From homeless to housed (and in better health)!

Colorado Health Foundation Symposium
July 25, 2019 1:45-3:15pm
Welcome & Introductions

- Carrie Craig
  - Colorado Coalition for the Homeless
- Katie Bonamasso
  - The Corporation for Supportive Housing
- Katie McKenna
  - Enterprise Community Partners
Supportive Housing
With two examples: FUSE & PFS
How do you describe supportive housing?
Supportive housing combines affordable housing with services that help people who face the most complex challenges to live with stability, autonomy and dignity.
FUSE

Frequent Users Systems Engagement
Thousands of people with chronic health conditions cycle in and out of jails, diversion courts, hospital emergency rooms and homelessness - at great public expense and with limited positive human outcomes.

**Targeted supportive housing** for this most vulnerable and costly of this group can reduce costs while getting better outcomes.

By finding a solution to the frequent user issue, the FUSE program serves as a catalyst for system change.
Communities spend billions of dollars on services that bounce vulnerable people between crisis services. CSH's FUSE model helps break that cycle while increasing housing stability and reducing multiple crisis service use.

**Data-Driven Problem-Solving**

- Cross systems data match
- Track Implementation
- Measure outcomes, impact and cost effectiveness

**Policy and Systems Reform**

- Convene multi-sector working group
- Troubleshoot housing placement and retention barriers
- Enlist policymakers to bring FUSE to scale

**Targeted Housing and Services**

- Create supportive housing, develop recruitment process
- Recruit and place clients into housing, stabilize with services
- Expand model and house additional clients

[Learning more on csh.org/fuse]
Data driven problem solving:
Finding the target population

ER/Hospital Inpatient
Prison/Jail/Courts
Detox
Population

Homeless
Population

Frequent
Users

Chronically
Homeless
30(+) Communities Strong

King Co FACT
KCC/SIF
10th Decile Project
Just in Reach 2.0
Project 25
Maricopa Co FUSE
Clark Co FUSE - Planning
KCC/SIF
Lane Co. FUSE - Planning

Hennepin Co FUSE
Washtenaw FUSE/SIF
Detroit FUSE
Columbus BJA FUSE

Iowa City FUSE - Planning
Denver FUSE
Chicago FUSE
Louisville ACT

Travis Co BJA
Tarrant Co FUSE

Penn Place FUSE
(Hvy)

Integrated Care for the Chronically Homeless

Harris Co MHJD Program

Rhode Island FUSE
CT FUSE CT SIF
NYC JISH
Hudson Co FUSE

Wash. DC FUSE
Fredericksburg FUSE
Richmond FUSE
MeckFUSE

Orlando Hospital FUSE
Palm Beach County FUSE - Planning

Columbus BJA FUSE

Pittsburgh FUSE

Harris Co MHJD
Integrated Care for the Chronically Homeless

Re-entry FUSE
Health FUSE
Health + Reentry focused FUSE
Denver Social Impact Bond Initiative

Enterprise Community Partners
Overview

Pay for Success
(a.k.a. social impact “bonds”)

Upfront Working Capital

Performance Based Contracts
## Denver SIB Initiative

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Why this Target Population?

- Each year, 250 chronically homeless individuals account four:
  - 14,000 days in jail
  - 2,200 visits to detox
  - 1,500 arrests
  - 500 Emergency Room visits
- Each year, the average cost to taxpayers per individual is $29,000, resulting from jail days, police encounters, court costs, detox, ER and other medical visits.
- Each year, the City spends approximately $7 million on 250 individuals to cover the expenses above.

Data Systems & Matching

Health Systems/ Emergency Department
City & County Jail and Detox
HMIS
Denver SIB Project Structure
SIB Services & Connections to Health

CCH
Housing First: A programmatic approach designed to quickly move *chronically homeless* families and individuals off the streets and into *permanent supportive housing*.

Uses *crisis intervention*, *rapid access to housing*, *intensive case management* and *support services* to prevent the recurrence of homelessness.
OUTREACH BEHAVIORAL HEALTH NAVIGATION

A clinical liaison from homelessness to home

• Wellness Plan
  • Link to immediate mental health, substance use and medical care
  • Assesses and makes referrals for urgent needs
  • Navigates health insurance needs

• Crisis Intervention
  • Flexible outreach in community
  • Liaison for homeless community members during transitional time
  • Supports intake and housing placement staff
  • Crisis Phone Coverage

• Wraparound services
  • Link to ACT Team/Supportive Services
  • Treatment Plan/Goal Setting
  • Community Based Referrals

• Disability Verification
  • Help to establish chronic homelessness
Housing Intake & Placement + ACT Team

Finding the Flow- Homeless to Home

**HIPS**
- Initial Outreach and Engagement
- Eligibility Assessment
- Housing subsidy paperwork
- Vital Documents
- Health Insurance
- Goal setting
- Housing Navigation & Placement
- Transfer to ACT Long Term Services

**SIB ACT TEAM**
- Case Management
- Mental Health Care
- Substance treatment Services
- Nursing care
- Psychiatric Treatment & Medications
- Educational and Vocational Services
- Benefits Acquisition
- Peer Mentoring and Support
- Long-term ongoing care
Models of Care:  
_Housing First + Assertive Community Treatment (ACT)_

Interdisciplinary team of professionals who provide intensive wrap around treatment including:

- Case Management
- Initial and ongoing assessment
- Nursing care
- Psychiatric Treatment & Medications
- Educational and Vocational Services
- Benefits Acquisition
- Substance treatment Services
- Peer Mentoring and Support
Service Model: Assertive Community Treatment (ACT)

- 75% of services provided occur out in the community.

- Team approach – staff work with all clients.

- Goal is to support an individual's ability to live successfully in the community.

- Harm Reduction – reducing the overall negative consequences associated with substance use.
Program Outcome Summary through 7/2018

- **Participants are getting housed and staying in housing**
  - 285 participants has been leased up
  - 85 percent of program participants remain in housing without having ever exited the program

- **Participants go to jail less than before**
  - 44 percent of participants had not returned to jail.
  - Prior to the program the target population spent an average of 77 days in jail.
  - Participants who have been housed for at least one year spend an average of 19 days in jail.

Given these outcomes, *housing stability investors* have received a total of **$1,025,968 in success payments** from the City of Denver.
PFS Drives Systems Change

- Cross-sector stakeholder engagement & ongoing partner for a common goal

- The use of data & evidence based practices to inform program development and ongoing project management

- Health & Behavioral Health Systems
  - Use of Medicaid to fund services in SH
  - Recognition from health sector that housing = health care
  - Broad application of ACT

- Criminal Justice System
  - Coordination between Denver DP, Sheriffs Department, Judges, DA’s office, probation & parole
  - Service provider presence at court has helped to reduce sentences for project participants.
  - Jail In-Reach and other exceptions for the project

- Pushing Government to invest in what works and move towards performance based contracts
  - SIB 2.0 – 75 slots performance based contract with CCH outside PFS structure
Questions?