Cost-Effectiveness of Permanent Supportive Housing and Recommendations for a New Service Delivery Model in Support of the Indiana Permanent Supportive Housing Initiative

from the

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This white paper was developed under the supervision of Rodney Stockment, Community Services Director at the Indiana Housing and Community Development Authority (IHCDA). Much of the content is based on the research and writing of Lauren Cooper, 2009 summer intern at IHCDA and senior at Duke University's Terry Sanford Institute of Public Policy. Additional support and comment was provided by Kirk Wheeler, Consultant to IHCDA and Manager of the Homeless Management Information System and Lori Phillips-Steele, Associate Director, Indiana Office of the Corporation for Supportive Housing. Significant contribution to the substance of the paper came from work completed by Marti Knisley of the Technical Assistance Collaborative.

Executive Summary

The intent of this white paper is to provide policy-makers, community leaders, advocates, community mental health providers and housing developers with a deeper understanding of why permanent supportive housing is a cost-effective solution to long-term homelessness and reduce long term care for individuals and families. The white paper contains an extensive literature review of the mounting evidence that permanent supportive housing is a cost-effective intervention for persons who are not only homeless, but who also face serious and persistent challenges such as mental illness, substance abuse, or HIV/AIDS and often facing periods of institutionalization in state operated facilities because more integrated community living settings are not available. The authors advocate that the evidence provided by these cost studies influence state policy to direct resources to the Indiana Permanent Supportive Housing Initiative (IPSHI).

This paper is structured in part around a separate expert position paper authored by Marti Knisley of the Technical Assistance Collaborative under contract to the Corporation for Supportive Housing. That paper , which is attached (Appendix A), defines the services required to provide true permanent supportive housing within the framework of Indiana Medicaid requirements and includes a pilot study that estimates the proportion of these services that will not be eligible for Medicaid reimbursement.

In recent years, permanent supportive housing has gained recognition as a successful combination of affordable housing and flexible services that can help individuals with special needs live more stable, productive lives. Permanent supportive housing refers to permanent housing units (typically rental apartments) linked with flexible community-based services. Permanent supportive housing is specifically intended for homeless individuals with disabilities who, but for housing, cannot access and make effective use of the treatment and services they need to stay stable; and who, but for supportive services, cannot access and maintain stable housing. By helping individuals and families move out of expensive systems of emergency and long term care and back into their own homes and communities, permanent supportive housing not only improves the lives of its residents, but also generates significant public benefits.

Background

In November 2007, IHCDA led a small delegation from Indiana to the Corporation for Supportive Housing's 'Supportive Housing Leadership Forum' in Arlington, Virginia. Indiana lacked, at that time, both the local capacity to develop permanent supportive housing and the state policy to sustain quality projects. The delegation recognized that Indiana needed to establish permanent supportive housing as the center-piece for the state's efforts to end long-term homelessness. The delegation returned to Indiana committed to launching a comprehensive initiative around the production of permanent supportive housing units. At the same time, the Division of Mental Health and Addiction (DMHA) of the Family and Social Services Administration was also undergoing a transformation process to improve the delivery of behavioral health services in Indiana. Recognizing that housing is an essential part of a complete recovery model for behavioral health, DMHA invited IHCDA to join their Transformation Work Group. In January 2008, IHCDA, DMHA, the Transformation Work Group (TWG), the Corporation for Supportive Housing (CSH), and the Great Lakes Capital Fund launched the Indiana Permanent Supportive Housing Initiative (IPSHI), a public/private venture designed to develop a minimum of 1,400 permanent supportive housing units over six years.

Predicated on the growing evidence that permanent supportive housing is a cost-effective solution for people who face the most complex challenges, IPSHI aims to end to the cycle of chronic homelessness and institutionalization rather than merely managing its symptoms. While homelessness remains relatively invisible to the average person in most Indiana communities, chronic homelessness makes a documented and costly impact on publicly-funded systems of health, social services, and criminal justice. In fact, Indiana can no longer afford to not take action. Local scholars estimate that health care and criminal justice expenditures for the chronically homeless population in the City of Indianapolis alone range from $3 million to $7.8 million each year, not including the high costs of emergency shelter (Wright, July 2007).

In March 2008, the State's Transformation Work Group adopted IPSHI as a strategic goal for Transformation. A Supportive Housing Work Group was convened as part of the Transformation process. A sub-committee of the Work Group was created to focus on the development of a fidelity model for permanent supportive housing and address service funding to support the model. The sub-committee included DMHA, OMPP (Office of Medicaid Policy and Planning), IHCDA, and CSH. The Technical Assistance Collaborative (TAC) is providing technical assistance and consultation to this effort.

The sub-committee developed a scope of work and defined the components necessary to develop a successful permanent supportive housing model for Indiana. This committee has completed its first task, a crosswalk of the services needed in permanent supportive housing and services in the

proposed updating of the state's Medicaid Rehabilitation Option (MRO). The crosswalk identifies services that can be covered through the Medicaid Rehabilitation Option for individuals who are eligible for Medicaid, and also those services that need to be funded through other sources.

The crosswalk, as developed in partnership with the TAC and CSH, includes the role of property management in supportive housing and the link between property management and services. The Permanent supportive housing/MRO crosswalk was also aligned with CSH's *Dimensions of Quality*. This crosswalk has emerged as a fidelity model for what is needed to make permanent supportive housing successful and has been recognized as a key component of the State's Recovery Model. We submit that the Permanent supportive housing/MRO initiative is an important element of Indiana's mental health system transformation because:

- **There is a significant body of evidence that permanent supportive housing works for people with disabilities, including those with the most severe impediments.** This is the well acknowledged "Housing First" principle which has been successful in New York and other well documented studies. Individuals with the most severe impediments may benefit the most. People with disabilities vastly prefer to live in their own apartment or their own home and supportive housing is less costly than other forms of government-financed housing or residential services. Studies show that permanent supportive housing leads to greater housing stability, improvement in mental health symptoms, reduced institutionalization, and increased life satisfaction. Adequate stable housing is a prerequisite for improved functioning for people with disabilities; it is a powerful motivator for people to seek and sustain treatment and it is cost effective.

- **Permanent supportive housing is effective when it is created with quality rental housing stock with a deep rental subsidy so people living on very low fixed incomes can afford to live in the community**. Rental resources can come from a variety of HUD and IHCDA funded sources. People using one of these sources have a standard lease that defines tenant protections but also defines responsibilities for the lease holder. People can access housing even with credit problems or some history in the criminal justice system through reasonable accommodation. The IPSHI is uniquely positioned to gain access to these resources on behalf of people with behavioral health and other disabilities.

- **People are more likely be successful in this type of housing if they have assistance in obtaining and sustaining housing, if they have a choice in housing, and if the housing is not conditioned on treatment.** This requires that a substantial stock and variety of housing be available within a jurisdiction and that disabled persons have choices among this stock. Traditional approaches, e.g. group homes, are neither faithful

to the permanent supportive housing model nor likely to promote community independence and recovery.

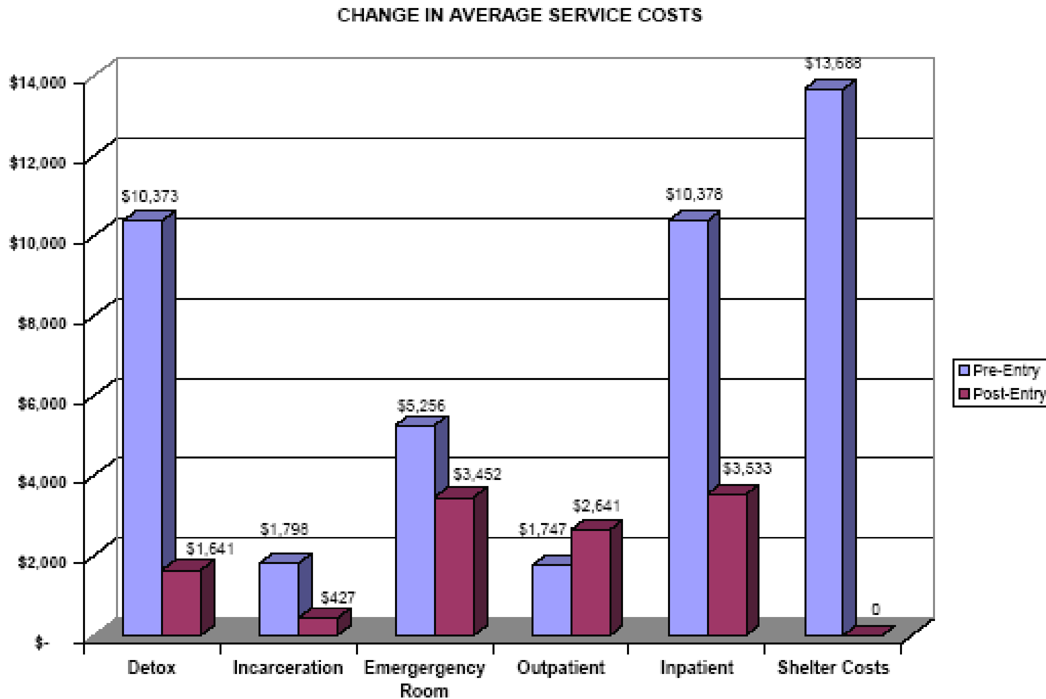
- **Services supportive of housing permanency by persons living with serious mental illness and concurrent disorders are specific to housing and available in the person's residence.** Providing services so a person can be successful in their own home is often the major determining factor in a person thriving in the community. The types and amount of services and supports tailored for and successful with this approach are now well defined. Services are individualized and provided in the home and community, and when necessary, include harm reduction, crisis intervention, assistance with negotiating with landlords, neighbors and others, community orientation, and often self monitoring and life skills training. These skills are not necessarily transferable without planning, adaptation, training, and careful oversight.

The body of literature documenting effectiveness of permanent supportive housing is growing and is bolstered by cost effectiveness data emerging from studies from Seattle to Chicago to Massachusetts and Maine and states in between. This white paper examines data from permanent supportive housing projects across the country to identify and monetize the savings such programs can offer public service providers touched by chronic homelessness. Permanent supportive housing has been consistently associated with cost reductions across systems of emergency care, public health, mental illness and addiction treatment, and safety and corrections. For example, findings include:

- 98% reduction in emergency room visits and 62% reduction in emergency room costs (Mondello 2007)
- 95% cut in mental health inpatient hospitalizations (Moore 2006)
- 71% decrease in Medicaid reimbursement costs (Andersen 2000).
- 97% reduction in nursing home nights (Nogaski 2009)
- 84% reduction in tenants' days spent in correctional facilities (Culhane 2002)
- 87% decrease in sobering center admissions (Larimer 2009)
- 84% reduction in detoxification costs (Perlman 2006) (For more examples from Denver, see Graph #1).

GRAPH #1

Observed changes in average service costs per resident of Denver's "Housing First Collaborative," obtained by comparing service usage in the 24 months before and after entry into permanent supportive housing (Perlman 2006, page 11)



Furthermore, studies have found that the overall costs of permanent supportive housing are similar to – and often less than – the costs of allowing persons with chronic illnesses or other special needs to remain homeless. In fact, accounting for the cost of housing and services, the net savings for a Massachusetts permanent supportive housing program were estimated at $8,949.00 per year per resident (See Graph #2) (MHSA June 2009). The same Massachusetts study reported retention rates of 84% for an average of 1.9 years housed.

The authors hope that after reading this white paper, Indiana policy-makers will take away a more complete understanding of why IPSHI is a cost-effective intervention that must be supported with more state resources to realize maximum cost savings across multiple systems.

Concretely, realization of this opportunity in Indiana requires:

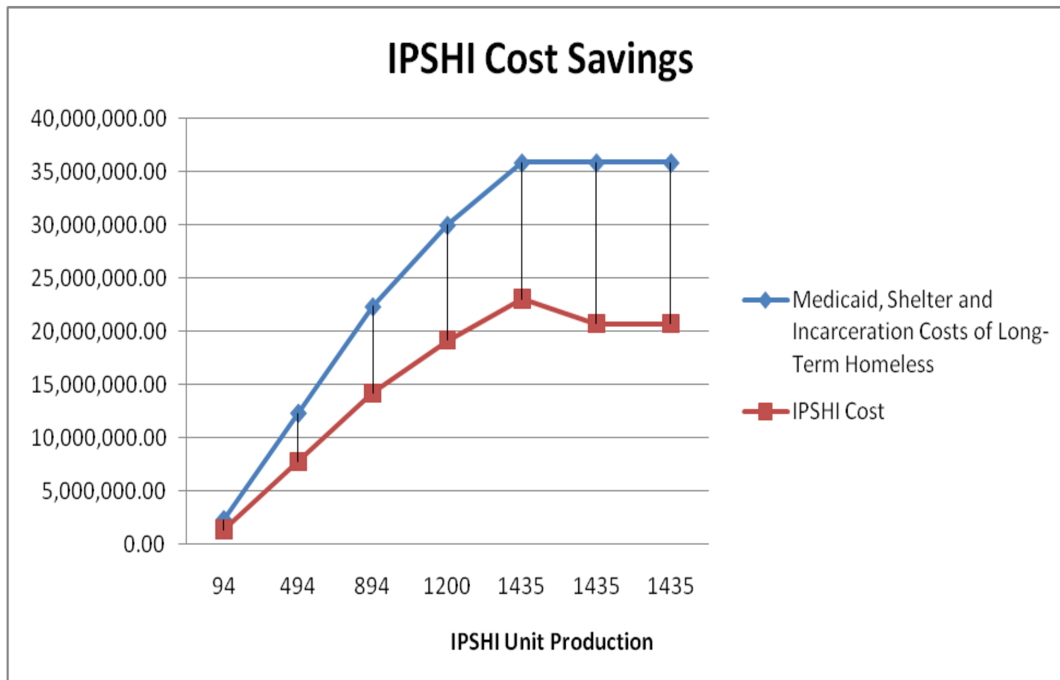
- Commitment of sufficient capital and operating funds to build and operate 1435 new units of permanent supportive housing.

- Recognition of Permanent Supportive Housing as a distinct entity within the DMHA defined Continuum of Care with particular assignment within the "service packages" for MRO eligible services.
- Additional funding of services not presently covered by Medicaid but required to allow sustainability and fidelity to the Corporation for Supportive Housing model for permanent supportive housing. It is this latter amount to which the following paragraphs refer.

Over the next five years, IHCDA has set a goal of creating 1,435 units of permanent supportive housing. The Graph #2 illustrates the cost saving that Indiana can achieve by creating the 1,435 units of permanent supportive housing over a period of seven years. IPSHI costs, including capital, rental subsidies and service costs, are compared to the cost of maintaining the current system of emergency care and incarceration. In years six and seven, IPSHI costs will be reduced as individuals recover from their mental illness and remain stably housed. **Rarely is government availed an opportunity to improve the quality of care and positive health outcomes while realizing significant cost efficiencies.**

GRAPH #2

IPSHI Cost (Capital, Operating, and Services) compared to the Costs of Long-Term Homelessness Associated with Emergency Systems: Medicaid, Shelter and Incarceration.



In order to reap the benefits of investing in permanent supportive housing, the state must also expand inter-agency coordination, overcome the challenges of "silo" funding, and remove certain barriers to resource access**. The authors estimate that by redirecting an additional $2,302,261 annually to fund non Medicaid MRO services for persons living in permanent supportive housing, the state could realize $15,180,417 in annual cost saving across multiple systems.** By enacting policy that directs funding to permanent supportive housing, the state will improve the delivery of behavioral and primary health services in Hoosier communities and work towards eradicating the negative impact of long-term homelessness throughout the state. Even more significant savings could be realized using permanent supportive housing as a model for community integration for individuals who remain in state operated facilities due to the current lack of community placement opportunities and for individuals who are discharged from corrections with severe mental illness and chronic addictions and at high risk of homelessness and re-offending.

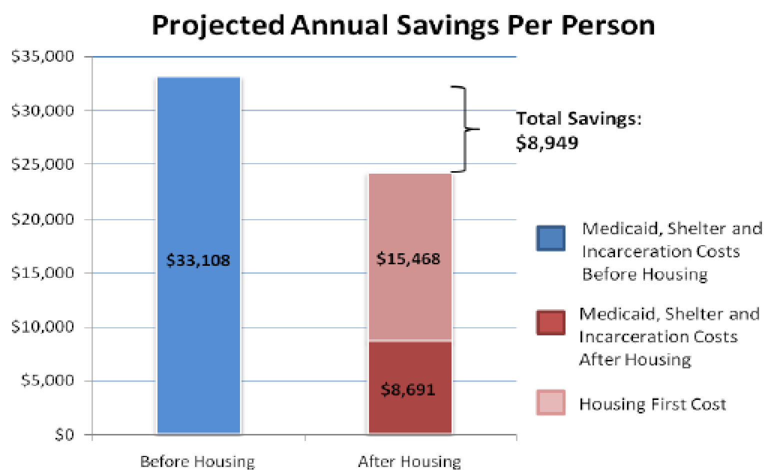
Introduction and Purpose

Background

Homelessness is often viewed as a one-dimensional issue. It is assumed that homeless persons, especially chronically homeless single persons, are a special class of social misfits who either cannot or do not wish to work and achieve stable community adjustment. However, we have increasingly found that the chronically homeless population is neither homogeneous nor one-dimensional. Research has demonstrated that the chronically homeless population includes many disabled persons who have medical, psychiatric, and/ or addiction issues that create barriers to achieving stable and fruitful recovery.

GRAPH #3

Estimated net savings, per resident, for a Massachusetts permanent supportive housing program (MHSA June 2009, page 11)



Unfortunately, when left on the streets, these persons utilize a substantial array of community resources in the form of emergency room care, public safety time, public health services, corrections time and, in many cases, continuing use of expensive emergency shelters. Research and practice have consequently shown that there are significant public costs to “doing nothing” to assist the chronically homeless population in breaking the cycle of long-term homelessness. Drawing on cost studies from across the country, this white paper will demonstrate that through coordination across multiple systems of care, permanent supportive housing offers superior cost savings and recovery outcomes when compared to alternate homeless interventions.

The National Alliance to End Homelessness supports a permanent supportive housing model, explaining “By examining the characteristics of homeless persons and the systems they interact with, (researchers) have learned that a small percentage of homeless persons…cycle between hospitals, emergency rooms, jails, prisons, and mental health and substance abuse treatment facilities. Furthermore, this small group of people, known as long-term or ‘chronically’ homeless, are very expensive to public systems of care. Permanent supportive housing can successfully provide this vulnerable population housing and services that effectively end their episodes of homelessness” (NAEH 2006). In general, permanent supportive housing has been shown to promote a sharp decline in tenants’ use of expensive emergency care services and an increase in tenants’ use of less expensive regular and preventative outpatient treatments. This results in savings across systems of emergency shelter, emergency room care, general public health care, mental illness and addiction treatment, and safety and corrections. While permanent supportive housing certainly levies costs of its own, including both the physical property costs and the operational costs of integrated social and health care services, most studies have shown that the total system savings equal or exceed the investment.

Research has also demonstrated that permanent supportive housing provides additional value to the community that exceeds basic cost-effectiveness. Permanent supportive housing encourages tenant engagement, skill building, resource access, civic participation, and leadership development. Ultimately, permanent supportive housing aims to empower tenants to be independent, responsible, and self-sufficient. Documented outcomes of this approach include improved tenant stability, increased income and employment, decreased substance abuse, and improved health care treatment. Communities with permanent supportive housing programs are also safer, more efficient, and more attractive.

IPSHI - Philosophy and Assumptions

Through the IPSHI, IHCDA and its partners have already taken steps to establish permanent supportive housing as a model for chronic homelessness recovery in Indiana. The Initiative’s primary goals are to reduce long-term homelessness, reduce the use of expensive emergency systems of care as primary homeless interventions, and improve Hoosier communities by developing high-quality permanent supportive housing projects. The Initiative intends to help

local housing developers, behavioral health providers, and homeless assistance networks develop permanent supportive housing using CSH's Dimension of Quality[1]. In this model, housing is not only affordable, but a foundation for recovery from mental illness or chronic addiction. IPSHI is also intended as a platform for state agencies and private foundations to bring together elements from housing, mental health services, social services, employment, income supports and addiction treatment to foster a more holistic, collaborative recovery system.

Permanent supportive housing efforts in Indiana under IPSHI are founded on a "housing first" philosophy. In a "housing first" approach, a chronically homeless individual or family is first provided with safe, stable, and permanent housing and then offered the appropriate flexible services to allow his or her recovery into community stability and independence. Because eviction is viewed as a last resort for the sake of retention and stability, abstinence from substance use and participation in services are not conditions of tenancy. This gives participants an opportunity to end their cycle through expensive systems of emergency care by working towards recovery from a stronger foundation. Research has shown that particularly when substance abuse disorders are present, a "housing first" philosophy is a major factor in a tenant's likelihood of long-term stability. IHCDA embraces a "housing first" strategy in response to homeless individuals with mental illness and other special needs because IHCDA believes that it is cost-effective to provide permanent supportive housing as an alternative to individuals and families cycling through less effective systems of emergency care.

To date, IPSHI has developed a strong pipeline for permanent supportive housing projects and provided training and technical assistance to developers through the Indiana Permanent Supportive Housing Institute[2]. Nevertheless, creating permanent supportive housing is a difficult endeavor. Permanent supportive housing integrates multiple housing and support service funding streams for the most vulnerable low-income households. Creating new permanent supportive housing also means changing the status quo in communities and systems of care – a change process that can be difficult.

Funding Implications

In Indiana, as in many other states, provision of permanent supportive housing is complicated by distinct funding "silos" across the structure of state government. Permanent supportive housing engages numerous public, private, and state service providers and offers benefits that span a wide range of state activities. Unfortunately, state and federal funding is not equally so flexible or

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[1] The Corporation for Supportive Housing's (CSH) "Seven Dimensions of Quality for Supportive Housing" offers a self-assessment tool that measures the quality of permanent supportive housing projects by examining the physical property and linked services in the context of national best practices for a successful recovery model. For more information on the CSH Dimensions of Quality, see Appendix B.

[2] The Indiana Permanent Supportive Housing Institute is a comprehensive, highly interactive project development initiative for permanent supportive housing in the State of Indiana. Comprised of teams based in Indiana, the Institute provides targeted training and technical assistance to development teams working on specific supportive housing projects for persons who are homeless in Indiana.

fluid. For example, Medicaid is a major payer for supportive services in Indiana. Therefore, Medicaid policies drive how other funding sources are used, including those most frequently used for permanent supportive housing services and operations. Community-based services are most often delivered in Indiana through the MRO that is limited to Community Mental Health Centers. Not only are such services limited to persons with a demonstrated mental illness or substance use disorder, they also require that an adult be deemed disabled and display current functional impairments within the Indiana Medicaid program. Studies have found that these Medicaid eligibility processes present a barrier in homelessness services. IHCDA believes that this barrier is real in Indiana, and costly to multiple systems throughout the state. It is also true that Indiana has not historically joined permanent affordable housing with supportive services – resulting in a knowledge gap that must be addressed for real progress to be realized.

In addition to demonstrating the cost-effectiveness and positive outcomes of permanent supportive housing, this white paper examines the challenges facing permanent supportive housing providers, and their tenants, in accessing Medicaid and other funding resources. It is IHCDA's vision that the partnership to provide permanent supportive housing will engage all relevant state agencies and departments, community mental health centers, and non-profit and for-profit entities to expand housing and human service collaboration and provide cost-effective solutions to the problem of long-term homelessness. Working from IPSHI's pipeline, we recommend that new partnerships among housing and service providers be created at both the funding and direct services level. These partnerships will add value to public sector activities and help create a shared mission across the systems that serve the lowest income households with special needs.

Literature and Data Review

To understand the extent of the potential benefits Indiana could accrue from additional permanent supportive housing units, one must examine the broad reach of the public costs of homelessness. Within any state or community, homelessness – particularly chronic homelessness – puts significant pressure on a variety of housing, social service, and health care systems. Researchers found that while the chronically homeless only account for 10% of the homeless population, they consume over 50% of all homelessness resources (Kuhn 1998). This means that the continuing cycle of chronic homelessness has a disproportionate impact on housing and service providers, clogging the system and preventing providers from best serving those individuals and families who could otherwise exit homelessness relatively quickly.

Additionally, in lieu of suitable housing, many homeless individuals with chronic conditions turn to alternate social service systems to seek temporary shelter and care. Beyond emergency homeless shelters, Indiana's jails, prisons, emergency rooms, nursing homes, safety personnel, and inpatient treatment facilities currently spend significant time and money caring for chronically homeless individuals. Housing and treating the chronically homeless is not the intended function or expertise of these health and safety systems, and consequently the cycle of

homelessness creates inefficiencies that negatively impact these systems and the rest of the populations they serve. These alternate systems are also more expensive interventions relative to permanent supportive housing. The Lewin Group completed a study on the costs of serving homeless individuals in nine major US cities. The study found that the median cost of permanent supportive housing per person per day is $30.48; compared to $25.48 for emergency shelter, $84.74 for prison, $70.00 for jail, $607 for a mental hospital, and $1,637 for a public hospital (2004). Permanent supportive housing is not the least expensive intervention per person per day but it offers a higher likelihood of long-term recovery outcomes.

In addition to lowering the costs of emergency care and promoting long-term recovery for the chronically homeless, studies have also shown that the cost savings associated with permanent supportive housing can exceed or at least offset the expense of the program itself. In a classic report on the costs of homelessness, Dennis Culhane and his colleagues at the University of Pennsylvania's 'Center for Mental Health Policy and Services Research' tracked 10,000 homeless persons with mental illness in a case-control study in New York City (2002). The researchers tracked the service use of these persons for two years before and after placement in permanent supportive housing funded by the 1990 New York/New York (NY/NY) 'Agreement to House Homeless Mentally Ill Individuals.' The agreement provided housing linked to a variety of psychosocial services such as vocational training, group and individual therapy, and case management. To determine service usage before placement, researchers gained access to data from seven databases on psychiatric, public health, and criminal justice systems in New York. The sample of homeless persons entering NY/NY housing was matched with an equal number of control subjects who remained homeless. Special efforts were made to ensure that the control subjects had similar demographics, mental illness conditions, and levels of pre-placement service usage. The researchers compared the resulting data to determine the extent of the homeless population's shelter use, inpatient hospitalization, and time spent in jail and prison before and after permanent supportive housing placement. The study found that the chronically homeless population costs taxpayers $40,500.00 per homeless person per year. This estimate includes the costs of emergency rooms, psychiatric hospitals, shelters, and prisons. Study findings revealed that after placement in NY/NY housing, there was an 86% drop in the number of shelter days per person, a 60% drop in state hospital use, and an 80% drop in the number of inpatient days spent in a public hospital. The housing program also cut residents' incarceration rates in half. These service reductions resulted in a per-resident cost savings of $16,282.00 per year. Therefore, savings in the public health, emergency shelter, and corrections systems covered 95% of the cost of the NY/NY housing program, calculated at $17,276 per person per year (Culhane 2002).

In recent years, similar or superior net savings have been recognized by a variety of other permanent supportive housing programs implemented across the country. In a San Francisco project intended to help homeless persons with mental health or substance abuse conditions, scholars Martinez and Burt estimate that the service reductions identified in the study translate

into public cost reductions of $1,300 per resident in the first two years of enrollment, offsetting at least 10% of the estimated yearly cost of the permanent supportive housing program (2006). In a report on a Seattle permanent supportive housing project for recovering alcoholics with co-occurring conditions, the ninety-five participants had total costs of $8,175,922 in the year prior to the study, which decreased to $4,094,291 in the year after enrollment, with net savings of $958.00 per participant in the first year. This is a 53% total cost rate reduction, obtained by comparing housed participants to both wait-listed controls and historical data on service usage. Total emergency costs for this sample declined by 72.95%, or nearly $600,000.00, in the two years after the program's launch (Larimer 2009). In an analysis of a Portland, Oregon effort to reduce chronic homeless, researchers estimated pre-enrollment costs for annual health care and incarceration at $42,075 per client. After one year in permanent supportive housing, those costs fell to $17,199. Accounting for the investment in services and housing, totaling $9,870, along with mainstream service use, total expenditure for the first year was $27,069, a 36.7% or $15,006.00 saving for the first year (Moore 2006). In Denver, Perlman found that the number of clients using emergency services such as hospitalization, substance treatment, inpatient treatment, Detox, and jail decreased by 60% in the two years following enrollment in permanent supportive housing. If housing and services were provided to all 513 chronically homeless individuals eligible in Denver, costs savings would total $2,424,131 (Perlman 2006). In a Minnesota project to house the homeless, a cost-study discovered that a single homeless adult costs public systems almost as much a providing permanent supportive housing, with 96% of the increased costs of the housing program due to the housing itself (NCFH 2009). In Massachusetts, the cost of street homeless was calculated at $28,436 per person per year compared to $6,056 for those housed in the permanent supportive housing project. As previously stated in the executive summary, with before housing costs of $33,108 and after housing costs of $8,691 for Medicaid, shelter, and incarceration and $15,468 for housing and services; savings in Massachusetts totaled $8,949 per participant per year (MHSA June 2009). An Illinois permanent supportive housing report identified a 39% reduction in the total cost of services for residents in the two years after housing. This figure includes services from Medicaid, mental health hospitals, substance use treatment centers, prisons, and country jails and hospitals. Mainstream service costs decreased by almost $5,000.00 per person for overall savings of $854,477 over two years for the 177 participants (Nogaski 2009). In Rhode Island, a cost-study revealed savings of $8,839 per person per year in institutional costs once enrolled in permanent supportive housing (Hirsch 2007). Analysis of a project in Maine identified $944.00 average net savings per person per year, accounting for program investment (Mondello 2007).

Beyond net savings, permanent supportive housing offers specific benefits to a number of publicly funded systems. In particular, this white paper will discuss the savings associated with emergency shelters, emergency rooms, general public health care, mental illness and addiction treatment, and safety and corrections. In addition, this literature and data review will highlight the more general benefits of permanent supportive housing, including tenant stability, tenant independence, and community development.

Emergency Shelter Usage

A traditional response to homelessness, emergency shelters are intended to offer short-term housing to those experiencing brief and sporadic episodes of homelessness. While the emergency shelter system can effectively serve those persons with truly temporary experiences of homelessness, emergency shelters are not intended or equipped to provide the kind of care that can help individuals with special needs overcome the cycle of long-term homelessness. Consequently, emergency shelters experience significant savings and improved efficiency when chronically homeless "frequent users" are relocated to permanent supportive housing units. Permanent supportive housing not only reduces the costs of publicly-funded shelters, but also frees up shelter beds and services for the individuals and families who need only emergency, transitional, or short-term assistance.

As a combination of housing and services intended to help tenants remain stable, permanent supportive housing, theoretically, should eventually eliminate the need for chronically homeless individuals to utilize emergency shelters at all. In practice, studies have shown that once placed in permanent supportive housing, tenants' reliance on emergency shelters does, in fact, diminish to almost zero. A cost analysis study of the permanent supportive housing project in Portland, Maine identified a 98% reduction in shelter visits among the ninety-nine tenants of the program (Mondello 2007). In a case-control study of Seattle's 811 Eastlake "housing first" permanent supportive housing project, researchers found that after one year in permanent supportive housing, the ninety-five clients involved had reduced their emergency shelter use by 92%; from 1,870 total shelter night per year to 156 total shelter nights per year (Larimer 2009). A similar analysis of the Denver program found that placement in a permanent supportive housing program reduced emergency shelter costs by an average of $13,600 per tenant in the two years following placement (Perlman 2006).

Emergency Room Services

Emergency shelter, while expensive on its own, is only the tip of the iceberg when it comes to the total public cost of homelessness. When seeking treatment and shelter, many homeless individuals with chronic conditions also turn to emergency room services as an alternative form of housing and care. Reviewing data from the Portland, Oregon project, Thomas Moore found that the total number of emergency visits for the thirty-nine residents of the program fell from seventy-nine visits for twenty-nine persons to seventy-five visits for ten persons in the first year housed. Moore estimates that each emergency room visit costs the public system an average of $492.00 (2006). In a case-control cost study including two permanent supportive housing developments in San Francisco, Tia Martinez, JD and Martha Burt, PhD found that two years after enrollment, the percentage of residents with an emergency room visit in the two year period fell from 53% two years before entry to 37% two years after entry. Additionally, the total number of emergency room visits for the sample of 236 individuals in the study decreased by 56%, falling from 457 total visits two years before entry to 202 total visits two years after entry. The average number of visits per resident also decreased from 1.94 visits in the two years before

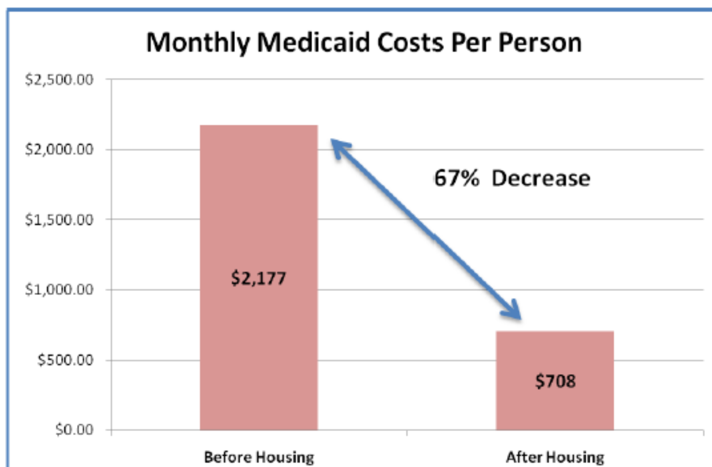
entry to 0.86 visits in the two years after entry (2006). In Illinois, emergency room usage decreased by 40% for residents in the two years following entry (Nogaski 2009). The Maine report identified a 62% reduction in total emergency room costs for its ninety-nine permanent supportive housing residents; from $206,451 the year before entry to $78,079 the year after entry, and a 66% reduction in participants' ambulance costs in the first year housed (Mondello 2007). A similar public health cost study from Seattle revealed that on average, tenants were 2.5 times less likely to visit the emergency room one year after enrollment in permanent supportive housing (Larimer 2009).

General Public Health Services

Public health scholars Martinez and Burt of the San Francisco permanent supportive housing study explain, "The costs associated with the health consequences of chronic homelessness fall disproportionately on municipal and state governments" (2006, page 992). Since many chronically homeless individuals suffer from a variety of co-occurring physical and psychiatric conditions, health care can be a significant public cost for this population whether they are housed or not. However, when this population remains homeless, public health costs are especially steep. Moore of the Portland, Oregon study explains, "For the most part, chronically homeless persons do not have the opportunity to do preventative health care activities prior to enrollment (in supportive housing). Only the worst of the physical problems are attended to while homeless and usually at the most expensive intervention level (ER and inpatient hospitalization). As individuals become more stabilized they are expected to utilize more health and dental services (if available) to deal with persistent and chronic physical health conditions and to utilize more services for minor health issues before they become major" (2006, page 9). By shifting tenants away from emergency inpatient treatment as a source of shelter and care, permanent supportive housing can put its residents in a better position to engage in more regular - and less expensive - outpatient and preventative treatments. For example, the Chicago study found that housing contributes significantly to improved HIV

GRAPH #4

Projected monthly Medicaid savings per resident of the Massachusetts "Home and Healthy for Good" permanent supportive housing program, confirmed by the Massachusetts Office of Medicaid (MHSA March 2009)

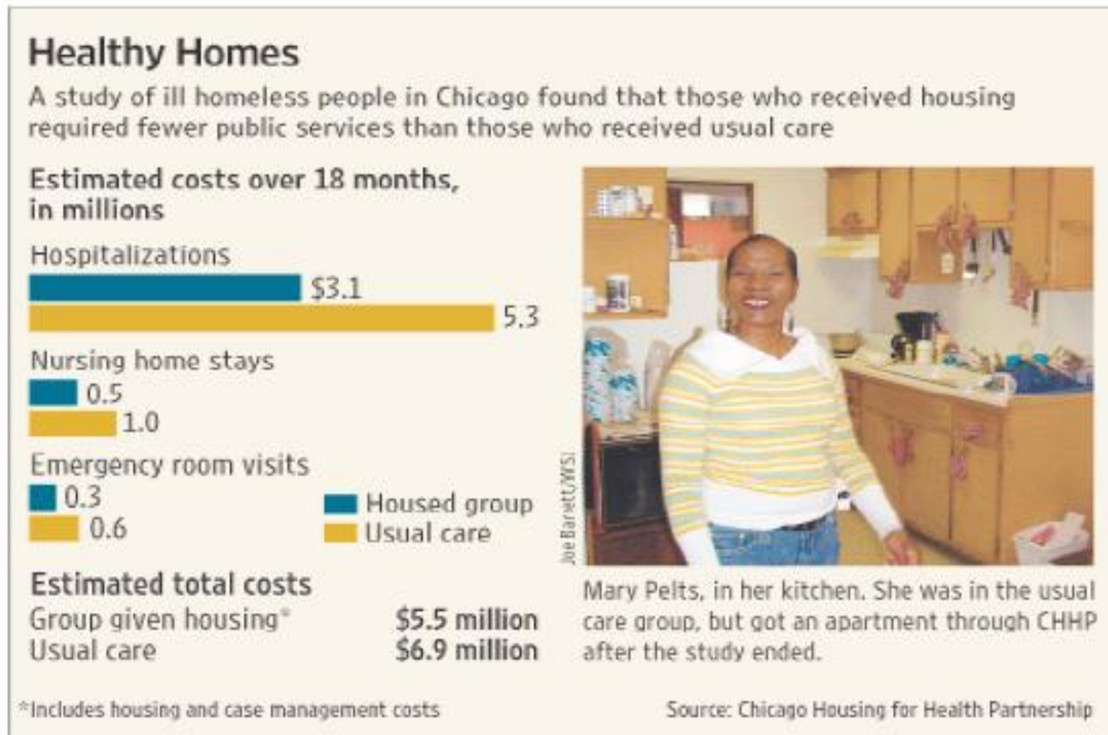


prevention, management and treatment (NAHC 2008). Additional research provides strong evidence that permanent supportive housing offers health care savings to state and local governments and improves treatment outcomes for tenants.

Culhane's NY/NY study found that permanent supportive housing reduced psychiatric inpatient days by 60.8% (2002). In Portland, Oregon, Moore discovered that residents' average inpatient hospitalizations per year fell by 88% after entry into permanent supportive housing; from 1375 hospitalizations the year before the program to 155 hospitalizations the year after entry, for a sample of thirty-five participants. Moore estimates the average cost of each hospitalization at $4,317. In the same Portland report, mental health inpatient nights fell from 355 total nights to 15 total nights for the thirty-five residents, a reduction of 95%, at an average cost of $800 per night (Moore 2006). Mondello's project in Maine identified a 77% cut in hospital admissions after entry into supportive housing, resulting in a 59% reduction in health care costs (2007). Perlman found that two years after entry into the Denver supportive housing project, the total number of residents' inpatient hospitalizations fell by 40%, inpatient nights decreased by 80%, and overall inpatient costs were cut by 66% (2006). For Martinez's sample in San Francisco, the mean number of admissions fell from 0.34 to 0.19 per person. Total admissions fell by 44% (2006). In the Illinois study, nursing home use decreased by 97%, and inpatient days fell by 83%

GRAPH 5

Outcomes of the Chicago Housing for Health Partnership (CHHP) program, linking hospitals and permanent supportive housing units. Featured in the Wall Street Journal, March 6 2008 (Barrett 2008)



at a 25% cut in costs (Nogaski 2009). Results from Rhode Island identified a decrease in hospitalizations from 543 to 149 nights for 50 participants, resulting in an annual cost reduction from $917,946 to $256,131. (Hirsch 2007). For the homeless population, Medicaid is the most frequent payer for mental health and medical services. In the Connecticut Demonstration study, permanent supportive housing reduced Medicaid reimbursement per tenant using medical inpatient services by 71% (Andersen 2000).

Medicaid expenses for Larimer's sample of seventy-seven in Seattle fell 41%, or over $1.4 million, in the first year after entry (2009). In Illinois, the number of Medicaid reimbursed inpatient psychiatric care users decreased almost 20%, and use of related services decreased over 66% for the sample of 177 (Nogaski 2009). The Massachusetts 'Home & Healthy for Good' permanent supportive housing program projected a 67% decrease in Medicaid costs per tenant of the program, from $2,177 per person per month before housing to $708.00 per person per month after housing. This projection was confirmed by the Massachusetts Office of Medicaid, which conducted an analysis of billing claims data to prove that chronically homeless individuals are extremely costly to the Medicaid system (See Graph #3) (MHSA March 2009).

Because of the deep connection between homelessness and public health, partnerships between hospitals and permanent supportive housing projects are a promising development. The Chicago Housing for Health Partnership (CHHP) is one such program which identifies chronically ill homeless individuals at hospitals and helps them transition into permanent supportive housing in order to maintain improved health while working towards long-term stability. CHHP Director Arturo V Bendixen explains, "Too often hospitals in our cities discharge their homeless patients to overnight shelter or other places which cannot meet their special healthcare needs. The CHHP model of service delivery provides our nation with an effective model for assisting this segment of the homeless population and saving taxpayer dollars" (Briggs 2008 page 1). This program was motivated by the fact that 32.4% of Chicago's Cook County Hospital inpatients were at high risk for homelessness. Providing 180 permanent supportive housing units, the CHHP program was able to house a high-risk segment of this population that contained 86% persons with substance abuse disorders, 46% persons with mental illness, and 34% persons with medical issues like HIV/AIDS. The housed group ended up using half as many nursing home days as their counterparts in a control group, and their overall medical expenses were significantly reduced. Patients stayed housed for up to four years and beyond, allowing them to improve their health status, find employment, and increase their independence from public health systems like emergency rooms and inpatient treatment facilities. The Wall Street Journal recently featured the CHHP program in an article on the success of permanent supportive housing as a health intervention. (See Graph #4) (Barrett 2008).

Mental Illness and Addiction Treatment

Research suggests that over 110,000 single adults with severe mental illnesses are homeless every day in the US (Culhane 2002). Understanding mental illness and addiction treatment is particularly important to understanding the chronically homeless population and their needs.

Almost every permanent supportive housing program featured in this literature review was developed to specifically target homeless individuals with severe mental illness conditions, substance abuse disorders, or some co-occurring combination. Often, these conditions are what prevent this population from exiting long-term homelessness on their own. On the other hand, some programs aimed at promoting the recovery of this population require that participants be at a certain stage of recovery or abstinence from substance use in order to receive publicly-funded housing assistance. Permanent supportive housing is different, providing a comprehensive package of both housing and services. All components of a permanent supportive housing program are meant to reinforce each other in order to support a homeless individual's holistic and lasting recovery. If individuals do continue to struggle with their addictions or conditions while housed, "housing first" approaches dictate that service interventions be employed, on-site, to work with the resident in an effort to avoid eviction and a continued cycle through homelessness systems and treatments. Since permanent supportive housing programs strive to overcome the challenges of mental illness and addiction with their tenants on-site, mainstream treatment services reap important benefits as permanent supportive housing programs take on much of the responsibility of caring for this population while simultaneously reducing this population's need for care.

In Seattle, Larimer found that total sobering center admissions for residents of the permanent supportive housing program fell by 87% in the first year of housing, from 6,432 admissions one year before entry to 837 admissions one year after (2009). Moore identified a 93% decrease in alcohol and drug treatment inpatient nights for residents of the Oregon project, falling from 3905 nights to 243 nights for the thirty-five participants in the first year, with each visit costing an average of $100.00 (2006). In the Denver study, Perlman found that incarceration costs were cut by 76% after the first two years of housing.(2006).

Safety and Corrections Services

Studies have also consistently demonstrated that permanent supportive housing can cut public costs for corrections and safety. Chronically homeless persons living on the street tend to have frequent contact with public safety and police personnel. Even more expensive, many homeless persons go through cycles of arrests and jail or prison time as a result of their presence on the street or their efforts to secure food and shelter. Once released from correctional facilities, individuals re-entering the community without housing, employment or other resources usually continue on through the same cycle of chronic street homelessness, returning to the same points of contact with public safety services and correctional institutions again and again.

Notably, Culhane's study found that the NY/NY program reduced days in a correctional facility by 84% (2002). Mondello identified a 62% reduction in incarcerations and a 66% reduction in police contacts in Maine (2007). Perlman found that incarceration costs were cut by 76% after the first two years of the Denver study (2006). For the Portland, Oregon study, incarceration days decreased by 94% after one year in housing, falling from 1478 days the year before entry to 74 days the year after entry for the thirty-five participants. The average daily cost for each day

was estimated at $115.00 (Moore 2006). Larimer discovered that total county jail bookings decreased by 45% in the year after entry into the Seattle housing project. Total county jail days for the same study fell by 42% (2009). A 38% cost reduction was identified for jails in the Rhode Island report. For all fifty participants, jail bookings fell from 919 nights to 149 nights in the first year housed (Hirsch 2007).

Tenant Stability

Of course, the savings offered by permanent supportive housing have no practical value without high levels of program retention. In order to truly end long-term homelessness for this population, permanent supportive housing must offer long-term stability. Evaluations of the permanent supportive housing projects reviewed in this white paper reveal that tenants do remain in permanent supportive housing long enough to substantially reduce their use of mainstream services and recognize the theoretical benefits of the program. The Minnesota study found that while tenants had only spent sixty-four days in their own housing in the 180 days before entry into the program, they spent 144 days in their own housing in the 180 days after entry (NCFH 2009). The Massachusetts study reported a retention rate of 84% stability. Out of 388 residents, 244 remained housed for an average of 1.9 years, 92 moved to other permanent supportive housing, 32 went back to homelessness, 10 were incarcerated, 12 died, and 18 were lost in the system (MHSA June 2009). In San Francisco, 81% of tenants remained housed at least one year, 63% remained housed at least 2 years, and 48% remained housed at least 3 years (Martinez 2006). In Larimer's report on Seattle, 66% remained housed one year (2009). In Denver, 80% of residents remained housed for six months, and 77% remained housed for two years (Perlman 2006).

Beyond retention, another important aspect of stability involves tenants' maintenance of an improved health and wellness condition. Without this kind of mental and physical stability, residents cannot be expected to utilize the services available to help them become more responsible and independent tenants and citizens. Perlman found that in the Denver program, 50% of residents had improved their mental health status, 64% reported improved quality of life, and there was a 15% decrease in substance abuse (2006). For tenants recovering from substance use in Seattle's project, Larimer found that mean number of drinks per day fell from 15.7 at entry to 14 at six months, 12.5 at nine months, and 10.6 at one year. This occurred in a "housing first" approach without abstinence requirements. The number of self-reported days of drinking to intoxication per month for the same sample fell from 28 at entry to 15 at six months, 20 at nine months, and 10 at one year housed (Larimer 2009).

Tenant Independence

While stability is certainly an important ingredient in ending the cycle of chronic homelessness, the lasting value of permanent supportive housing lies in its potential to help tenants achieve eventual independence from the program and other forms of public assistance. Although

permanent supportive housing is still a fairly new model for treating homelessness, preliminary outcomes have certainly shown that permanent supportive housing can equip many tenants with the resources to substantially decrease their reliance of public systems of assistance. In Maine, residents increased their income by 69% (Mondello 2007). In Denver, average income increased from $185.00 per month at entry to $431.00 per month two years after entry (Perlman 2006).

Community Development
Beyond savings in the social service sector and the increased stability and independence of tenants, permanent supportive housing offers general benefits that entire communities can appreciate. Eradicating the presence of chronic and street homelessness promotes community development outcomes with high universal value. In the Connecticut Demonstration, permanent supportive housing increased neighborhood property values for eight of the nine projects reviewed (Andersen 2000). The Furman Center study in New York City revealed a net increase in nearby property values within 1000 feet of a permanent supportive housing development over a five year period (Furman Center, 2008.) In Seattle, Larimer's study compared the six month periods before and after the launch of the permanent supportive housing program to discover that the Downtown Seattle Association's Metropolitan Improvement District reported a 21% decrease in the number of calls for the county sobering unit van (Mondello 2007). No community desires for homelessness to threaten the safety and appeal of its streets. By reducing street homelessness (Larimer 2009), permanent supportive housing is a win-win for both the community and the residents of the program.

Limits of Cost-Study Data

The preceding literature and data review is intended to provide an overview of the current body of research on permanent supportive housing as a solution to long-term homelessness. While merits such as cost-effectiveness and successful outcomes are the foundation for massive national support for the permanent supportive housing treatment model, there are certainly limits to the data and important issues that must be addressed as the housing community continues to refine this model for chronic homelessness recovery.

Capturing All Relevant Costs
As reflected in this white paper, most studies on the service reductions associated with permanent supportive housing are limited to systems of emergency shelter, emergency rooms, public health care, mental illness and addiction treatment, and safety and corrections. There is also limited working knowledge on the benefits accrued through tenant stability, tenant independence, and community development. While savings in these realms have proven significant, there may be other categories of both savings and costs that have yet to be rigorously examined. For example, the costs and savings associated with outcomes such as new income, employment, taxes paid, reductions and increases in public assistance, court time, use of alternative subsidized housing (such as section 8 vouchers), public health insurance costs, food

subsidies, academic or trade skills education, encounters with child protective services, loss of property, harm caused to others, and family-related improvements have yet to be thoroughly explored.

In addition to capturing all categories of costs and savings, there is also the question of utilizing accurate and reliable statistics on cost data. In many cases, emergency rooms and health care providers do not itemize their billing for indigent care. By lumping this kind of care for the homeless into different parts of the different budgets, the data offered by these systems may not provide a complete picture of the actual public dollars spent on care for this population. Exploring permanent supportive housing projects and cost studies in countries with more socialized medical systems or more detailed billing practices would be an interesting start to more accurately understanding the full costs of emergency health care for the homeless.

There is also only limited research on how to make a permanent supportive housing project as cost effective as it can be. The programs studied in the literature review represent a variety of states, each which calculate a different cost for the housing and services provided through their respective permanent supportive housing offerings. We know that on the whole, permanent supportive housing tends to be a cost-effective model. However, as programs continue to emerge, it will be useful to understand best practices for cost efficiency within any certain program. For example, developers can save money by using a scattered-site model that identifies apartments or units already available for rent on the market (Bazelon Center 2009). This would be a much less expensive alternative to developing a new building, but it may not suit the needs of certain specially targeted projects.

Lack of Long-Term Data

As evidenced in the literature review, most studies on permanent supportive housing are fairly recent. While the timeliness of this literature and data increases its relevance and credibility, the limited window of analysis does limit how far we can measure the long-term outcomes of these programs. This is particularly important because permanent supportive housing is approached as a solution for truly long-term homelessness. Before entry into the permanent supportive housing programs reviewed in this white paper, tenants averaged up to 8.6 years homelessness (Moore 2006). Most studies included in this literature review, however, only offer results for a one to two year period since the programs in question were so recently established. This leads to the question; as these permanent supportive housing programs continue, will mainstream service use continue to decline? Will service use increase in some areas and fall in others? Scholars have suggested that the costs of programs may actually peak at the beginning, and as the program continues, costs will fall and even higher levels of savings could be realized. In regards to the Portland, Oregon permanent supportive housing project, Thomas Moore, PhD notes, "Experience suggests that the first year of treatment is the most expensive. Based on this, it is highly recommended that further studies, over a greater period of time, be undertaken to

demonstrate the on-going cost savings…as clients remain stabilized in the community over multiple years" (2006 page i). Moore goes on to explain that in studies on recovery from alcoholism, costs do not usually drop significantly until the third year. It is quite possible this could also be a trend in supportive housing costs. The California study featured a fairly substantial five year window. The authors emphasized that significant reductions like a 62% decrease in inpatient days, 64% cut in inpatient admissions, and 69% reduction of inpatient charges did not materialize until the second year of the program (Linkins 2008). They believed this was the case because tenants experienced a delay in accessing Medicaid treatment needs, such as surgery that had been necessary for quite some time, but could not be funded until enrollment was completely processed.

In a related question, as long-term recovery treatment helps tenants improve their physical and mental health and stability, how will permanent supportive housing programs address the potential "graduation" of participants into independent living? What forms of public assistance will remain necessary, and how will the provision and delivery of those services be managed?

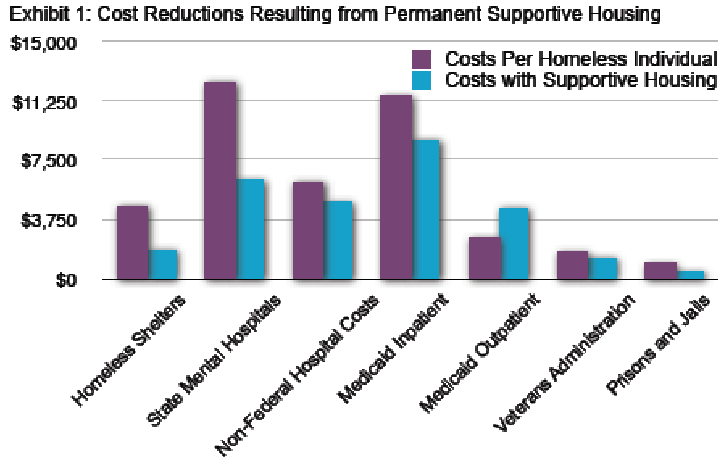
Translating Theoretical Cost Savings

While cost analysis studies identify high levels of savings in the public sector, it is important to note that the cost savings estimated in these reports may not lead to actual monetary reductions in the budget for individual public service agencies. For example, a prison or homeless shelter has already set the parameters of its physical building capacity and salaried staff. It would likely take years of very significant service reductions for these providers to be able to actually eliminate costs like space, capital investments, or staff. While some of the benefits of permanent supportive housing are so significant that they may realistically lead to a cost reduction as extreme as closing or downsizing certain emergency shelters, it is unlikely that savings could lead to the shutdown or downsizing of an established jail or prison that also serves a variety of other populations besides the homeless. However, the costs savings and service reductions in these arenas can certainly improve efficiency and operation within the existing system. Larimer of the Seattle report explains, "In addition to real dollar savings, reduced use of other services by the study population has implications for improved service delivery; greater access to care for other individuals; and increased ability of police, judicial, and jail personnel to focus of issues of higher priority to public safety" (2009 page 1356). In this way, while the savings identified may not always translate into dollar-for-dollar budget cuts, they are certainly of high value to the social service realm and the community at large.

Along the same lines, one concern in establishing funding streams for permanent supportive housing addresses the idea that the savings recognized in one system may not be compensated back to another. For example, the corrections system may accrue many benefits from permanent supportive housing, but that does not necessarily mean the corrections system is assisting with the costs of the program. From the perspective of the state, there are certainly net savings to be realized from permanent supportive housing, but potential individual developers will likely not

GRAPH #6

While some service use does increase after housing, total costs of services usually fall as tenants switch from more expensive emergency care to less expensive regular care (NAEH 2006, page 4)



be able to absorb all the costs of investment. Culhane explains, "The challenge facing proponents of a national strategy to increase the supply of supportive housing will be to determine how costs can be paid for in one area (for housing or housing support services), when the bulk of the savings from the intervention will accrue elsewhere (state mental health services, Medicaid, etc.)" (Culhane 2002) The NY/NY housing program reviewed by Culhane was so successful in achieving and measuring savings because organizers in New York put together a complete "package" of federal, state, and city resources to pay for the operating and service costs of the program. Participation from all relevant parties is therefore required for such comprehensive success. This is why it is so vital to establish collaborative partnerships and lines of communications between all systems involved in the effort to end long-term homelessness. By working together to look at the big picture, more substantial savings and outcomes can be planned and achieved.

Another common question about the savings associated with permanent supportive housing deals with the reality that while inpatient and emergency service usage decreases when housed, outpatient and prevention treatment usage tend to increase. Many critics wonder if these changes offset one another to result in no actual net benefit to systems of health care. As discussed in the literature review, the pattern of switching from crisis care to regular care is real and usually perceived as an important signal of healthy recovery and stability. The Minnesota study is one study that identified this change in service usage, noting that tenants used less detox, inpatient, and corrections services and more pharmacy and outpatient services (NCFH 2009). It is important to recognize that while actual service *use* may remain roughly the same, the resulting *costs* do not. Regular and preventative treatments tend to be much less expensive than intensive emergency care. For an example of the cost savings promoted by changing trends in service usage, see Graph #5 from the National Alliance to End Homelessness (NAEH 2006 page 4).

Medicaid Enrollment and Barriers to Efficiency

As previously stated, services for mentally ill homeless persons are very closely tied to processes for determining Medicaid eligibility. As an important funding stream for permanent supportive

housing, Medicaid is an important factor in the kind of treatment tenants will receive and how that treatment will be funded and categorized. When this funding is difficult to access, the potential for recovery through permanent supportive housing in severely limited and delayed. Specific to Indiana, local scholar and dean of Indiana University's School of Public and Environmental Affairs Eric Wright, PhD explains "There is a need for projects to help people more quickly access mainstream subsidies such as disability determination and Medicaid eligibility. Determination of disability would lead to a consistent source of income, while a determination of Medicaid eligibility would lead to better mental and physical health care… Administrative barriers often restrict access to mainstream programs and decrease the likelihood that homeless people will apply for the programs" (Wright September 2007). Without timely access to Medicaid eligibility and enrollment, it will be difficult for permanent supportive housing programs to maximize savings and tenant outcomes.

A recent analysis of the relationship between existing Medicaid Rehabilitation services and the services needed under a Permanent Supportive Housing model reveals substantial opportunity to serve the needs of long-term homeless persons within the medical necessity guidelines for Medicaid. These services include skills training related to the location, procurement and maintenance of safe, affordable housing, development of appropriate skills for budgeting, negotiating and maintaining one's own home and nurturance of skills for community integration and assimilation. Additionally, case management is indicated to assess, coordinate and monitor the person in his/her pursuit and sustaining of appropriate housing.

There are some necessary supports that do not fit neatly into current Medicaid Rehabilitation guidelines. These include but are not limited to providing liaison services between the supported person and the landlord/property manager; building familiarity with and skill in negotiating tenancy requirements; developing an appropriate housing stock such that applicants are not placed on waiting lists which could be detrimental to their recovery and stability and provision of 24 hour back up to avoid situations which might lead to eviction. These services must somehow be funded if the permanent supportive housing model is to enjoy success in Indiana.

Bringing Permanent Supportive Housing Home for Hoosiers

There is reason to believe that the cost savings and positive outcomes of permanent supportive housing outlined in this literature review could also be recognized in Indiana. In Indianapolis, the Coalition for Homeless Intervention and Prevention (CHIP) contracted with Dr. Eric Wright and the Indiana University Purdue University Indianapolis Center for Health Policy to estimate the public health care and criminal justice-related expenditures of serving homeless individuals who are "frequent users" of public services. The study included ninety-six individuals over three years (2003-2006), concluding that Marion County and the City of Indianapolis expend between \$5,912 and \$15,560 each year in the public health and criminal justice sectors to respond to the needs of the average homeless person with mental illness or substance abuse issues (Wright, July 2007). Many of the individuals in the study also faced significant mental health or substance

use-related challenges. The homeless census estimates approximately 500 individuals fit into this category annually in Indianapolis, suggesting an annual cost of between $3 million and $7.8 million to Marion County and the City. These costs are associated only with public health and criminal justice related expenses and do not include shelter and other emergency services, which could substantially increase these cost estimates.

CHIP also contracted with Wright to study the impact of the 'Action Coalition to Ensure Stability' (ACES) pilot program. ACES served chronically homeless individuals with co-occurring mental illness and substance abuse disorders. Analysis of the ACES program demonstrated a 75% reduction in public health care costs when compared to participants' medical charges before enrollment in the program. These charges accounted for a $9,000 cost reduction for each of the forty-nine clients studied. When extrapolated to the entire 121 clients who participated in the program, estimated savings exceed $1 million (Wright 2006).

While Indiana-specific data is limited to these two reports, the body of research on permanent supportive housing demonstrates that permanent supportive housing offers a humane and cost-effective solution to long-term homelessness. In the words of Culhane, "The emergency assistance system is not appropriate as a source of long-term housing and services for families and individuals in need." (2008). This is just as true in Indiana as in the other states that have recognized massive benefits from permanent supportive housing development. In the Indiana cost studies, Dr. Wright found that for Indianapolis, the average number of inpatient visits per homeless person in a period of 3.5 years was seventy-three. The average cost of inpatient care per person over those 3.5 years was $11,772. This totals $1,130,122 in health care costs for the ninety-six Indianapolis participants studied. Dr. Wright also found that criminal justice encounters for the ninety-six intensive users totaled $599,525 for a 3.5 year period (Wright 2006). These statistics emphasize that Indiana is already paying a high cost to manage the cycle of chronic homelessness. Dr. Wright explains, "Expanding access to (permanent supportive housing) programs - and coordinating this type of care with existing housing and social services - would help provide better care for this high-need population and reduce the financial stress on our criminal justice and public healthcare system" (Wright September 2007). Based on the savings demonstrated by other states, developing additional permanent supportive housing in Indiana could cut these costs and promote a more effective approach to long-term, recovery-based treatment.

Conclusion and Recommendations

In the words of Culhane, a clear leader in research on permanent supportive housing, "Among advocates for the homeless in the US, a truism has long held that homelessness is more expensive to society than the costs of solving the problem" (Winter 2008). By reviewing the body of literature and data on permanent supportive housing, this white paper has intended to demonstrate that permanent supportive housing is a cost-effective, humane, and sustainable

intervention that could bring significant benefits to Indiana's homeless population and public service system.

In 2008, the US Department of Housing and Urban Development (HUD) estimated that there had been an 11.5% decline in chronic homelessness since 2005, or a drop of 20,000 persons. HUD attributes this decline to the funding of 60,000 units of permanent supportive housing since 2001 through the McKinney-Vento permanent housing set-aside (Culhane, December 2008). This point is emphasized by nationally recognized reductions in homelessness in many of the states with permanent supportive housing programs featured in this white paper. According to data from the National Alliance to End Homelessness, in recent years Denver has reduced homelessness by 11.5% in metro regions, including a reduction in street homelessness from 1,000 to 600 persons. Philadelphia and Pennsylvania have reduced street homelessness by over half, Portland has housed 660 of its 1,600 chronically homeless persons, and San Francisco has reduced homelessness by 28% and street homelessness by 40% (NAEH 2006). It is time for Indiana to fall in line, acknowledging that there are high costs to 'doing nothing,' to re-direct the cycle of chronic homelessness and following national trends to establish permanent supportive housing as the working model for treating chronic homelessness (Graph #2). While IPSHI has developed a focused coalition of support and a strong pipeline of projects, research has shown that the combination of housing and services makes permanent supportive housing a success. IHCDA has already committed substantial capital and operating resources to the IPSHI. In order for Indiana to realize the full potential of supportive housing through IPSHI, policy-makers must implement recovery based services, find additional supportive service funding for permanent supportive housing and streamline the process for procuring such funding.

The IPSHI represents an attempt to apply national best practices to the issues of chronic homelessness in Indiana. The goals of the Initiative include:

- Extend the reach of supportive housing to new communities
- Increase the capacity and number of nonprofits providing supportive housing at the local level
- Improve the connection between behavioral health services and housing systems
- Reduce the number of individuals and families who experience long-term and chronic homelessness

To achieve these goals, the initiative is divided into two phases. The first phase is the Demonstration Project (2008 – 2010) and the second phase is the Expansion Project (2009 – 2013). The Demonstration Project (2008 – 2010) includes the following strategies: 1) launch the Corporation for Supportive Housing's Permanent Supportive Housing Institute (Institute) to provide the training and technical assistance needed to bring supportive housing on-line, 2) the development of an Indiana service delivery model using CSH's Dimensions of Quality in Supportive Housing, and 3) the development of financial models and multi-agency funding strategies for housing and services. There is a goal of producing a minimum of 500 units during

the first phase. During the second phase, the Expansion Project, IHCDA and its partners will create an additional 600 units, evaluate the first phase and the permanent supportive housing projects that have come on line, develop best practices based on the outcome of evaluation activities, and establish new target units.

There has been significant achievement to-date on IPSHI strategies. IHCDA has made a multiple year commitment to the Institute to train and develop teams who can create supportive housing projects that meet the parameters for permanent supportive housing. IHCDA has redistributed resources to ensure the financial feasibility of supportive housing including the project based Housing Choice Vouchers, streamlining of the application process, set-asides of HOME Investment Partnership funds and Low Income Housing Tax Credits, creating a pool of funds for pre development activity and technical assistance at all phases of project development. As a result of this commitment, to date, there are nearly 700 units in the pipeline.

In March of 2008, as a result of IHCDA and DMHA talking about how to work together to implement IPSHI, the State's Transformation Work Group adopted IPSHI as a strategic goal for Transformation. A Supportive Housing Work Group was convened as part of the Transformation process. A sub-committee of the Work Group was created to focus on the development of a fidelity model for permanent supportive housing and addressing service funding to support the model. The sub-committee includes DMHA, OMPP, IHCDA, and CSH. The Technical Assistance Collaborative (TAC) is providing technical assistance and consultation to this effort.

The sub-committee met in September 2008 to discuss the IPSHI housing goals; the State's Transformation Plan; the State's work to re-define Medicaid Rehabilitation Option (MRO) covered services and financing and delivery of mental health services; narrowing the gap between the number of units of supportive housing and the services needed and what can be covered under Medicaid and what needs to be covered through other funding sources – either because of enrollment/eligibility guidelines or because the services are not coverable.

The sub-committee developed an agreed upon scope of work and the components necessary to develop an Indiana model. The first task completed was a service delivery crosswalk of the services needed in permanent supportive housing. The crosswalk was aligned with CSH's Dimensions of Quality and includes a description of the role of property management in supportive housing. It identifies those services which can be covered through Medicaid Rehabilitation Option as defined by the Finance and Delivery Transformation work for individuals who are eligible for Medicaid and those services which need to be funded through other sources. It also includes the role of property management in supportive housing and the link between property management and services. Although important to a discussion about funding, this crosswalk has emerged as a fidelity model for what is needed to make supportive housing successful and recognized as a key component of the State's Recovery Model.

In June 2009, the workgroup decided that the model of services described in the crosswalk could serve as the practice and fidelity model for permanent supportive housing service delivery for IPSHI projects. Further, the work group decided to utilize the organizations participating in the Institute to demonstrate the feasibility of this model as the MRO initiative is getting underway. The goal is to align the Expansion phase of the IPSHI with the roll out of Medicaid and MRO changes occurring in July 2010 (Appendix A).

The efficacy of using MRO services as the principal service resource for permanent supportive housing in Indiana is indisputable – it works. Housing is a great stabilizer and people who have histories of refusing to enter the service system or who have dropped out but have very compelling service needs often do well in supportive housing particularly if they are provided choice of units, services are flexible, the housing is affordable, and community resources are accessible. Providing and/or arranging for assistance to consumers with getting and keeping a home is an important endeavor for DMHA and local service providers. With the leadership of the IPSHI, the Community Mental Health Centers in Indiana can help make supportive housing possible and successful for consumers. If strategically pursued, permanent supportive housing can also have an extremely positive impact of the costs of health care and other public services in the state.

This initiative requires consistent clear leadership and additional steps to: (1) provide clarity for community mental health centers on how to build capacity and proceed to implement permanent supportive housing; (2) assure Medicaid eligibility for eligible residents of Permanent Supportive Housing is pursued in a timely fashion; (3) assure regulatory and implementation support of permanent supportive housing;(4) assure community mental health centers can meet MRO standards and achieve fidelity to permanent supportive housing simultaneously; and (5) assure community mental health centers can cover costs associated with effectively implementing permanent supportive housing.

There are three types of costs associated with implementing the program

1. The first is the cost to providers of building capacity to deliver services. Judging from key informant interviews, the IHCDA-CSH Indiana Supportive Housing Institute appears to be an excellent venue for assisting providers to build capacity and is recommended as one approach to accomplish this recommendation. **IHCDA is committed to the training and ongoing monitoring necessary to provide the training and guidance necessary to build and maintain service capacity, as well as developing and maintaining quality permanent supportive housing.**

2. The second cost is the direct services cost for interventions for consumers who are not or have not yet been made eligible for benefits at the time they enter the program. Engaging people when they are living on the street or in a shelter, in jail, or institutionalized can take several months. Providers are more likely to take referrals of more severely disabled individuals who are either homeless or living in a setting where they were precluded from

being eligible for benefits if they can be reimbursed during the 'engagement' period. Engagement typically takes three to four months and this study revealed that it takes approximately the same amount of time for potential permanent supportive housing recipients to gain access to Medicaid benefits. Some of the residents who are otherwise eligible for permanent supportive housing may not meet Indiana Medicaid medical necessity requirements, e.g. those with a primary substance abuse disorder. **Based on the Crosswalk study, these initial and/or non-eligible services will account for about 25% of the service costs at any given time**. To achieve this level of efficiency, DMHA and OMPP need to be full partners with IHCDA and CSH in assuring providers have the tools and support to meet MRO standards with fidelity to quality supportive housing models.

3. The third cost relates to the administrative level of effort necessary to facilitate and sustain positive working relationships between the services and the housing components of permanent supportive housing. This includes active coordination of the roles and responsibilities of both services staff and property managers or landlords. While the services in the Medicaid Rehabilitation Option can be utilized as the primary service model for people in permanent supportive housing, there are costs for providers to deliver high quality services, particularly for people who have not had stable housing, beyond what is reimbursable in the MRO. However, these costs can be identified and incorporated into a single adjustable rate based on cost, or can be packaged into a single definable "service pack" to be used concurrently with MRO services. If state funds are available for this purpose, Indiana can benefit tremendously from the housing and services resources that come with permanent supportive housing.

***GRAPH #7** Permanent Supportive Housing Costs Over Seven Years: Total of 1,400 Units of Permanent Supportive Housing*

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7
IPSHI Pipe Line Units	94	494	894	1200	1400	1400	1400
MRO Service Cost	819,052.08	4,304,380.08	7,789,708.08	10,455,984.00	12,198,648.00	9,758,918.40	9,758,918.40
Non MRO Service Cost	170,452.08	895,780.08	1,621,108.08	2,175,984.00	2,538,648.00	2,030,918.40	2,030,918.40
Housing Costs	564,000.00	2,964,000.00	5,364,000.00	7,200,000.00	8,400,000.00	8,400,000.00	8,400,000.00
IPSHI Costs (MRO Service + Non MRO Service + Housing)	1,553,504.16	8,164,160.16	14,774,816.16	19,831,968.00	23,137,296.00	20,189,836.80	20,189,836.80
Estimated Cost of Long-Term Homeless on Emergency Systems of Care	2,538,000.00	13,338,000.00	24,138,000.00	32,400,000.00	37,800,000.00	37,800,000.00	37,800,000.00
Cost Savings to State	984,495.84	5,173,839.84	9,363,183.84	12,568,032.00	14,662,704.00	17,610,163.20	17,610,163.20

The TAC/CSH report (Appendix A), presents clear evidence that while permanent supportive housing will require state agencies to “change the way they do business” and reallocate funds to this new strategic initiative, the state will benefit both in the realization of cost savings across multiple systems and an improved efficacy in the delivery of services. Permanent supportive housing has three primary costs: capital, operating and service. Graph 7 illustrates the costs for the IPSHI if 1,400 units are developed over a seven year time frame. As this graph illustrates, the primary service funding mechanism is Medicaid MRO. The Medicaid costs are not “new” but simply more closely identified with the permanent supportive housing units they support. In this approach, the state would be required to redirect $2,030,928.40 annually by year six; however, the authors estimate that the state could realize cost savings of $17,610,163 over the “cost of doing nothing.” Clearly, this would be an effective use of state resources and increase the quality of life in Hoosier communities.

The authors believe that implementing this funding along with the attached action plan (Appendix C) will put Indiana in a position to provide national leadership on how a small state can develop and implement a recovery based service delivery model within permanent supportive housing. If the recommendations outlined within this paper are implemented, Indiana will realize cost savings across multiple public and private sectors and the state will improve the effectiveness of its community based behavioral health services. It should be noted that the IHCDA commitment to this effort will produce substantial economic development, including the creation of several hundred new construction jobs over a five year period. Additionally, all 1435 new units are expected to add to the tax base of their local communities.

Action Plan

In order to fully operationalize permanent supportive housing in Indiana and fully realize the cost savings described in this white paper, there are a number of steps that must be taken (Appendix C). First, IPSHI and its partners must develop a State Housing Policy that clearly specifies the need for permanent supportive housing in Indiana for homeless individuals and families experiencing homelessness and individuals leaving state operated facilities at risk of homelessness. Second, add permanent supportive housing to the Division of Mental Health and Addiction Continuum of Care. Third, develop a financial strategy and commitment for closing the service funding gap for the IPSHI units as they are developed. Four, develop strategies to ensure that Medicaid eligibility is pursued in a timely fashion. Five, identify and support the training and capacity building needs required as the State moves from traditional residential models to supportive housing.

By expanding the impact of IPSHI to include permanent supportive housing for individuals leaving group homes, state hospitals and nursing homes, the State can realize even greater systems savings. This strategy should be built on the foundation that has been created through IPSHI by identifying the financial impact and savings; identifying the sources of funding for

development, operating and services; and, developing a strategic plan for implementing permanent supportive housing as a response to more costly residential care models.

As clearly demonstrated in this white paper, permanent supportive housing is a cost effective intervention by helping individuals and families move out of expensive systems of emergency and long term care and back into their own homes and communities. Permanent supportive housing not only improves the lives of its residents, but also generates significant public benefits. By enacting policy cited in this paper that directs funding to permanent supportive housing, the state will improve the delivery of behavioral and primary health services in Hoosier communities and work towards eradicating the negative impact of long-term homelessness throughout the state.

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Appendix A

Recommendations for Utilizing Medicaid Rehabilitation Option (MRO) Services as the Services Platform for the Indiana Permanent Supportive Housing Initiative

May 1, 2010

Purpose

The purpose of this paper is to report findings and recommendations from an analysis of the fit between needed services for people to access and sustain permanent supportive housing as part of the Indiana Permanent Supportive Housing Initiative (IPSHI) and the proposed services under Indiana's Medicaid Rehabilitation Option (MRO). This report also provides information on the Medicaid and SSI/SSDI eligibility of potential IPSHI project recipients and on key cross cutting management issues associated with implementing the Permanent Supportive Housing (PSH) and MRO initiatives.

Background

In January 2008, the Indiana Housing and Community Development Authority (IHCDA), the Transformation Work Group (TWG) of the Division of Mental Health and Addiction (DMHA) in the Indiana Family and Social Service Administration, the Corporation for Supportive Housing (CSH), and the Great Lakes Capital Fund launched the Indiana Permanent Supportive Housing Initiative (IPSHI). The IPSHI is a public/private venture designed to develop a minimum of 1,100 permanent supportive housing units in Indiana over six years for persons who are homeless with challenges of mental illness and substance abuse.

In March 2008, the State's Transformation Work Group adopted IPSHI as a strategic goal for Transformation. A Supportive Housing Work Group was convened as part of the Transformation process. A sub-committee of the Work Group was created to focus on the development of a fidelity model for permanent supportive housing and address service funding to support the model. The sub-committee includes DMHA, OMPP (Office of Medicaid Program and Policy), IHCDA, and CSH. The Technical Assistance Collaborative (TAC) is providing technical assistance and consultation to this effort.

In September 2008, the group began discussion of the mutuality of the IPSHI housing goals, the State's Transformation Plan, and the State's work to improve the financing and delivery of mental health services through re-defined Medicaid Rehabilitation Option (MRO) covered services. Specifically the group discussed how to forge a clear linkage between the PSH units

being developed and the services needed to support people in these units. The group also addressed which people are eligible and what services can be covered by Medicaid and what needs to be covered through other funding sources either because of eligibility restrictions or timeliness of coverage or because the services are not coverable.

The sub-committee developed a scope of work and defined the components necessary to develop a successful PSH model for Indiana. This committee completed its first task, a **crosswalk of the services needed in permanent supportive housing and services in the proposed updating of the state's MRO**. The crosswalk identifies services that are covered through the Medicaid Rehabilitation Option as defined by the Finance and Delivery Transformation work for individuals who are eligible for Medicaid, and also those services that need to be funded through other sources. The crosswalk includes the role of property management in supportive housing and includes a description of the role of property management in supportive housing and the link between property management and services. The PSH/MRO crosswalk was also aligned with CSH's ***Dimensions of Quality***. This crosswalk has emerged as a fidelity model for what is needed to make permanent supportive housing successful and has been recognized as a key component of the State's Recovery Model. The PSH/MRO initiative is an important element of mental health system transformation because:

- **There is a significant body of evidence that permanent supportive housing (PSH) works for people with disabilities, including those with the most severe impediments**. Individuals with the most severe impediments may benefit the most. People with disabilities vastly prefer to live in their own apartment or their own home and supportive housing is less costly than other forms of government-financed housing or residential services. Studies show that PSH leads to greater housing stability, improvement in mental health symptoms, reduced institutionalization, and increased life satisfaction. Adequate stable housing is a prerequisite for improved functioning for people with disabilities; it is a powerful motivator for people to seek and sustain treatment and it is cost effective.

- **Permanent supportive housing is effective when it is created with quality rental housing stock with a deep rental subsidy so people living on very low fixed incomes can afford to live in the community.** Rental resources can come from Housing Choice Vouchers (Section 8), other housing subsidies availability through public housing authorities, McKinney-Vento Homeless Assistance Act funds, and/or deeply discounted rents in units subsidized with tax credits, trust funds, or other sources. People using one of these sources have a standard lease that defines tenant protections but also defines responsibilities for the lease holder. People can access housing even with credit problems or some history in the criminal justice system through reasonable accommodation. The IPSHI is uniquely positioned to gain access to these resources on behalf of people with behavioral health and other disabilities.

- **People will more likely be successful in this type of housing if they have assistance in obtaining and sustaining this housing, if they have a choice in housing, and if the housing is not conditioned on treatment.** Providing services so a person can be successful in their own home is often the major determining factor in a person thriving in the community. The types and amount of services and supports tailored for and successful with this approach are now well defined. Services are individualized and provided in the home and community, and when necessary, include harm reduction, crisis intervention, assistance with negotiating with landlords, neighbors and others, community orientation, and often self monitoring and life skills training. These skills are not necessarily transferable without planning, adaptation, training, and careful oversight.

The body of literature documenting effectiveness of permanent supportive housing is growing and is bolstered by cost effectiveness data emerging from studies from Seattle to Chicago to Massachusetts and Maine and states in between. A summary of this data is referenced in ICDHA's White Paper: "Cost Effectiveness of Permanent Supportive Housing" (August 2009) outlining benefits for Indiana. While this paper focuses largely on the studies of outcomes in PSH projects for people who are homeless, there is strong efficacy of PSH when this approach is used systemically for other target populations as described in TAC's "Literature and Bibliography on Supportive Housing Best Practices" (2010). Most studies show the cost benefit accruing to health care and to a lesser extent behavioral health care. This is largely the result of people benefitting from PSH after continuous or significant episodic use of long term, emergency and/or acute care prior to being offered PSH.

In June 2009, the workgroup decided the model of services described in the crosswalk could serve as the practice and fidelity model for permanent supportive housing service delivery for IPSHI projects. Further, the workgroup decided to utilize the organizations participating in the Institute to assess the feasibility of this model as the MRO initiative begins. The goal was to evaluate effectiveness and practicality of these services and this type of funding. *The added benefit to testing this alignment is the information it can provide for assessing the cost effectiveness of permanent supportive housing for the DMHA priority groups, including people leaving psychiatric institutions and people utilizing high cost Medicaid and other stated funded mental health, addiction, and health related services.*

Summary of Activities

The IPSHI Provider Task Force tested the proposed services model utilizing Medicaid Rehabilitation Services as the primary service platform for persons in permanent supportive housing to determine:

- The number of people receiving SSI or SSA disability benefits prior to or after accessing permanent supportive housing and the time between application and receipt;
- Direct services staff time, by type of direct and ancillary service activity at the unit level, necessary for people to be successful in permanent supportive housing; and
- Other service provider activities essential to the success of PSH, includes the funding and organizational arrangements needed for this initiative to be successful.

Timeframe and Process: The Provider Task Force began meeting in October 2009 and completed their tasks during November and December 2009. At the October meeting, IPSHI representatives provided an overview of the proposed tasks, discussed the PSH/MRO crosswalk, and carried out a pre-test of the simulated time study.

The Provider Task Force members and staff in their organizations completed two tasks. The first task was to determine the percent of persons accessing benefits and the amount of time and effort associated with accessing benefits for consumers. The second task was a simulated 'time study' of direct services for a one-month period. For this study, staff completed weekly worksheets for two to four weeks displaying their time in fifteen minute increments for:

- Direct services potentially billable under the Medicaid Rehabilitation Option (MRO) such as case management and skill training and development;
- Non billable support services activities such as travel, training, documentation, staff meetings, supervision and leave; and
- Activities related to outreach and engagement and property manager/landlord contacts.

This time study was conducted as a simulation using mock profiles of persons with severe mental illness, including those with addiction disorders who have histories of multiple

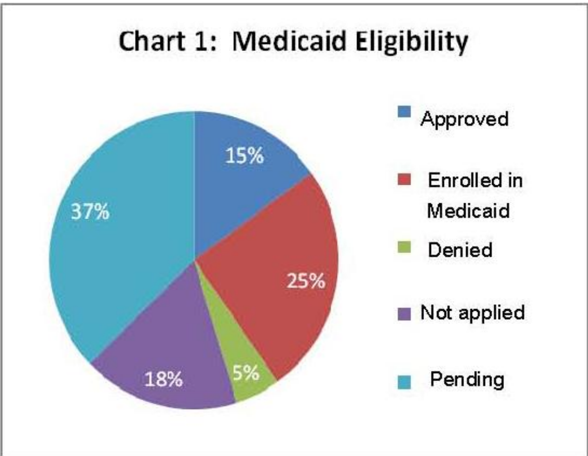
hospitalizations, homelessness, and disruptive lives, and for whom living in PSH would be a significant challenge to them and to staff assisting them.

In addition to the above data collection tasks, each agency assigned administrative staff to participate in key informant interviews to discuss their perspective of activities and resources essential to successful implementation of permanent supportive housing. The key informant interviews also elicited information on the management tasks related to coupling the housing projects with the provision of services covered by the proposed MRO.

Eligibility Analysis

Table 1 depicts the eligibility of a cross section of persons from four CMHC IPSHI caseload (N=40) for SSI/SSDI and Medicaid who had entered the program in 2009. This analysis was conducted to determine the percentage of people on each agency's caseload who have applied for benefits, the status of their applications, and the amount of time between application and receipt of benefits. This analysis is consistent with expectations for a ***new*** caseload of people entering PSH primarily aimed at persons who have experienced homelessness prior to their admission into the program. It is fairly consistent with percentages found for people entering PSH from institutions, jails, or prisons.

Of people entering the program, 25 percent were already enrolled in Medicaid. An additional 15 percent were approved for and enrolled in Medicaid after entering the program; 37 percent of people had made an application which was pending.



The average time from application to approval for Medicaid was slightly less than four months. Five percent of applicants had been denied at the time of the survey and 18 percent who recently entered the program had not yet applied for Medicaid. These findings suggest that over time a majority of project participants can be made eligible for and be enrolled in Medicaid. However, it appears this does not happen immediately.

Forty eight percent of the sample was receiving either SSI or SSDI benefits. Eighteen percent were still appealing a denial of benefits at the time of the survey; several have appealed multiple times. Eight percent were pending approval and 10% were denied and were no longer

appealing their denial. Ten percent had not made application at time of the study. This can be interpreted to project forward that at best, 75 percent of recipients will have a modest income to live on and 25 percent will likely have no income, at least during the first few months of tenancy.

Time Study Data Analysis

Tables 1-4 depict direct and services support activity for five community mental health agencies (Dunn/Centerstone, CMHC, Regional, Southwestern, and Midtown) during the time study period. The centers were asked to report their total time over a one-month period. Each agency utilizes staff somewhat differently depending on their staffing approach and size of their program. However, these differences were adjusted to assure comparable reporting across agencies. A review of the data did not reveal any variations, such as extended leaves or other variables that might have skewed the data. This study did not include any analysis of cost associated with the time spent in each activity.

Table 1 reflects the breakdown between time spent in direct client and collateral contacts as defined in Indiana's proposed MRO service definitions, time (costs) that are directly allocable to individual practitioners spent in activities that support this direct service and time spent in unique Permanent Supportive Housing activities that support people getting and keeping housing. It is incumbent for providers to develop business and clinical practice to assure staff carry out these functions.

Generally providers set productivity targets for direct staff at 55-65% percent of their available time to cover their costs and deliver quality services. Allocable costs include those costs which are critical to practitioners providing services including supervision, trainings, documentation and record keeping, travel and other administrative activities.

As reflected in the PSH-MRO Crosswalk, providers perform two unique duties that are essential to the success of PSH. One is engaging people who have been chronically homeless or cycling in and out of homelessness and institutions, as well as people who have been institutionalized for a long period of time assuring persons they serve will accept housing and can become eligible for housing as well as eligible for services. These activities often occur before or at the same time Medicaid eligibility is being established. Second, PSH providers must secure and maintain contact and agreements with property managers and landlords. A portion of time spent in this activity is not consumer specific or part of the individual consumer's recovery planning. While it is possible this can be accomplished as part of a provider's business practice, it is not advisable to assume this can be fully accomplished as part of standard business practice.

This analysis reveals that the IPSHI PSH and the proposed MRO services paradigms are compatible, that staff can meet likely productivity requirements and agencies can retain fidelity to PSH. There are limited but necessary engagement, outreach and property manager/landlord liaison activities.

Table 1: Total Service Activity

Activity	% of Time
Time spent delivering MRO services	57%
Time spent in allocable activities (travel, documentation and record keeping, staff meetings, training, and leave time)	36%
Time spent in activities related strictly to PSH (outreach, property/landlord contact)	7%

Direct Service (Billable) Activities

The agencies were asked to report on Case Management and Skill Training and Development at the sub-service (activity) level as depicted in **Table 2**. This table presents a breakdown of the percentage of time reported in each of the listed sub-service activities as a percentage of billable time.

Table 2: Direct Service (Billable) Activity

Activity	% of time
Case Management	
1. Needs Assessment	7%
2. Service Planning Development	7%
3. Referral and Linkage	9%
4. Monitoring and Follow-up	11%
5. Evaluation	6%
Skill Training and Development	
1. Training in illness self-mgmt.	8%
2. Skills training (food prep, money mgmt., maintaining a living environment)	11%
3. Training in use of community services	11%
4. Medication related education and training	12%
5. Training in skills related to locating and maintaining a home	16%
6. Social skills training related to work environment	2%

Non Billable Activities

Typically, administrative activities such as: documentation, travel, staff meetings, and supervision are typically built into a rate calculation.

Table 3: Direct Allocable Activities

Routine Non Billable Activities	% of total time	% of non billable
1. Staff meetings, training, and supervision	10%	27%
2. Record keeping and documentation	9%	22%
3. Travel	3%	6%
4. Leave and Other	14%	29%

Table 4: Supportive Housing Related Activities

Supportive Housing Related Non Billable Activities	% of total time	% of non billable
1. Property Manager/Landlord contact	2%	5%
2. Outreach/Engagement	5%	11%

Key Informant Interviews

Seven key informant interviews were held with community mental health administrators and staff directly responsible for supportive housing projects across the sites during November 2009. Key informants were queried about their project approach, their history with supportive housing, and their approach to activities listed on the PSH-MRO Crosswalk (size, start-up and management challenges, how responsibilities are aligned within their agency and allocation of time across the various duties). In addition, there were qualitative and process questions regarding preparation for MRO changes, workforce issues, and staff performance.

With respect to their approach to PSH, all the respondents appear to understand the desired PSH approach and relationship between their work in PSH and the MRO changes to the degree that the information about these changes was available at the time of the interview. Several respondents expressed some concern about workforce preparation and the degree to which there would be a steep learning curve for staff taking on PSH and MRO changes simultaneously. In addition, several respondents displayed a high level of understanding of the differences between providing residential services and providing PSH-related services. One respondent spoke to the paradigm shift that needs to occur with staff as they move toward doing more PSH.

Perhaps the most striking response from several informants was that they would find a way to make these changes work within their agency with current resources because it was the right

thing to do and because it was worth the effort, meaning they do this not because they are paid to do it but because it is the right thing to do. Several respondents described staff being asked to wear multiple hats so that their agency could actively pursue PSH. This means managing PSH services delivery along with their other assigned duties. Additionally, one person indicated the time study reinforced what they already knew about how staff time was allocated.

It became clear during the key informant interviews that the agencies selected for participation in the time study have ‘self-selected’ PSH as a strategic and worthwhile endeavor. All of the interviewees understood the value of the program and the challenges of changing their business and clinical practices to achieve fidelity to the PSH model. While this is a positive reflection on the IPSHI, it remains to be seen how widespread this awareness is with the entire community mental health provider community in Indiana. It also speaks to the need for support for these providers. IHCDA is committing substantial resources that if continued would significantly expand PSH in Indiana. Based on experience in other states, this level of commitment requires a concomitant investment of direct services and services administrative support. To go to scale, provider agencies will need to increase their administrative capacity to manage these programs beyond trying to do it because it is the right thing to do.

Recommendations

The efficacy of using the MRO as described in the draft MRO documents as the principle service resource for PSH in Indiana is indisputable – it works. Housing is a great stabilizer and people who have histories of refusing to enter the service system or who have dropped out but have very compelling service needs often do well in supportive housing particularly if they are provided choice of units, services are flexible, the housing is affordable, and community resources are accessible. Moreover, there is growing and extensive body of research on the efficacy of PSH for very high cost users of emergency rooms, hospital, residential treatment, and nursing homes and other high cost services interventions. Hence, providing and/or arranging for assistance to consumers with getting and keeping a home is an important endeavor for DMHA and local service providers. With the leadership of the IPSHI, the CMHCs in Indiana can help making supportive housing possible and successful for consumers. If strategically pursued, PSH can also have an extremely positive impact of the costs of health care and other public services in the state.

This initiative requires consistent clear leadership and additional steps to: (1) provide clarity for CMHCs on how to build capacity and proceed to implement PSH; (2) assure Medicaid eligibility is pursued in a timely fashion; and (3) assure regulatory and implementation support of PSH;

(4) assure CMHCs can meet MRO standards and achieve fidelity to PSH simultaneously; and (5) assure CMHCs can cover costs associated with effectively implementing PSH.

There are three types of costs associated with implementing the program. The first is the cost to providers of building capacity to deliver services. Judging from key informant interviews, the IHCDA-CSH PSH Institute appears to be an excellent venue for assisting providers to build capacity and is recommended as one approach to accomplish this recommendation. However to do this, DMHA and OPP need to be full partners with IHCDA and CSH assuring providers have the tools and support to meet MRO standards with fidelity to PSH simultaneously. Pre-service training can be helpful to achieving this goal but experience shows staff will need to adopt new skills to shift to the PSH service delivery model that requires resources well beyond pre-service training. This includes resources dedicated to periodic internal and external fidelity reviews and to mentoring and coaching staff who are being asked to shift to delivering PSH services.

The second cost is the direct services cost for interventions for consumers who have not been made eligible for benefits at the time they enter the program. Engaging people when they are living on the street or in a shelter, in jail, or institutionalized can take several months. Providers are more likely to take referrals of more severely disabled individuals who are either homeless or living in a setting where they were precluded from being eligible for benefits if they can be reimbursed during the 'engagement' period. Engagement typically takes three to four months and this study revealed that it takes approximately the same amount of time for potential PSH recipients to gain access to Medicaid benefits. This will have a greater impact during the first year or "start up" year for a PSH project because most new participants are not yet eligible for benefits. In subsequent "maintenance" years, there will likely be a 15-20 percent turnover in PSH tenants, meaning this percentage of participants are not going to be eligible for Medicaid for 90 to 120 days per year. However, since IHCDA will continue to fund new PSH projects, "start-up" will be continuous in some communities. Thus "start-up" and "maintenance" may be blurred and planning for such is advised.

The third cost relates to the administrative level of effort necessary to facilitate and sustain positive working relationships between the services and the housing components of PSH. This includes active coordination of the roles and responsibilities of both services staff and property managers or landlords. From a direct services perspective this is likely 5 percent of the cost of delivering services. If these PSH related administrative costs are added to the costs associated with the costs associated with serving people not yet Medicaid eligible, it is likely to be 20-25% of the cost of serving someone in PSH.

In summary, the services in the Medicaid Rehabilitation Option can be utilized as the primary

service model for people in PSH. There are costs for PSH providers to deliver high quality PSH services, particularly for people who have not had stable housing or been living successfully in the community beyond what is reimbursable in the MRO. However, these costs can be identified and incorporated into a single per diem for a PSH definable service to be used concurrently with MRO services. If funds are available for this purpose, Indiana can benefit tremendously from the housing and services resources that come with PSH.

Appendix B

CSH Dimensions of Quality

Defining the Seven Dimensions of Quality for Supportive Housing
Through communication with supportive housing tenants, providers, funders, and other stakeholders - and through involvement in successful supportive housing projects around the country - CSH has identified the following Seven Dimensions of Quality for supportive housing.

Dimension #1: Administration, Management, and Coordination
All involved organizations follow standard and required administrative and management practices, and coordinate their activities in order to ensure the best outcomes for tenants.

Dimension #2: Physical Environment
The design, construction, appearance, physical integrity, and maintenance of the housing units provide an environment that is attractive, sustainable, functional, appropriate for the surrounding community, and conducive to tenants' stability.

Dimension #3: Access to Housing and Services
Initial and continued access to the housing opportunities and supportive services is not restricted by unnecessary criteria, rules, services requirements, or other barriers.

Dimension #4: Supportive Services Design and Delivery
The design and delivery of supportive services facilitate access to a comprehensive array of services, are tenant-focused, effectively address tenants' needs, and foster tenants' housing stability and independence.

Dimension #5: Property Management and Asset Management
Property management activities support the mission and goals of the housing and foster tenants' housing stability and independence, and appropriate asset management strategies sustain the physical and financial viability of the housing asset.

Dimension #6: Tenant Rights, Input, and Leadership
Tenant rights are protected within consistently-enforced policies and procedures, tenants are provided with meaningful input and leadership opportunities, and staff - tenant relationships are characterized by respect and trust.

Dimension #7: Data, Documentation, and Evaluation
All involved organizations reliably capture accurate and meaningful data regarding the effectiveness, efficiency, and outcomes of their activities, and use this data to facilitate, and improve, the performance of those activities on an ongoing basis.

Seven Dimensions of Quality for Supportive Housing: Definitions and Indicators is available at:
http://www.csh.org/index.cfm?fuseaction=Page.ViewPage&PageID=4435

Appendix C

IPSHI Action Plan

Below are the recommended steps to operationalize the fidelity model and implement the cost savings described in this white paper:

1) Supportive Housing Policy/Plan
    - Develop a State Housing Policy/Plan (determine compatibility of TWG's adoption of supportive housing and the development of a State Housing Policy)
    - Identify roles of each stakeholder and a clearly defined charter agreement including tasks and completion dates
    -
2) DMHA Continuum of Care
    - Incorporate supportive housing definition into the DMHA Continuum of Care

3) Develop a financial strategy and commitment for closing the funding gap for IPSHI units as they are developed (addressing the need for funding between now and July 2011 and reallocated State funds beginning July 2011)
    - Identify the capital, operating, and service costs associated with developing and operating supportive housing;
    - Identify the resources designated for capital and operating (in other words, demonstrate the resources committed by IHCDA);
    - Create a timeline for units coming on line;
    - Determine the level of funding needed to pay for services defined in the crosswalk including Medicaid and non-Medicaid eligible expenses (use the results from the recent analysis of needed services for people to access and sustain permanent supportive housing);
    - Develop the process for allocating the resources (i.e., a state supported rate or fee) with a focus on providing incentives and financial support to centers to implement supportive housing;
    - Identify cost savings to the system; and,
    - Incorporate the financial strategy into the State Housing Policy and request for a service funding commitment.

4) Develop a strategy for ensuring Medicaid eligibility is pursued in a timely fashion.
    - Review Medicaid application process to identify barriers to homeless persons who apply for Medicaid;
    - Review sample of Medicaid denials to determine most often cited reason for denial of cases;
    - Provide additional training for DDS/Medicaid eligibility staff on co-occurring disorders cases;

5) Capacity Building and Training

- Identify the policy and cultural shifts required as the State moves from traditional residential models to supportive housing;
- Use the identified "shifts" as the foundation for on-going capacity building and training;
- Develop and provide capacity building for centers interested in expanding supportive housing options;
- Continue Supportive Housing Institutes and further integrate crosswalk into the supportive housing institute sessions.
- Integrate supportive housing and the crosswalk in trainings on new MRO packages
- Develop and provide capacity building trainings for centers interested in expanding supportive housing.
- Provide on-going support and training once projects are operational

6) Develop a strategy for deinstitutionalization from group homes, state hospitals and nursing homes. The strategy will include housing placement plans and development of supportive housing.

- Incorporate the financial impact of decreasing State Hospital beds
- Incorporate the financial impact and possibility of Group Homes closing
- Include CSH and IHCDA in planning for the shift from a Group Home model to supportive housing
- Share examples from other states of the impact of closing Group Homes without a supportive housing strategy in place
- Work with CSH and IHCDA to develop a strategy for increased funding for operating and services
- Work with CSH and IHCDA to establish housing set-asides for deinstitutionalization
- Include CSH and IHCDA in planning for the shift from a Group Home model to supportive housing