THE BRONX HEALTH & HOUSING CONSORTIUM

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DOHMH Planning Forum Testimony

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The Consortium organized in 2011 with the purpose of establishing a collaborative network of providers in the Bronx with the shared goal of streamlining client access to health care and quality housing. The Consortium is comprised of representatives from health, housing, social service, governmental agencies, and the four Health Homes in the Bronx. The Consortium gained momentum following the implementation of Health Homes as the partner agencies felt an urgent need to increase communication, collaboration, and their shared goal of improving health outcomes for their enrolled clients.

The underlying reason for developing this consortium is based upon the premise that shared housing and health care provider understanding is necessary to support high cost/high need clients who require intensive, coordinated services to achieve improved health outcomes. Yet these resources are costly and scarce. With the recent implementation of health care reform and the establishment of Health Homes to focus on high cost Medicaid populations, it became apparent that the homeless and precariously housed populations are a significant driver of inappropriate health care utilization and high Medicaid costs due to the lack of integrated, coordinated services including stable housing. The coordination among local government agencies, hospitals, and social service providers has created a more comprehensive approach to homelessness that has proven effective.

There are more than 20 nonprofits actively participating in the Consortium. The range of services provided by these groups includes housing, community based health care, social services, behavioral health, harm reduction, and case management to name but a few. There are five government offices regularly represented at Consortium meetings and events. These government officials have been committed to supporting our efforts to formally organize, disseminate information, and advocate for services. Foundation staff and owners of private businesses have also attended events and expressed interest in participating as affiliates and offering resources as appropriate.

The Consortium recently conducted a survey of participating health and housing organizations to determine the key issues that need to be addressed. Several issues emerged including increased housing for Health Home clients who do not meet criteria for existing housing programs, increased availability and access to respite beds, and better coordination between housing providers and hospitals/Health Homes.

HOUSING

We need to build on the momentum around supportive housing and continue to fund and build new housing. Push for release of Medicaid Redesign Team (MRT) funded housing. The MRT housing must serve some of the currently identified populations and expand its admission criteria to address the unmet needs of the more recently engaged clients enrolled in the Health Homes, many of whom are at risk of homelessness. Many Health Home clients do not fit neatly into current housing eligibility criteria so the MRT housing needs to move out of the realm of specialized government funded models such as OASAS, NYS OMH, and NYC DoHMH and work towards achieving integration into OTDA Homeless Housing Assistance Program (HHAP) funded units, NYS Division of Homes and Community Renewal, NYC Housing Preservation and Development (HPD) units that would have social/case management services funded through some MRT resources and rental subsidies funded through some combination of tax credits, HUD subsidies, and MRT funds.

A stronger system to provide support such as rental subsidies and emergency funds to households currently facing eviction is needed. In the Bronx, about 50% of households are spending 50+% of their income on rent. This is not sustainable and as a result, Health Homes and others are working with clients whose housing issues are getting in the way of their ability to keep healthy. We have noted a rising number of people using hospital emergency rooms as temporary housing.

Funding levels are also preventing current programs from providing adequate numbers of units. The OMH rate for Supported Housing beds has not been enhanced to the OASAS rate nor is it adequate to cover rental subsidies as well as case management services. As a result, fewer units are being made available by landlords to people with mental health needs in the community. If rates were raised to a level that corresponds to real NYC rental levels, more units could be made available more quickly. By targeting these units for high cost Medicaid recipients, health care service utilization savings could potentially more than offset the marginal increase in funding levels.

<u>Accountability for the Housing Providers</u>

Funders need to hold the housing operators accountable to provide services to the clients identified in the operating contract.

There is a very fragmented system where the housing operators state that they will provide services to a particular population with a set process for screening and admitting them to units. But the government is not monitoring the contracts and there is no mechanism in place for clients (or service providers) to grieve how they have been processed. Only the SPOA process for SPMI clients has firmly established timelines creating a degree of accountability; everything else is a bit of a free for all.

<u>Centralized Clearing House of Housing Availability and Referral Procedures</u>

There is no central registry of available housing nor is there a clear set of instructions for how to assist clients to access the housing in a timely manner. Although the

vacancy updates managed by the Center for Urban Community Services (CUCS) lists vacancies in the mental health units many of the providers do not consistently provide current, accurate information.

There should be some centralized service where one can enter characteristics about clients and learn the housing options for which they qualify. This service should also include access to application instructions and required forms.

INTEGRATING SERVICES TO SUPPORT PERSONS IN HOUSING

Damp/Wet Beds

The levels of service need to be matched to the needs and abilities of the persons in housing. The level of service intervention needs to be flexible in order to address the changing needs of clients. Services have the goal of increasing housing stability and overall health and wellbeing. Clients who have active substance abuse and/or untreated psychiatric illnesses need to be safely housed in settings where there is a high level of access to service, either on site or through mobile outreach. Services are offered on a voluntary basis unless there is a question of the individual's danger to self or others. Most of this housing is for single adults.

Respite, Step Down, and Transitional Beds

Individuals being discharged from inpatient treatment settings who do not have a place to move require a temporary setting that will continue to work with the client to achieve appropriate long term or permanent housing. These settings would typically serve persons who are engaged in accepting and using services even though there will likely be relapses or other issues. These beds require linkage to services, both behavioral health and medical, as well as ongoing case management to assist with referrals to long(er) term housing.

Step down beds are a way of enabling people to leave hospital by moving to and being specially cared for in a residential care home bed. To be supported through this scheme you must be medically stable and be unlikely to benefit from further time in hospital, but unable to go straight home.

Respite care is the provision of short-term, temporary relief to those who are caring for family members who might otherwise require permanent placement in a facility outside the home.

The concept of ***transitional housing*** has a long history in the fields of mental health and corrections, predating its application to the homeless arena by decades. State and local public mental health and corrections departments developed these residential programs to ease the transition back into regular housing for people leaving mental hospitals or prisons. These community-based transitional programs were developed for many reasons, including a desire to avoid the high cost of institutional versus community-based care and a desire or legal obligation to maintain some intermediate level of supervision over people being released from institutions. One of the historical motivations for developing transitional community residential settings comes closest to the one driving the growth of transitional housing programs for homeless people.

Officials running state agencies and institutions saw people fail in the community and return to institutions when they did not have the skills, connections, or supports that would help them establish themselves independently. Transitional programs were developed to increase the likelihood that those released from institutions would, once reinforced by the learning and development acquired during a period in a transitional program, be able to sustain independent living in the community.[1]

In NYC there are very few options for individuals without permanent housing. Currently there are shelters and 3/4 houses. Health Home patients need access to all three options while awaiting access to long term or permanent housing.

Permanent and Supportive Housing

Permanent housing is a major need. Scatter site rental apartments are a short term solution to the housing shortage. Rents continue to rise and the provision of subsidies to special needs groups, including the Health Home households, squeezes out access for low income working households who do not have the benefit of subsidies. In the long term, this is a lose-lose situation for people who live in the Bronx.

Single site capital projects with mixed use facilities and integrated tenant populations are key to addressing the need sustainably. Construction creates new affordable housing units so desperately needed in NYC and also hold down costs in the long term. The projects enhance the community by providing attractive facilities frequently with 24 hour security. The addition of storefronts and other spaces also contribute to the community by making additional services and resources accessible.

It is important to develop housing that is not segregated by disability group and ideally has a range of tenant incomes so that it is not segregated by poverty level. Housing should be developed by housing agencies and include the special needs groups (and their funding streams) such as NYS OMH, NYS OASAS, HASA, or DoHMH but these buildings need to create opportunities for Health Home households who do not meet the criteria for special needs funding. The special needs groups should not be permitted to use the new MRT funding to interrupt their maintenance of effort thus displacing the Health Home patients from these opportunities.

COMMUNITY BASED SERVICES

Psychiatry

Clients need to have access to psychiatrists at community based outpatient programs within 72 hours of initiating their request. The programs should be able to see clients who have Medicaid pending. Some percentage of slots should be accessible to the uninsured. Clients also need rapid access to medication.

There are lengthy wait times to be seen by community based psychiatrists. Clients resort to using emergency departments to jump the queue at the outpatient department or clinic. This approach to mental health treatment is very expensive and inefficient.

[1] **Characteristics of Transitional Housing for Homeless Families Final Report**; Martha R. Burt; Urban Institute; September 7, 2006.

Hospitals that train psychiatrists should be required to coordinate residencies with community based outpatient psychiatric services to increase the availability of psychiatrists in the community and to reduce time on the wait list. Community based psychiatric services need to make greater use of nurse practitioners and the medical schools need to mandate training rotations in the community based outpatient programs.

For the purposes of special need housing applications, there should be a specialized service to assist uninsured applicants for 2010e housing to be assessed by a qualified mental health practitioner and get a report that can be used to support their housing application. The HRA PACT unit that processes the 2010e housing applications should be required to accept the psychiatric reports signed by licensed nurse practitioners.

ACT/AOT and Other Mobile Psychiatric Services

Each of these services operates very differently depending upon the service provider and the government office providing monitoring and oversight. Uniform standards and a higher degree of accountability are required across all community based services. There also need to be mechanisms for consumer feedback to these services as well as feedback from community based services that share these clients. As part of the monitoring process the regulatory and funding bodies should have structured means for the various constituents to regularly provide feedback and be able to file grievances. Comments, satisfaction ratings, and grievances should be tracked and this information should be included as part of the overall grading/rating that determines the length of operating certificates and potentially the billing rates.

RECOMMENDATIONS

Based upon the need for increased access to housing, dissemination of information related to eligibility and availability, the need for more community based psychiatric resources, and increased accountability the Consortium makes the following recommendations:

1. Use MRT funds in conjunction with OTDA HHAP, DHCR, HUD, and tax credits to create integrated and affordable housing opportunities primarily through capital construction while using scatter site rentals in the short term to provide immediate availability to Health Home patients and their families. MRT funds should create new housing opportunities and be used to supplant other funding.
2. The admission criteria for MRT funded housing must target patients who have high medical utilization rates and are homeless or at risk of homelessness (unstably housed) similar to HHAP definition of homeless. Eligibility criteria for housing status should not be the same as the NY/NY criteria.
3. Per unit funding levels for rentals (scatter-site) housing needs to be increased from current rates in order to rent quality apartments as well as provide the associated case management services required to ensure stability and retention in services and housing leading to reduced Medicaid costs.
4. Increase the availability of respite, step down, and transitional housing units to reduce the frequency and duration of inpatient hospitalizations as well as reduce use of emergency services including hospital emergency departments.
5. Increase the availability of community based psychiatric services by requiring training programs to provide psychiatric residents to community based outpatient treatment programs and making greater use of licensed nurse practitioners to deliver services.
6. There should be a specialized psychiatric service to assist uninsured applicants and those not currently engaged in psychiatric treatment to obtain assessments for 2010e housing applications. Licensed Nurse Practitioners should be eligible to submit reports without a doctor's co-signature.
7. Uniform standards and a higher degree of accountability are required across all community based psychiatric services. Funding and regulatory entities need to monitor regularly to the standards and services defined by the contracts and regulations.
8. Client satisfaction (including housing and community services that share patients with psychiatric services) and grievances should be solicited, tracked, and be a significant component of the ratings that determine length of certification and reimbursement rates.