration and Partnerships
- Assessing Strengths and Risks

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Opportunities

- Build off of existing strengths.
- How does the current system already support the mandate for community integration?
- What Key Relationships Already Exist?
- Cross Agency Collaborations?
- How can Consumers help?
- How can resources be maximized or reallocated?

Partnerships

- Medicaid/Managed Care
- SMHA/SSA
- Employment/Labor
- Transportation
- Welfare
- Housing
- Primary care/Health
- Dental
- Consumers and Families
- Public Health
- Tribal Council
- Federal, state, county, local,
- Executive, Judicial, Legislative branches
- Academia
- Corrections/Criminal Justice
- Protection & Advocacy
- Regions

Potential Roles

- Stakeholders
- Consumer Leadership & Advocacy Groups
- Mental Health Trust Authority
- Mental Health Board
- Legislative involvement
- Activities: Data reviews, program model reviews and development; regulation reviews

Boundaries

- State responsibility
- Stakeholder roles
- Providers
- Involve Subject Matter Experts
- Managing expectations

The Box, the Mirror, and the Broken Record

Key Olmstead Plan Ingredients

- Populations
- Data
- Housing
- Employment
- Wellness and Integrated Healthcare
- Transportation
- Supports and Services
- Funding
- Policies, Rules and Regulations
- Outcomes
- Training and Workforce Development, including use of Peer workforce

Population Focus

- Behavioral Health
- Intellectual and Development Disabilities
- Physical Disabilities
- Traumatic Brain Injury
- Co-occurring or multi-occurring disorders
- Age Groups? (e.g. Child/Adolescents; Adults; Older Adults)

Perspective

- Institutional

  - State hospital
  - Nursing Facility
  - Board and Care (aka Assisted Living, Adult Homes, Residential Care Facilities)
  - Incarceration

- At-Risk of Institutionalization

  - Homelessness
  - At home with aging parents
  - Other substandard living conditions
  - Cuts in services

Discussion

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What does your data tell you?

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Where are people served?

- How many are hospitalized?
- Incarcerated?
- Homeless?
- Board and Care?
- Emergency room data?
- Contacts with crisis system?
- Access to community services? (ACT, PSH, Supported Employment)
- Is the level of services enough?

Outcomes

- What outcomes are being tracked?
- Are they the right outcomes to measure?
- How well is the system performing in the area of community integration?
- Benchmarks?

Assessing Risk - Inpatient

- Role of Inpatient (perceived/actual)
- Use of inpatient
- # of people hospitalized who do not meet civil commitment criteria
- # of people hospitalized due to lack of community options
- Emergency Department boarding
- Quality of discharge planning

Assessing Risk - Residential

- Role of Residential; System beliefs
- Where do people live?
  - congregate group homes
  - nursing homes
  - board and care facilities
  - homeless
- Size of residential environments
- Restrictions in group homes

Assessing Risk - Access

- Are community-based services accessible?
  - Type, frequency, intensity, flexibly delivered
- Is there a wait to see a psychiatrist or clinician, or to get into a program?
- Is criteria to access programs too stringent?
- Is length of stay, level of support too lean?

Assessing Risk – Resource Allocation

- % of funds for inpatient vs community services
- % of funds for congregate living vs independent living (housing + services)
- % of funds for facility based day programming vs ACT, Community Supports
- $ spent on housing in congregate settings

Discussion

Funding

- How to shift toward priorities
- Reallocation and Reinvestment
- Medicaid
- Housing (new 811 award is an opportunity)
- Maximizing state and federal resources
- State funds
- ACA Impact
- Best practices
- Examples from States

Policies and Regulations

- Help push change.
- Important to identify changes needed to existing;
- Important to identify new policies and regulations that are needed.
- May address how the system approaches:
  - Wellness and Recovery
  - Hospitals
  - Housing approaches (e.g. Housing First, PSH)
  - Employment

Quality/Outcomes/Evaluation

- The Strategic SH Plan, or Olmstead Plan should include an approach to identify and measure outcomes, and drive change based on performance and results.
- What are the issues in your system?
- What outcomes should you track?
- Where are people?
- Why do certain things occur in the system?

Training and Workforce Development

- Is there enough workforce?
  - Are certain types of new staff/clinicians needed?

- New skills must be taught.
  - Recovery orientation
  - Emphasis on competency &skill development
  - Housing Focused
  - Person Centered Planning
  - Knowledge and best practices/models that support community inclusion and integration

Discussion

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State Experiences

- Community Integration/Olmstead takes resources, new and/or re-allocated
- Leadership
- Working with Governor's office, Budget offices and other State agencies, legislature.
- Prepare Staff
- Prepare Stakeholders
- Anticipate and manage resistance
- Talking about it is not a good defense, nor is a plan that sits on a shelf.
- Permanent Supportive Housing, ACT and Crisis services are core components of plans and Settlement Agreements

Cautions

- Just because it's in the community doesn't mean it's integrated;
- "Choice" may have different meanings;
- A plan to plan is not a plan;
- Budget cuts and bureaucracy do not trump civil rights;
- Beliefs and opinions regarding whether a person is ready for more independent living or what an integrated setting is may conflict with what the Courts decide

Takeaways

- An Olmstead Plan is a system change document.
- Be comprehensive, but realistic. A plan should be actionable and achievable.
- Have short and long term goals.

Takeaways

- Better to have a short, actionable plan than a ZZZ page document that just states the issues and reasons why progress can't be made.
- The Plan should be developed with stakeholder involvement.
- Track and report on progress.

Discussion

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Litigation

Key Olmstead Litigation - Georgia

- Target population: 9,000 individuals with SPMI who are currently being served in the State Hospitals, who are frequently readmitted to the State Hospitals, who are frequently seen in Emergency Rooms, who are chronically homeless, and/or who are being released from jails or prisons.
- Also includes Developmentally Disabled.
- 2010 – 2015
- Significant expansion of community services.
- Specific limitations on # and size of residential options.

Georgia

- "Supported Housing includes scattered-site housing as well as apartments clustered in a single building. By July 1, 2015, 50% of Supported Housing units shall be provided in scattered-site housing, which requires that no more than 20% of the units in one building, or no more than two units in one building (whichever is greater), may be used to provide Supported Housing under this agreement.

- "It is the intent of the parties that approximately 60% of persons in the target population receiving scatter-site Supported Housing will reside in a two-bedroom apartment, and that approximately 40% of persons in the target population receiving scattered-site Supported Housing will reside in a one-bedroom apartment."

*Excerpted from Georgia DOJ Settlement Agreement

Key Olmstead Litigation - Illinois

- 3 cases (Colbert, Williams, Ligas)
- Colbert – Nursing Home residents who can move to more integrated settings
- Williams – Individuals with mental illness in large IMDs
- Ligas – Developmentally Disabled in ICF-DD's of nine or more, or who are at risk of going into these settings

Key Olmstead Litigation – New Jersey

- Target Population: Individuals with mental illness in state psychiatric hospitals who no longer meet commitment criteria and are awaiting community placement.
- Filed by Protection & Advocacy group
- Serve 1,065 being discharged from state hospitals or who are at risk of hospitalization
- 2010 -2014

Key Olmstead Litigation – Delaware

- DOJ CRIPA investigation into state psychiatric hospital; led to investigation of community system; Settlement Agreement
- Target population is individuals with serious mental illness who are at the highest risk of unnecessary institutionalization
- Significant expansion of community services, housing and other supports
- 2011-2016

Delaware

- "All new housing created under this agreement will be scattered site supported housing, with no more than 20% of the units in any building to be occupied by individuals with a disability known to the State."

- "All new housing created under this agreement will have no more than two people in a given apartment, with a private bedroom for each person. If two people are living together in an apartment, the individuals must be able to select their own roommates."

*Excerpted from Delaware DOJ Settlement Agreement

Key Olmstead Litigation – North Carolina

- DOJ investigation of Adult Care Homes; Settlement Agreement
- Target population: SPMI/SMI
- 3,000 housing slots between 2012-2020 to move people into more integrated settings
- Expansion of community services
- Loss of Medicaid revenue (IMD issue).

North Carolina

Housing Slots created pursuant to Settlement:

- are permanent housing with Tenancy Rights;
- are scattered site housing, where no more than 20% of the units in any development are occupied by individuals with a disability known to the State, except as set forth below:

  - Up to 250 Housing Slots may be in disability-neutral developments, that have up to 16 units, where more than 20%of the units are occupied by individuals with a disability known to the State
- the priority is for single-occupancy housing

* Excerpted from NC DOJ Settlement Agreement

Key Olmstead Litigation – New York

- Litigation filed by P&A group; USDOJ became a party later.
- Target Population: Thousands (4,000) of individuals with mental illness living in Adult Homes in NYC.
- Settled July 2013.

Key Olmstead Litigation – Connecticut

- Litigation filed by P&A.
- Target Population: Individuals with mental illness living in Nursing Homes who can live in more integrated settings.
- In final settlement discussions.

New Hampshire

- 2014 Settlement – June 2017
- Persons with serious mental illness
- Crisis (i.e. mobile response, crisis apts)
- Assertive Community Treatment
- Supported Housing (i.e. scatter-site; 10%) and Community Residences (i.e. up to 4 people). 600+ people
- Waiting List
- Supported Employment
- Peer and Family Supports

Oregon

- Voluntary Compliance Agreement
- Outcomes based
- Linked with overall health system transformation

Alaska Division of Behavioral Health
Strategic Supportive Housing Plan

Presented by:
Sherrie Hinshaw, DBH Office of Integrated Housing
Jim Yates & Patti Holland, TAC, Inc.
May 20, 2015

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Background

- DMH is committed to providing increased integrated, supportive housing opportunities for consumers & to identify the best use of available resources to achieve this goal.
- The Mental Health Trust, in partnership with DBH contracted with the Technical Assistance Collaborative (TAC) to develop a Strategic Supportive Housing Plan.
  - TAC is a national, non-profit firm that provides consultation and technical assistance on behavioral health and affordable housing policy, system design and implementation, Medicaid and other financing strategies.

Strategic Supportive Housing Plan

- Three year plan that includes specific actionable steps for DBH and its' partners to implement.
- Stakeholder involvement
  - Four focus groups:
    - Housing resources and maximization
    - Housing eligibility
    - Services
    - Workforce Development
  - Key informant interviews
  - Meeting with DHH leadership
  - Assessment of current housing and service systems

Scope of Work

- Conduct a review of existing affordable housing resources and program in Alaska through federal, state or other funding mechanisms.
- Assess how housing and services resources are arranged and leveraged, and how leveraging might be improved.
- Provide consultation on evidenced based practices and successful state structures to support home and community based services that promote recovery, well-being and community integration.

Contact Us

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The Evolution of PSH – Aligning Policy and Reality

Presented by: Patti Holland
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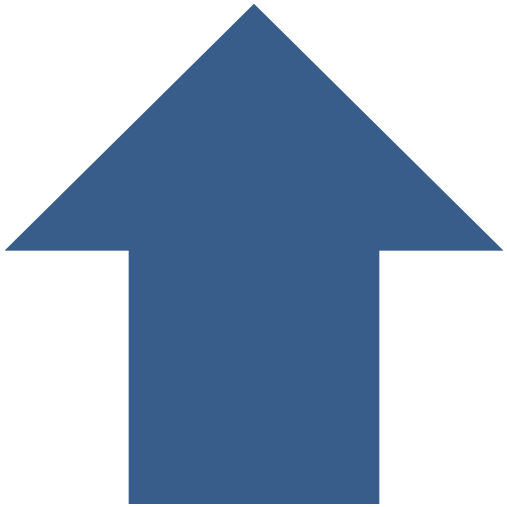
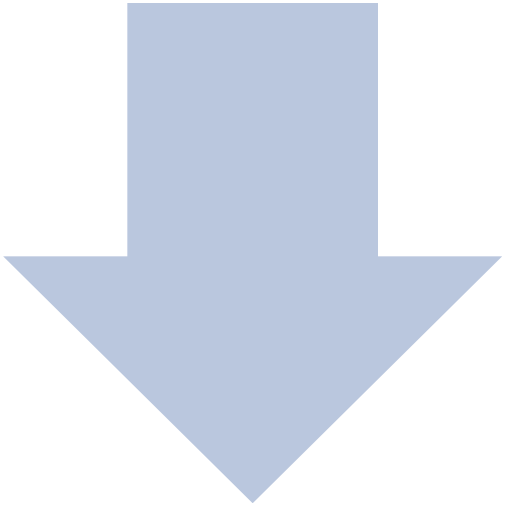
October 12, 2015

State & System Struggles



Increasing Demand



Decreasing Budgets

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State & System Struggles

- Addressing the varied housing and residential treatment (i.e. not housing) needs across populations.
- Balancing current resources with current and emerging needs
- Maximizing stock and demand while creating a steady pipeline of new housing opportunities
- Geographic challenges: rural/remote/frontier areas; high cost areas; historic low vacancy rates in areas

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State & System Struggles

- Prioritizing and configuring services to meet complex needs of individuals who cross systems
- Avoiding “Drive-by” Case Management
- Bundling/braiding Medicaid and non-Medicaid funds
- Delivering PSH to uninsured individuals
- Working with managed care to cover services in PSH
- Addressing workforce availability and capacity

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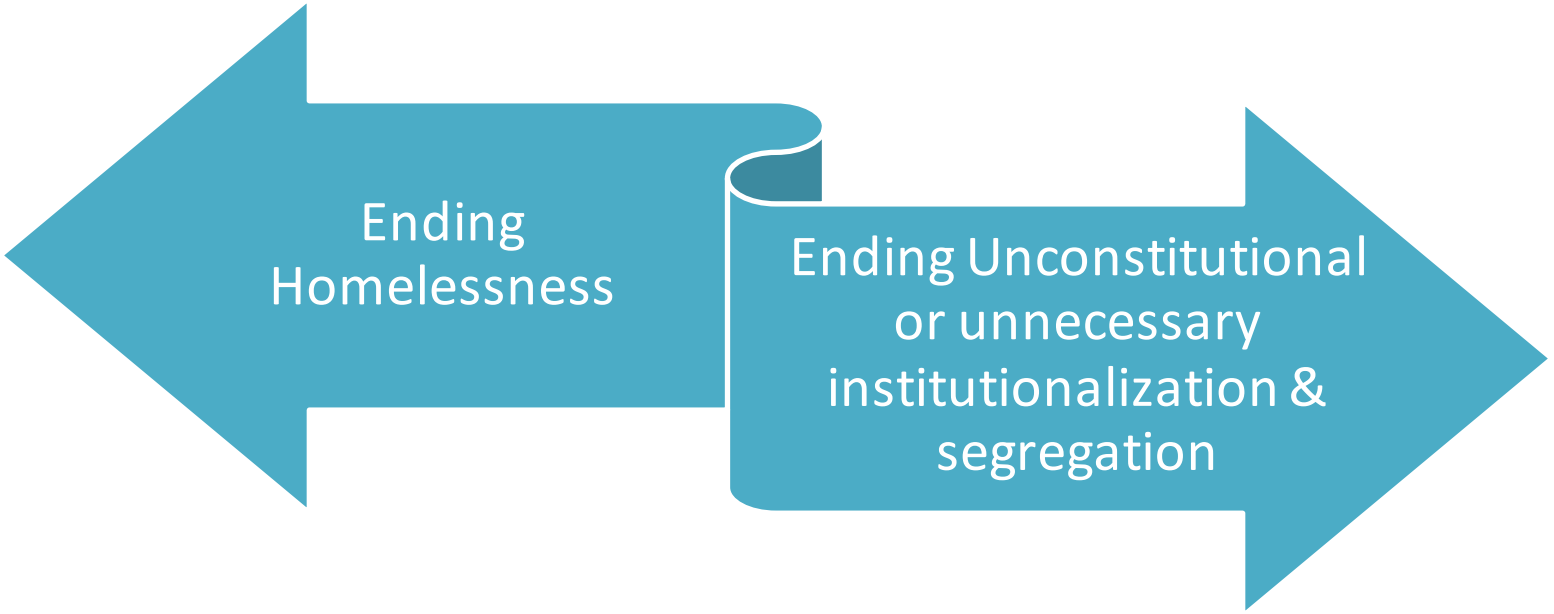
Competing Demands?



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Historical Response To Homelessness & Institutionalization

- Homelessness – spike in 1980's viewed as short term problem.
  - Response = emergency shelter
- People with disabilities
  - Response was institutionalization and segregation
- "Housing Readiness"
  - Moved to a linear continuum
- Permanent Supportive Housing
- Housing First Approach

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The Mandate for Community Integration

- In the landmark *Olmstead v. L.C.* decision (1999), the U.S. Supreme Court held that states have an **affirmative obligation** to ensure that individuals with disabilities live in the least restrictive, most integrated settings possible.

- The regulations implementing Title II define an integrated setting as one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible."

- 28 C.F.R. § 35.130(d)
- 28 C.F.R. § Pt. 35, App. A (2010) (addressing § 35.130)

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Olmstead as Leverage: Shaping Priorities

- Several states are in some stage of litigation or settlement agreement implementation.
- AZ, CT, GA, II, DE, MO, MN, MS, NJ, NC, NY, NH, OR
- Olmstead litigation/settlements drive state funding decisions (i.e. who gets services)
- This may impact the availability of services for other populations with disabilities.

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Olmstead settlement remedies and implementation trends

- Target populations
- Expansion of community services
  - ACT, Community Support Teams, Supported Employment, Peer and Family Supports, Crisis Services
- New and/or re-allocated resources
  - Cost savings for services or subsidies
- Expansion of integrated housing
  - Permanent housing, Housing First, Affordable, Set-aside units in larger housing developments, choice
- Medicaid opportunities
  - HCBS waivers, MFP, Medicaid expansion, improved authorities (1915(i))

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Competing Demands or Policy Alignment?

Homeless Policy	=	PSH
Community Integration Policy	=	PSH
Disability Policy	=	PSH
Medicaid & Healthcare Policy	=	PSH
Housing Policy	=	PSH
Correctional/Justice Policy	=	PSH
Policy Alignment	=	PSH

13% of homeless individuals were in an institution the night before becoming homeless.

(2013 HUD Annual Homeless Assessment Report)

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“The ache for home lives in all of us. The safe place where we can go as we are and not be questioned.”

Maya Angelou

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Permanent Supportive Housing (PSH)

Nationally recognized, proven and cost-effective solution to the needs of vulnerable people with disabilities who are homeless, institutionalized, or at greatest risk of these conditions.

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Permanent Supportive Housing (PSH)

Permanent. Tenants may live in their homes as long as they meet the basic obligations of tenancy, such as paying rent;

Supportive. Tenants have access to the support services that they need and want to retain housing; and

Housing. Tenants have a private and secure place to make their home, just like other members of the community, with the same rights and responsibilities.

SAMHSA, PSH Toolkit

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What PSH Is – And Is Not

Permanent	NOT	Transitional
Supportive	NOT	Directive
Housing	NOT	Program

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Key elements of PSH

- May be “elementary” but are the foundation on which positive outcomes occur.
- If the elements are not present, it is not PSH.

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Key Elements of PSH

(Adapted from SAMHSA PSH Toolkit)

- Tenant Choice
  - Tenants define housing needs and preferences.
  - Tenants choose whether or not to participate in services.
  - Depending on model of SH, tenants choose where they want to live.
- Access
  - Despite common housing barriers such as lack of income, poor credit/criminal/housing histories, active substance use or mental illness
- Quality
  - Housing is similar to what others in the community live in and have access to.

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Key Elements of PSH

(Adapted from SAMHSA PSH Toolkit)

- Integration
  - Access to housing that others without disabilities or histories of homelessness have access to, broad spectrum of neighbors as in other housing.
- Rights of Tenancy
  - Lease in own name. Tenant rights including privacy, limitations on landlord access, can remain in housing as long as basic requirements of tenancy are met.
- Affordability
  - Typically no more than 30% of income towards rent.

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Key Elements of PSH
(Adapted from SAMHSA PSH Toolkit)

- Coordination between housing and services; AND

- Delineated roles.

A functional separation between housing and services is a distinguishing element of PSH.

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Housing First Approach

- A focus on helping individuals and families access and sustain permanent rental housing as quickly as possible without contingencies or time limits;
- A variety of services delivered to promote housing stability and individual well-being on an as-needed basis; and
- A standard lease agreement to housing – as opposed to mandated therapy or services compliance.

National Alliance to End Homelessness

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Support Services

- Tenant Choice
  - Type, location, frequency, intensity
  - Services change over time as needs change
- Housing Focus
  - Choose/Get/Keep Housing
  - Community inclusion and participation
  - Beyond “maintaining” to thriving
- Assertive Outreach and Engagement
  - Just because you get fired doesn’t mean you’re off the job
- Case/Care Management
- Recovery Support
  - Natural support systems
  - Employment and Education

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Demonstrated Outcomes

- Population and Systems Outcomes
  - Access to housing
  - Access to housing supportive services (e.g. case management, peer supports, linkage to healthcare)
  - Reduced hospitalization
  - Reduced utilization of institutional settings (e.g. nursing homes, prison/jail, psychiatric hospitals)
  - Reduced homelessness
  - Per capita expenditures

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Demonstrated Outcomes

- Individual Outcomes
  - Housing stability
  - Housing satisfaction
  - Increased employment
  - Reduced re-hospitalization
  - Reduced crisis/emergency service use
  - Reduced detox. services
  - Reduced arrests
  - Reduced victimization
  - Reduced mental health symptoms (e.g. depression, anxiety)
  - Social connectedness

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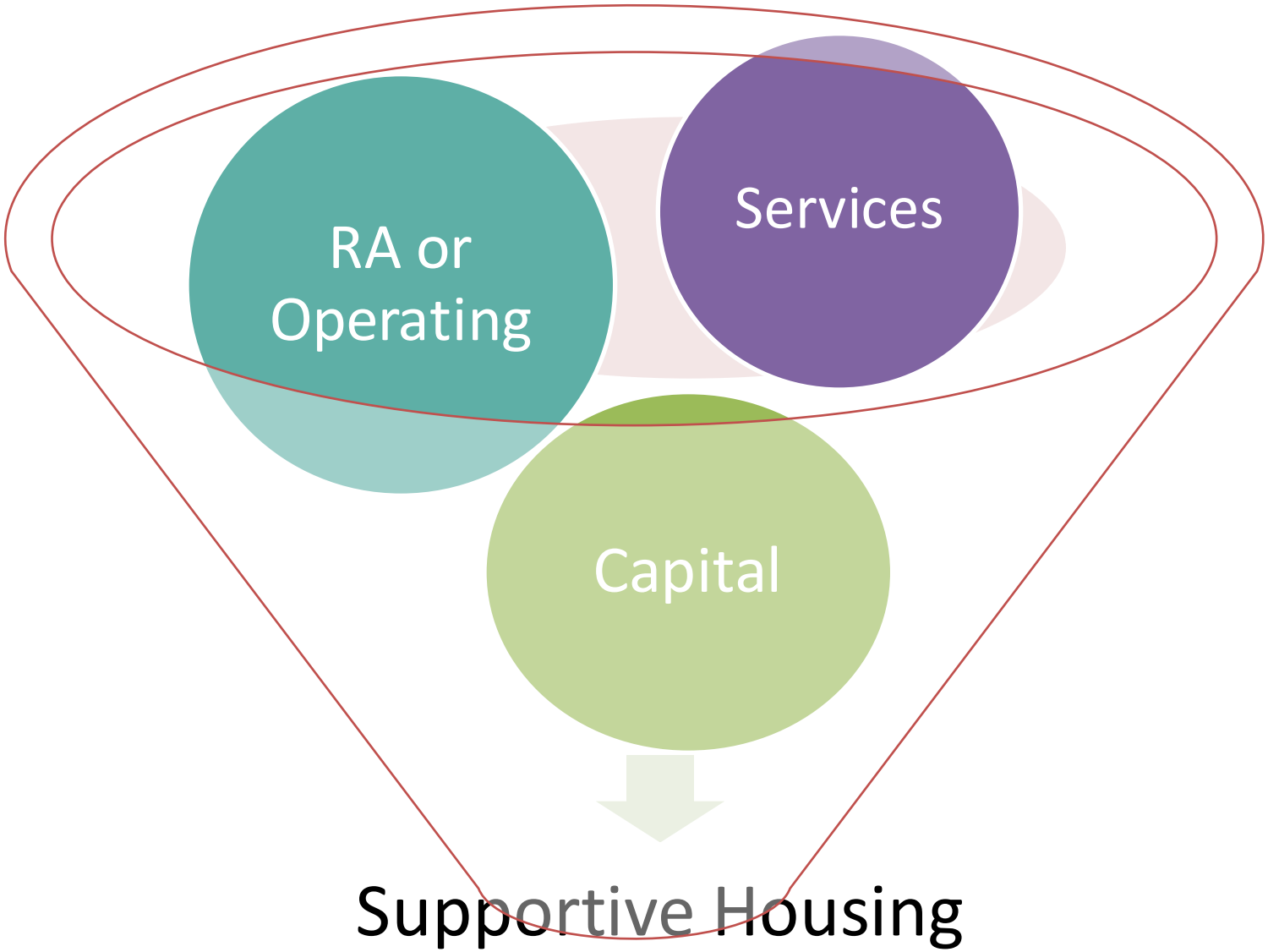

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Maximizing Housing Resources

- HUD Section 811 PRA (29 states)
- National Housing Trust Fund
- HUD Continuum of Care
- Low Income Housing Tax Credits
- State capital assistance programs (i.e. HTFs)
- Public Housing Authorities
- HOME Program
- State-funded Housing Assistance (30 states with RAP programs; Moving Home in Alaska)

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HUD 811

- NC, PA, IL pioneered an integrated approach to financing PSH in LIHTC properties – a model subsequently adopted by Congress for the modernization of HUD's Section 811 program in 2010

- Common policy principles across all three states include a mixed-income LIHTC platform, cross subsidization, low/no debt to help lower subsidy costs, and creative use of capital to finance ELI affordability.

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National Housing Trust Fund

- Targeted primarily to rental housing for Extremely Low Income (ELI) households
- Will be allocated to state housing agencies in early 2016
- Capitalization of fund for first year is part of HUD budget discussions
- 90% of the funding directed to the production, preservation, rehabilitation, and operation of rental housing
- At least 75% of the rental funds must benefit ELI households
- Under the formula, each state must receive a minimum of $3,000,000
  - (1) capital for the development, rehabilitation and preservation of rental housing; and (2) operating subsidies

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Alignment of Federal Policy around Integration

- DOJ Definition of Integration (June 2011)
- HUD Olmstead Guidance, including "Olmstead Preference" (June 2013)
- HHS/CMS Home and Community Based Services Final Rule (January 2014)
- CMS Informational Bulletin on Housing-related Activities and Services (June 2015)

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Community Integration Defined

"Integrated settings are located in mainstream society; offer access to community activities and opportunities at times, frequencies and with persons of an individual's choosing; afford individuals choice in their daily life activities; and, provide individuals with disabilities the opportunity to interact with non-disabled persons to the fullest extent possible.

Evidence-based practices that provide scattered-site housing with supportive services are examples of integrated settings."

U.S. Department of Justice. *Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C.*

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Integrated Settings

- Located within communities.
- People have a choice in what to do, how often, when and with whom.
- People have opportunities to interact with a variety of people, with and without disabilities to the maximum extent possible.

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Community Integration Defined

"By contrast, segregated settings often have qualities of an institutional nature. Segregated settings include, but are not limited to:

(1) congregate settings populated exclusively or primarily with individuals with disabilities;

(2) congregate settings characterized by regimentation in daily activities, lack of privacy or autonomy, policies limiting visitors, or limits on individuals' ability to engage freely in community activities and to manage their own activities of daily living; or

(3) settings that provide for daytime activities primarily with other individuals with disabilities."

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Segregated Settings

- Institutional in nature.
- Only, or primarily people with disabilities live in the setting.
- Structured and regimented.
- Limitations on what can be done, when, guests, etc.
- Lack of privacy and autonomy.

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Medicaid HCBS (1915i & 1915c,k) Settings Rule

- The setting is selected by the individual from among setting options including non-disability specific settings; choice of setting must be documented in person-centered service plan.
- Individuals must have options available for both private and shared living; provider owned or controlled housing must facilitate choice regarding roommate selection.
- Separation of housing and services is not required; choice regarding services including choice of provider in provider-owned housing must be addressed in person-centered service plan.

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Cautions

- Just because it's in the community doesn't mean it's integrated.
- "Choice" may have different meanings.
- Budget cuts and bureaucracy do not trump civil rights.
- Beliefs and opinions regarding whether a person is ready for more independent living or what an integrated setting is may conflict with what the Courts decide.
- Considering Group Homes and other congregate models – system needs to ensure options and balance.

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Medicaid and Housing Costs

- Should Medicaid pay for Housing?
- Safe, decent, affordable housing is a social determinant of health, but should we expect health insurance to pay for it?
- Places greater financial burden on state/county govt. and takes pressure off of federal housing policy and spending.
- What about the uninsured or underinsured?

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Paying for services in PSH

- There is no “PSH” service.
  - Should there be?
- What is the array of services an individual needs?
- What could be covered by Medicaid?
- What cannot be covered by Medicaid and needs another funding source?
- It’s not one or the other!
- Models of reimbursement.

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Strategic Planning for PSH

- Leadership articulates vision and establishes and drives policy.
- Establish a cross-system, coordinated and collaborative approach to PSH policy.
- Establish a PSH pipeline over a designated number of years
- Create systems to prioritize and coordinate access to PSH opportunities.

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Strategic Planning for PSH

- Establish sustainable funding sources for services delivered to individuals living in PSH settings.
- Services are provided in home and community settings to promote housing stability, successful tenancy and community inclusion.
- Strengthen community provider workforce capacity to effectively deliver home and community based services.

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Housing As The Foundation

- Ending homelessness is possible
  - But it is not easy
  - Requires commitment
  - Requires change & making some tough decisions
- Housing is the primary solution
  - Some need short term and minimal assistance
  - Others require longer term and more comprehensive support
- Supportive Housing prevents and ends homelessness for our most vulnerable citizens.

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