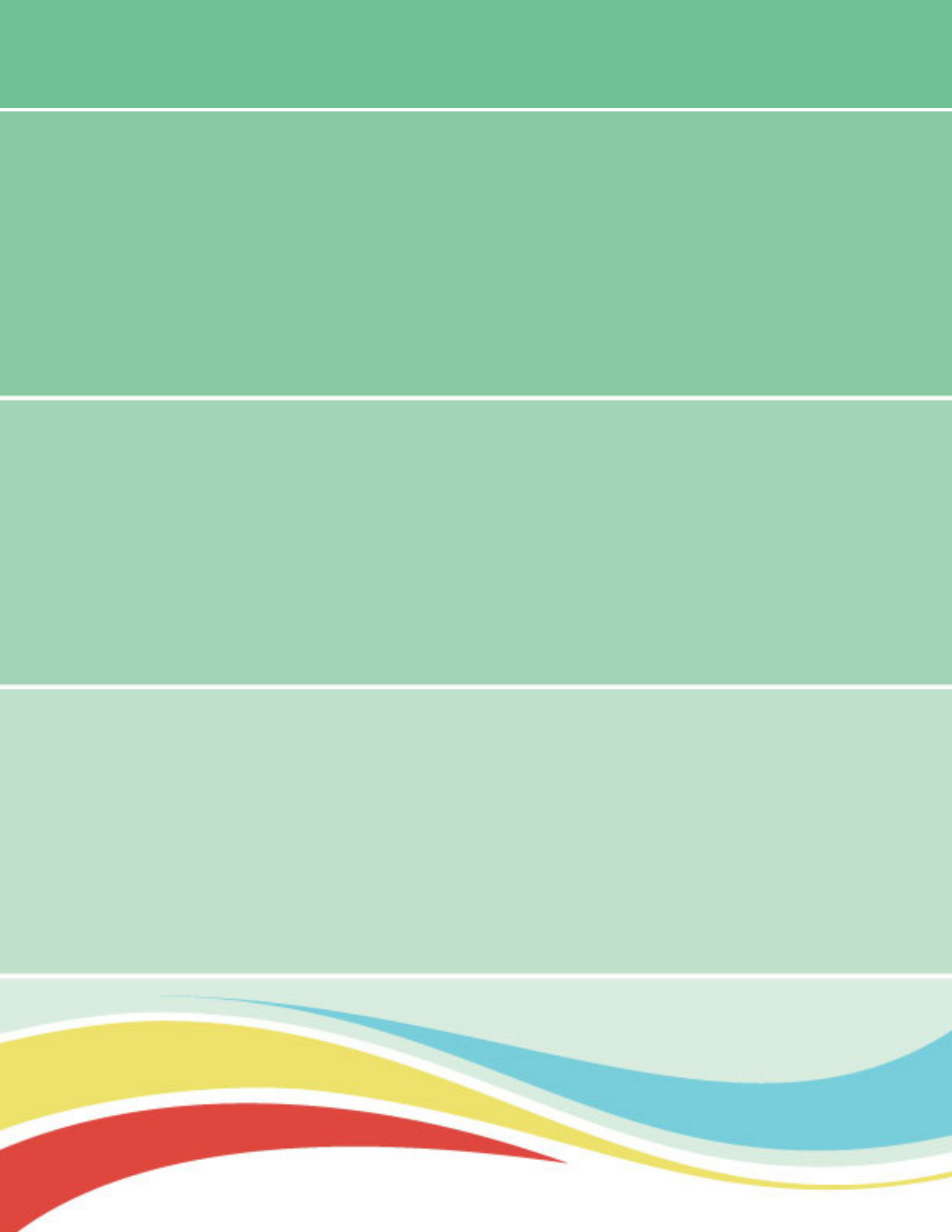APRIL 2021

REPORT ON THE FINDINGS OF THE FLORIDA HIGH NEEDS HIGH COST PILOT

HOUSING STABILITY FOR CHRONICALLY HOMELESS PERSONS WITH HIGH NEEDS

Savings in Community Provided Services

Greater Permanent Housing Retention

Better Personal Outcomes

Florida Housing
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KEY FINDINGS

Studies around the nation show that cost savings to public systems, particularly crisis services, occur when high utilizers of these services are provided with supportive housing. Supportive housing is a highly effective strategy that combines affordable housing with community-based services to help people maintain a stable home. It is a proven model to help people who are not stably housed or who are experiencing homelessness, as well as persons with disabilities who can live independently in their communities with supportive services.

In 2014 Florida Housing Finance Corporation awarded $10 million in housing development financing through a competitive application process to three experienced non-profit developers. The target population at the three properties was extremely low-income persons experiencing chronic homelessness who were high users of publicly funded crisis services. Florida Housing sought providers that were working in partnership with a network of organizations that would be able to provide the service supports necessary for the pilot.

Table 1 shows the Pilot Sites awarded funding.

This report describes and compares the three pilots that were part of the state pilot and summarizes the research evaluating costs to public systems prior to housing compared to after housing was obtained. Findings also include evaluations of residents' personal outcomes prior to move-in and after living in housing for two years. The report discusses concerns that arose during implementation related mainly to the lack of integration in the housing and services infrastructure in Florida, particularly around coordination and funding of services in supportive housing settings. Finally, the report proposes housing and services best practices in serving persons who are high utilizers of public services.

People experiencing chronic homelessness typically have complex and long-term health conditions, such as mental illness, substance use disorders, physical disabilities, and other medical conditions. This report uses the term "high needs" to refer simply to the panoply of conditions many persons experiencing homelessness have. As a result of these often acute, unresolved concerns, these individuals may rely heavily on public crisis services. This report refers to persons in these situations as "high utilizers."

The final research reports for each pilot can be accessed here: https://www.floridahousing.org/programs/special-programs/report-on-the-findings-of-the-florida-high-needs-high-cost-pilot-april-2021.

Table 1. Pilots Funded			
County	**Name**	**Provider**	**Number of Units***
Duval	Village on Wiley	Ability Housing, Inc	43
Miami-Dade	Coalition Lift	Carrfour Supportive Housing, Inc	34
Pinellas	Pinellas Hope V	Catholic Charities Diocese of St Pete	45

* The Duval and Miami-Dade pilots also include residents from other supportive housing sites in their studies.

The three sites in this Florida pilot showed overall savings in community-provided services, some substantial, even after the cost of housing and supports provided to residents was included in their analyses.

- **Supportive housing for persons experiencing chronic homelessness with high needs can save local and state governments money,** particularly services in the public healthcare system such as emergency care, hospital stays and in-patient behavioral health services serving indigent patients.

- **Moving into permanent supportive housing also reduces interaction with the criminal justice system,** reducing costs borne by both local and state governments along with attendant costs to move someone through the judicial process.

- **Resident stability in housing usually decreases supportive service costs over time.** While initial costs to assist a new resident with tenancy supports and service coordination may be high, across the board studies find that as a resident stabilizes in their home, service coordination costs and even services costs usually decrease. Even if a resident continues to need services such as behavioral health care, these costs typically are lower than the crisis services often incurred before housing was obtained.

- **Permanent supportive housing is successful in helping persons experiencing chronic homelessness with high needs achieve and sustain housing stability.** In the Florida pilot, these residents were more likely to increase their incomes, obtain health insurance, and show greater satisfaction with their quality of life.

- **Most pilot residents who had formerly experienced chronic homelessness successfully retained their housing.** All three pilots showed excellent housing retention during the two-year study period.

The results of the state pilot show that this approach can both save money and create strong opportunities for persons experiencing chronic homelessness to succeed in supportive housing. However, Florida does not yet have a robust, integrated housing and services framework in which to promote such programs. When Florida Housing initially sought proposals to fund this pilot, we wanted to fund proposals that showed how well-developed local and regional housing and services partnerships could bring their knowledge, experience and funding to their local pilots. Florida Housing understood that each pilot and its sponsoring organization would need this capacity in order to adapt and forge more sophisticated approaches to successfully serve persons with high needs experiencing chronic homelessness. Those involved in the pilots helped Florida Housing develop the best practices summarized below and more fully described in the report.

> **The three pilot sites showed overall savings in community-provided services and better resident personal outcomes with excellent housing retention.**

HOUSING AND SERVICES BEST PRACTICES IN SERVING HIGH UTILIZERS OF PUBLIC SERVICES

Based on peer discussions with the three pilot leaders about the strategies implemented in their pilots, Florida Housing concludes that the following best practices are important to implement to serve residents with high needs, not only to help these Floridians, but also to create opportunities for cost savings in the state.

Residents' Expectations and Goals. Expectations for residents' optimal stability and quality of life must be based on their own expectations and goals. Use of the Housing First approach in tenant selection responds to this person-centered principle.

Housing Stability Supports and Resident Services Coordination. New residents must have immediate access to supports related to developing and maintaining housing stability; addressing trauma and acute issues; and accessing community-based supportive services, health and behavioral health services, peer supports and motivational interviewing. On-site Resident Services Coordinators are the linchpin for success of this approach. These staff should be overseen by the non-profit housing provider with experience in resident services coordination at appropriate staff-to-resident ratios discussed in the report. The "Housing Stability Framework" model is fully described in the report.

The first 12-24 months are critical. Residents with high needs who have been chronically homeless require intensive resident services coordination particularly for the first 12-24 months after moving into permanent supportive housing.

Experience working with residents with high needs is essential. Experienced, mission-focused housing owners and Resident Services Coordinators are essential to implementation success.

Access to services funding is crucial. Housing providers must be able to access services funding from an established, integrated housing and services infrastructure to achieve long-term success, including funding for resident services coordination.

Local partnerships increase the likelihood of success. From a thoughtful coordinated entry process working with the local homeless Continuum of Care and member organizations, up to the state/regional level with Managed Care Plans and Managing Entities, housing providers need access to an integrated services funding model that ensures residents are efficiently supported. Ideally these entities should be working with housing service providers to clarify roles and responsibilities, as well as how funding can best used to support residents with high needs.

Access to operating assistance for supportive housing that serves residents with high needs will provide for sustainable housing over the long term. The most successful pilots were able to obtain some type of rental assistance that will assist in maintaining the condition of their housing over time. While affordable housing rent levels are lower than market rate rentals, rents are mostly higher than residents with extremely low incomes can afford, much less households that have not achieved housing stability and are high utilizers of crisis services.

Continued predictability and availability of financing to develop supportive housing must occur. The predictability of housing development funding within an established housing and services infrastructure is important for long-term success. Predictability is an important component to increase the capacity of the supportive housing industry. It is critical that Florida Housing continues to provide reliable annual funding opportunities for such housing.

Efforts to coordinate housing and services dollars should be made at the state and local level to support housing providers. While this has occurred on a limited basis through demonstrations or among a few formal agreements between a housing provider and Managing Entity or Managed Care Plan, there is no state infrastructure in place where housing and services funding streams merge to assist the hardest to serve. Currently the responsibility for braiding funding most commonly lies with individual providers on the ground or with the service recipients trying to navigate multiple systems. Interagency collaboration among state policy makers (including Managing Entities and Managed Care Plans) and an emphasis on how funding is prioritized for services and coordination would greatly benefit individuals with high needs. Florida's interagency Council on Homelessness could be a useful starting body for agencies to work together to develop a policy approach, bring funding together and coordinate interagency collaboration to address these issues.

The Housing Stability Framework discussed in the report also would be ideal for persons leaving institutionalized settings, because they need strong supports to live independently. National studies show that savings are garnered from these transitions – supportive housing with a strong housing stability framework is less expensive than institutional settings. In addition, **creating housing stability with intensive wrap-around services for families in the child welfare system** has shown success in pilots around the country.
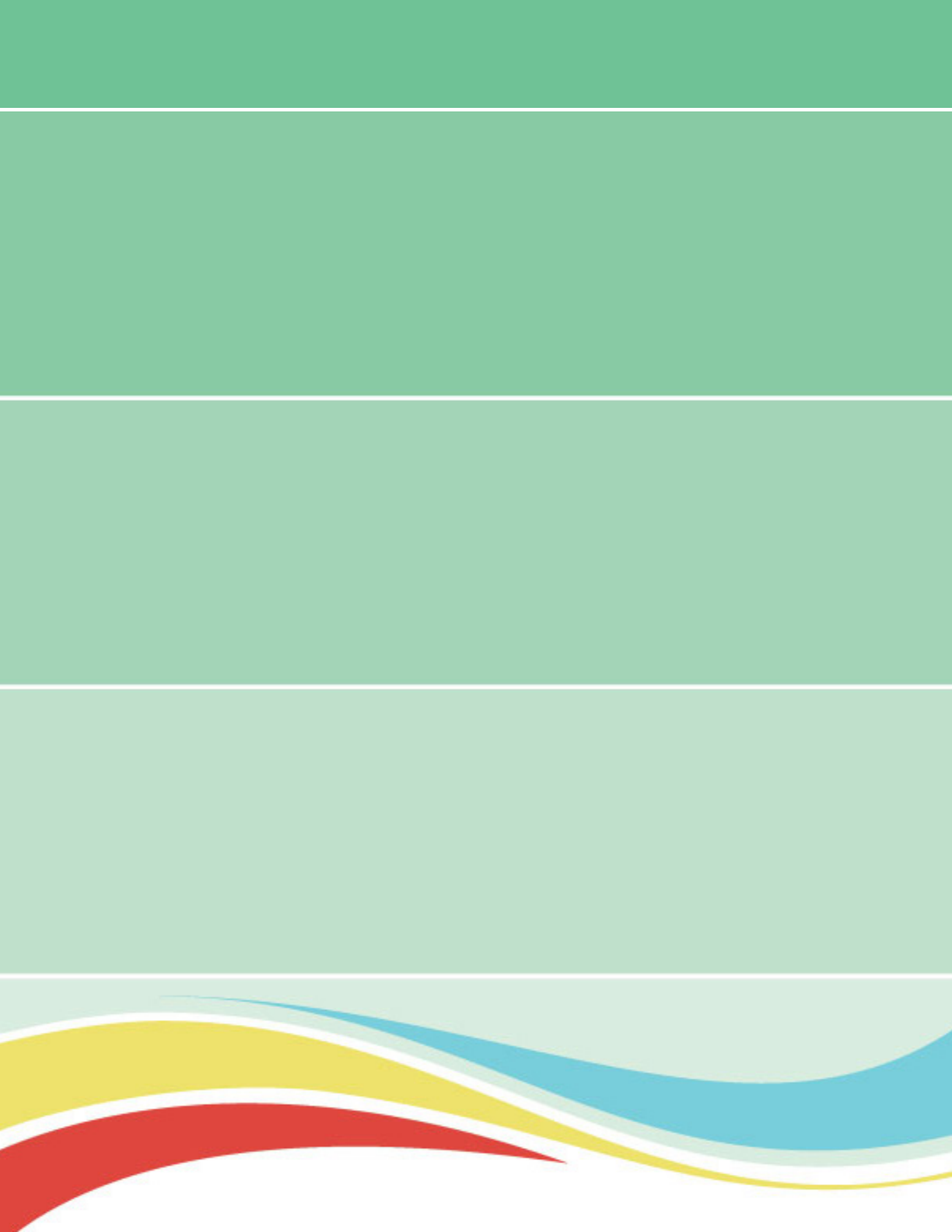
INTRODUCTION

Studies around the nation show that cost savings to public systems, particularly for crisis services, occur when individuals who are high utilizers of these services are provided with supportive housing.[1] Supportive housing is a highly effective strategy that combines permanent affordable rental housing with community-based services to help people maintain a stable home. It is a proven model to help people who are not stably housed or who are experiencing homelessness, as well as persons with disabilities who can live independently in their communities with supportive services.

Florida Housing Finance Corporation is the state's housing finance agency with the mission of financing affordable homeownership opportunities and development of rental housing using federal and state resources. Late in 2012, Florida Housing hosted a forum with state agencies and key stakeholders to discuss best practices to integrate supportive housing and community-based services.[2] The group agreed it would be helpful to pursue a pilot to develop supportive housing targeting persons experiencing chronic homelessness who are high utilizers of expensive, publicly funded crisis services, such as emergency rooms and jails. The purpose of the pilot would be two-fold: to evaluate whether cost savings are possible in Florida when providing supportive housing; and to measure whether residents participating in the pilot could also have improved personal outcomes.

This report describes the Florida High Needs High Cost Pilot and summarizes the results of the cost savings evaluations as well as residents' personal outcomes. After summarizing the pilots' results, the report discusses concerns that arose during implementation related mainly to the fragmentation of the housing and services infrastructure in Florida, particularly around coordination and funding of services in supportive housing settings. Finally, the report outlines housing and services best practices in serving persons who are high utilizers of public services, providing a housing stability framework to guide future work in this area. A glossary of terms is provided at the back of the report.

People experiencing chronic homelessness typically have complex and long-term health conditions, such as mental illness, substance use disorders, physical disabilities, and other medical conditions. This report uses the term "high needs" to refer simply to the panoply of conditions many persons experiencing homelessness have. As a result of these often acute, unresolved concerns, these people may rely heavily on public crisis services. This report refers to persons in these situations as "high utilizers."

Implementation of the Pilot. Using $10 million appropriated by the State Legislature, Florida Housing awarded development financing through a competitive application to three experienced non-profit housing providers with committed local supportive service partners. In addition to the applicant's ability to successfully develop and manage a property and experience serving persons experiencing chronic homelessness, Florida Housing sought housing organizations that were part of a broader community partnership with a network of participating organizations that would be able to provide the services and supports necessary for the pilot.

The Community's Approach to Prioritizing Individuals for Residency. The highest scoring applications described a comprehensive, seamless network of agencies and other organizations to identify and screen potential residents, and coordinate access to community-based supports and resources before and during residency. Key partners expected to be involved in such a network included the local homeless assistance Continuum of Care (CoC) lead agencies and member organizations; Florida's behavioral health Managing Entities, Medicaid Managed Care Plans and providers of supportive services; associated local governments and other entities providing emergency, health care, law enforcement, legal and other services; and associated state agencies/regional offices.

Florida Housing also sought pilots in communities with established approaches to identify, screen, prioritize and assess chronically homeless individuals' interest in and appropriateness for supportive housing, and determine how they would use these approaches to create a pool of prospective high utilizer residents for the pilot sites.

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[1] https://www.csh.org/resources/faq-is-supportive-housing-cost-effective/.

[2] Participating state agencies included the Florida Department of Children and Families, Elder Affairs, the Agency for Persons with Disabilities, the Agency for Health Care Administration (the state's Medicaid office) and the Governor's Office.

Evaluation of Savings and Residents' Personal Outcomes. Each pilot committed to partner with knowledgeable researchers to carry out a multi-year study. The purpose of the research was to evaluate whether cost savings are possible through coordinated local and state public-private partnerships to provide permanent supportive housing – that is, affordable rental housing with supportive services. The research was also required to provide an evaluation of the residents' health, self-sufficiency and other outcomes over the study period. Resident participation in the studies was voluntary.

Each study included costs of any residency/shelter and services for two years before residency, and for two years after the supportive housing and services were provided. In addition to housing costs, the public system utilization costs include the judicial system, emergency shelters, emergency and inpatient hospital/clinic stays, physical and behavioral health services and other homelessness services.

Each of the three pilot sites used advanced-degree researchers currently or historically associated with universities or institutes in multi-disciplinary areas of public and behavioral health, criminal justice and other capacities. Each study was done separately from the others, although Florida Housing regularly convened meetings for the pilot peers to resolve data compilation issues related to the studies and share successes and seek guidance with the implementation of their pilots. The three research designs were reviewed by Florida Housing, the Florida Department of Children and Families (DCF) and Agency for Health Care Administration (AHCA) staff before implementation. The three pilot reports may be found on Florida Housing's website. https://www.floridahousing.org/programs/special-programs/report-on-the-findings-of-the-florida-high-needs-high-cost-pilot-april-2021.

Research Design. Each pilot evaluated two key questions:

- Are there cost savings to public services in Florida when chronically homeless, high utilizers are provided supportive housing and services? If so, what are they?

- What are the quantitative and qualitative outcomes of residents' health and well-being over the study period?

As described below, all pilots showed cost savings, as well as increased resident perceptions of quality of life, better health indicators, and where measured, increased resident income and/or benefits such as insurance.

THE DESIGN OF EACH PILOT

Pilot Sites awarded funding were:

- **Duval County**
  - Village on Wiley, a 43-unit property, new construction.
  - Housing Provider: Ability Housing, Inc.
  - Another 49 residents with high needs were housed in scattered-site units throughout the area and were part of the pilot evaluation.
  - Supportive services were provided by a contracted service provider and a substance use treatment provider, as well as through other referrals.
  - All of these residents received the same level of services and were invited to be part of the research; ultimately, 68 participated in the evaluation.
  - Researcher: Health-Tec Consultants, Inc.

- **Miami-Dade County**
  - Coalition Lift, a 34-unit property, acquisition/ rehabilitation.
  - Housing Provider: Carrfour Supportive Housing, Inc.
  - Carrfour provides many supportive services to its residents and partnered with Citrus Health Network, a Federally Qualified Health Center (FQHC), that provided additional services.
  - In this pilot, there were three separate study groups: the residents at the Coalition Lift property who chose to participate in the study, an additional 11 formerly homeless residents in units scattered throughout the area, and 21 individuals who were not housed and remained homeless or didn't seek housing services during the pilot. This pilot did separate evaluations of each study group to determine whether savings were possible when differing levels of service were provided for these groups.
  - Researchers: University of South Florida Policy & Services Research Data Center and Behavioral Science Research Institute.

- **Pinellas County**
  - Pinellas Hope V, a 45-unit property, new construction.
  - Housing Provider: Catholic Charities, Diocese of St Petersburg.
  - This property was built on an existing campus run by Catholic Charities to serve people experiencing homelessness. The campus provides various housing options, including emergency shelter, transitional housing and permanent housing.
  - Catholic Charities hired Resident Services Coordinators. Some additional services were provided by Catholic Charities. Funding also supported on-site behavioral health care.
  - All residents at this property were invited to participate in the study; in the end, 22 residents chose to participate.
  - Researchers: University of South Florida, including its Policy & Services Research Data Center.

The Properties' Physical Settings

The Duval and Miami-Dade properties are both in-town settings with access to public transportation, amenities and services. As stated above, the Pinellas property is part of a campus with a variety of homeless shelter, transitional and permanent housing options. This property is in an industrial, somewhat rural part of the county with limited access to public transportation, community services, commercial businesses and amenities.

The Resident Referral and Selection Processes

All three pilots used a "Housing First" approach to resident selection. Under Housing First, permanent housing is provided without conditions. This means that properties accept residents without prior requirements for sobriety, compliance with medications or participation in programs. After the resident has moved in, properties following Housing First principles limit lease terminations to severe lease violations and only after strenuous efforts to resolve any problems, along with continuing services to assure housing stabilization in the resident's unit.

As stated by the National Alliance to End Homelessness:

> "... housing is meant to serve as a platform from which residents can pursue personal goals and improve their quality of life. This approach is guided by the belief that people need basic necessities like food and a place to live before attending to anything less critical, such as getting a job, budgeting properly, or attending to substance use issues."[3]

The Housing First approach incorporates resident choice in both housing selection and participation in supportive services and prioritizes supports to help new residents stabilize in their housing.

Both Duval's and Miami-Dade's resident selection processes were embedded in their local homeless coordinated entry processes. Miami-Dade's approach formally integrated more facets of the community's

public systems of care than either of the other pilots. This pilot's approach started by gathering lists of the persons who were the highest utilizers of publicly funded services in each of five local systems in the county: the criminal courts, the Miami-Dade Homeless Trust CoC Homeless Management Information System (HMIS), Jackson Memorial Hospital (the county's indigent care public hospital), Thriving Mind South Florida[4] and local homeless outreach teams.

> **Housing is meant to serve as a platform from which residents can pursue personal goals and improve their quality of life.**

The 800+ individuals on the resulting list were first ranked in each system, and then combined and statistically ranked based on highest service utilization. Individuals in the study often were found across more than one system and likely impacted all systems. Then Miami-Dade pilot staff worked with homeless system coordinated entry partners to locate and recruit individuals, ultimately looking for the top ranked 300 people on the list to recruit into the pilot. Once the person was located, engaged, and agreed to housing, the intake was processed through the county's coordinated entry system for official referral. Most residents in this pilot came off the streets with limited previous interaction with homeless services.

The Duval Village on Wiley pilot used the Northeast Florida Homeless CoC Coordinated Intake and Assessment pre-screening process with the VI-SPDAT to identify and recruit participants.[5] However, these initial screenings with the VI-SPDAT did not always

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[3] https://endhomelessness.org/resource/housing-first/.

[4] Contracting with the Florida Department of Children and Families as the South Florida Behavioral Health Network.

[5] The VI-SPDAT = The Vulnerability Index–Service Prioritization Decision Assistance Tool is a commonly used pre-screening triage tool to quickly assess the health and social needs of persons experiencing homelessness and match them with the most appropriate support and housing interventions that are available. The VI-SPDAT allows homeless service providers to similarly assess and prioritize the universe of people who are homeless in their community and identify whom to treat first based on the acuity of their needs.

delineate high utilizers, and the Duval pilot did not have the capacity to trace someone across all public systems such as was done in the Miami-Dade pilot. To address this the housing provider, Ability Housing, created a document that the CoC used to further screen referrals to measure crisis service utilizations – essentially a modified version of the relevant parts of the VI-SPDAT, along with individuals' self-reported information about utilization of public systems. Duval pilot leaders estimate that approximately 75 percent of the residents in its pilot came from the streets, and the rest from emergency shelters.

The Pinellas pilot was in a different position because at the time of the pilot launch, its county's coordinated entry system was still in development. As a result, many of the homeless individuals initially referred to the pilot were not high utilizers.

As the process was refined, Pinellas coordinated entry system managers began sending clients who scored the highest on the VI-SPDAT – meaning they were the most vulnerable – rather than evaluating clients based on their high utilization of public services. The Pinellas pilot did not have appropriate services in place to support this extremely vulnerable group and, consequently, there was high resident turnover at the Pinellas Hope property in the first year. Over time, the staff at the Pinellas pilot worked with the coordinated entry system to take referrals who were high utilizers, but less vulnerable and more appropriate for the level of services that were available at this pilot site. Most residents moved into the property from an emergency shelter, but a few also came out of medical respite facilities or social service programs.

Public Funding to Support Housing

Financing from Florida Housing and other mainly public sources paid for the three properties' development costs. Because most residents with high needs were moving in with minimal or no income to pay rent, additional operating support was critical to ensure that the properties are sustainably maintained over the long term.

Miami-Dade and Duval applied for and received grants from their homeless CoCs to support operations for a portion of their units. Miami-Dade also obtained rental assistance from the US Department of Housing and Urban Development through a local public housing authority (typically a 20-year contract for project-based vouchers).

Catholic Charities chose not to seek rental assistance for the Pinellas pilot. As a non-profit with a model that relies on private donations to operate many of its programs, Catholic Charities originally charged residents of the Pinellas pilot 30 percent of their income for rent, expecting to make up the difference in donations. However, Catholic Charities found that over half of the residents initially paid no rent because they had no income. Ultimately its rent structure was changed to require that all residents pay something toward rent. After the pilot phase was completed, Catholic Charities began seeking rental assistance from the local public housing authority to assist with these costs.

Supportive Services Approaches and Partners

While all three local pilots operated somewhat differently, two core tenets guided each pilot. First, services were resident centered. This means that expectations for residents' optimal stability, self-sufficiency and quality of life were based on each resident's own expectations and goals.

Second, each pilot's service model included an overarching framework to promote housing stability. Traditional supportive housing integrates community-based services with housing to promote independence and successful personal outcomes for residents. Some residents require more services or services over a longer period. But as the three pilots were evaluating the success of their pilots, everyone agreed that a more robust support framework made a difference. We found that for the residents with high needs, it was crucial to employ a more robust, person-centered "housing stability" approach to help residents both obtain and maintain permanent homes.

In addition to traditional services, such as coordinating access to community-based health care and education/employment supports, this approach incorporates a set of "tenancy supports" matched to the needs of each resident. These support services must be implemented immediately upon residency, if not before. They orient and support residents in the basics of what goes into living independently and successfully in a home, such as housekeeping, coaching on developing relationships with property managers and neighbors, directly interfacing with property managers as needed to assist with issues residents may have, and banking and shopping for necessities.

In addition, more intensive services, such as psychiatric medication management, are often needed to support the high needs of most residents in the pilot.

However, when working with a resident with high needs, it is not enough for tenancy supports and other supportive services simply to be made available to a resident. Staff must work more closely and frequently with residents than is often done in traditional supportive housing to integrate all services and supports tailored to each person's individualized needs to help them achieve housing stability and access needed community services, including health related services.

Supportive housing properties financed by Florida Housing currently are required to make service coordination available to all interested residents. Service coordination requirements at most of these properties are focused on ensuring that residents are assisted with referrals to community-based services. Currently, housing stability services are not required as part of this service. In addition, Florida Housing's coordinator qualifications and experience requirements are not as extensive as those found to be important in this pilot. Even without Florida Housing requiring tenancy supports, many supportive housing properties do provide these supports to assist residents with managing lease problems when they occur to help them keep their housing.

To ensure that services are provided within an integrated framework, pilot leaders found key clinical tenets were necessary to support these residents. Chief in this approach to promote an assertive and integrated approach to providing services and supports, each pilot employed multiple Resident Services Coordinators full time and on site to work closely with residents to develop and implement housing stability plans responsive to the needs and desires of each resident. These coordinator positions were provided in addition to other on-site staff who assisted residents with services.

Pilot implementers agreed that these coordinators should be highly trained and experienced in serving residents with high needs and should be part of a team of people dedicated to helping each resident achieve housing stability. Each pilot's Resident Service Coordinators also worked to ensure that services tailored to each resident were made available, including access to transportation to access community-based services and programs.

Resident Services Coordinators do not take the place of targeted case managers, although there may some overlap between what both positions do. Compared to Resident Services Coordinators, targeted case managers more narrowly focus on behavioral health care for their clients. When case managers work on Intensive Case Management teams, they are typically responding to crisis situations such as treatment to keep clients from being re-hospitalized or placed in crisis units rather than being focused on developing longer term supports to help residents stay stably housed.

While these two approaches overlap at times, the technique used in this pilot calls for ongoing support across a range of supports for residents, from learning how to live independently, to a variety of services, including behavioral health care as needed, to help a resident live independently. It is possible that with

> More intensive use of highly qualified Resident Services Coordinators on site was critical to the success of the pilots.

Resident Services Coordinators in place, there may be less need for targeted case managers; however, this pilot did not evaluate this hypothesis. **Appendix A** outlines training, skills and experience requirements recommended for Resident Services Coordinators.

Only the Miami-Dade pilot implemented a team-based approach with Resident Services Coordinators as a core part of its team. While the Duval pilot did not use a team approach, Ability Housing, the housing provider, oversaw the hiring and day-to-day work of its Resident Services Coordinators to ensure those employed in these roles were experienced and capable of working with residents with high needs.

In the Pinellas pilot, Resident Services Coordinators worked more on their own without strong linkages to outside community-based services providers. Thus, they were required to be more reliant on their own skills, knowledge and resourcefulness. Those running

the Pinellas pilot learned from their experience that it was problematic to rely on less experienced Resident Services Coordinators, in particular because this pilot had fewer linkages to community-based services. Less experienced Pinellas coordinators tended to simply solve residents' problems rather than helping residents to build their own capacity to solve problems as they arose.

Appendix A provides an overview of the housing stability framework, including tenancy supports, a list of supportive services typically provided in traditional supportive housing, more intensive services for residents with high needs, and the clinical framework for providing housing stability supports and services to high utilizers. A detailed Resident Services Coordinator position description used by the Miami-Dade pilot based on what was learned in that pilot is provided at the end of the appendix.

Service Models Implemented by the Three Pilots

The three pilot sites used different service models to support their residents, summarized in **Appendix B**. Miami-Dade had an on-site clinical model, whereas Duval used a more traditional tenancy support model, linking people to services in the community, but with stronger on site resident services coordination and tenancy supports. Pinellas deployed services as much as possible, though was underfunded in this area.

Miami-Dade. This pilot's housing provider, Carrfour, has separate housing development and services arms in its organization, and it mainly relies on its affiliated subsidiary for property management services. To provide additional services on site and off site, Carrfour with Citrus Health Network, an FQHC and a community mental health provider, encompassing medical and behavioral health care with its own funding streams to augment the pilot's services approach.

At the Coalition Lift property, an array of clinical and community-based services was made available to promote housing stability and achieve other personal goals. Residents received intensive services through a wrap-around trauma-informed care team similar to the Assertive Community Treatment (ACT) model, with housing stability Resident Services Coordinators and many supportive services available on site. In addition to trauma-informed care, the modified ACT team incorporated motivational interviewing and formal peer supports to support residents' work toward independence.

The Carrfour/Citrus team provided housing-focused resident services coordination and mental health services on site based on need. Services funded through the CoC paid for Resident Services Coordinators; peer specialists; nursing case management; SSI/SSDI Outreach, Access, and Recovery (SOAR); life skill training, education and employment supports; food and transportation; utility assistance; and health care costs not covered by other funding (e.g., Medicaid or mental health services).

The group of residents living in scattered sites received supportive services more traditionally provided in supportive housing, focused on developing independent living skills, providing support with treatment and supporting contact between residents and their external support systems, rather than the ACT team approach with Resident Services Coordinators and more intensive health care services.

Duval. This pilot's housing provider, Ability Housing, is an affordable housing developer-owner that specializes in supportive housing. This developer has an internal resident services coordination arm that evaluates and pairs residents at its supportive housing properties with appropriate external services and actively oversees implementation and effectiveness on behalf of its residents. Ability Housing contracts with an external property management company to oversee day-to-day operations at many of its properties.

For this pilot, Ability Housing partnered with the Sulzbacher Center to provide resident coordination services that incorporated a strong housing stability focus. At the pilot outset Ability Housing itself paid for these Resident Services Coordinators, because no specific

public funding was available to pay for coordination services. However, Ability Housing knew that housing stability resident services coordination was critical to the success of its residents with high needs in this pilot and continued to seek funding to support this approach.

Ultimately, Ability Housing obtained funding through grants from Florida Blue and the CoC, as well as a small amount of funding from Lutheran Services Florida, the area's Managing Entity, to pay for Resident Service Coordinators and some other services.[6] Ability Housing's on-site partner for substance recovery services was Gateway Community Services, which provided its own funding source to pay for services it provided to residents.

Additionally, residents in the Duval pilot received certified peer support counseling; SOAR services; Medicaid/Medicare enrollment; transportation services; access to employment services; and enrollment into primary/specialty health care services. Scattered site residents received the same access to case management and services.

Pinellas. This pilot's housing sponsor, Catholic Charities, is a housing developer-owner that manages its properties and provides basic services directly to residents. This pilot's service model is different still, relying mainly on the Resident Services Coordinators hired by the housing provider, Catholic Charities, to provide most of the supports for residents. These coordinators focused mainly on providing tenancy supports and limited referrals for community-based services. Residents at the property also had limited access to on-site nursing staff who had health care oversight of the entire campus. Resident Services Coordinators were paid for with a multi-year grant from the County to Catholic Charities. To supplement the coordination of services provided by Catholic Charities staff, the pilot included a partnership with three local behavioral health care agencies using a Cooperative Agreements to Benefit Homeless Individuals (CABHI) grant to provide services to residents.[7] When the federal CABHI grant ended, the County continued to support these on-site behavioral services.

At the beginning of the Pinellas pilot, Catholic Charities' approach to service provision was to rely mainly on its own staff for basic services, along with the externally provided behavioral health services. When Catholic Charities changed leadership during the pilot, new leadership began to reach out to develop more community partnerships with service providers to lessen reliance on its Resident Services Coordinator staff to act as subject matter experts across the spectrum of resident needs.

Resident Services Coordinator-Resident Ratio. HUD reports that a strong evidence base exists for "high-acuity" populations – i.e., a person's level of illness severity or their severity of needs – to be served through an integrated team staffing model approach with a ratio of no more than 1-to-20 for high-acuity populations. High-acuity staffing models that focus on an individualized approach versus a team approach are recommended to address smaller caseloads sizes and should not exceed a 1-to-15 staff to client ratio.[8]

The Miami-Dade pilot's housing stability Resident Services Coordinator staffing-to-resident ratio was the lowest, at one Resident Services Coordinator for every 17 residents. Duval's ratio was 1-to-20, and Pinellas's resident services coordination ratio was 1-to-24 residents. In interviews with the pilot leaders after the completion of the pilot, the Miami-Dade leaders expressed satisfaction with their pilot's 1-to-17 ratio. The Duval pilot's leaders suggested that, particularly at the start of the pilot when many new residents were moving in at once, it would have worked better to have a lower services coordination ratio of 1-to-15, but that after residents were settled and began to stabilize, the 1-to-20 ratio worked well. In the Pinellas pilot, the Resident Service Coordinators worked more on their own without the same type of support team as the Miami-Dade pilot or the community-based partnerships of the other two pilots. Pinellas leaders thought that a 1-to-15 ratio would have worked better throughout the pilot.

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[6] Managing Entities are under contract with the Department of Children and Families to provide funding and oversight for behavioral health services.

[7] CABHI funding is part of the federal Substance Abuse and Mental Health Services Administration (SAMHSA).

[8] COVID-19 Homeless System Response: Primer on Serving People with High-Acuity Needs at https://files.hudexchange.info/resources/documents/COVID-19-Homeless-System-Response-Primer-on-Serving-People-with-High-Acuity-Needs.pdf.

Findings of the Florida High Needs High Cost Pilot

THE RESEARCH AND OUTCOMES

Each pilot evaluated two key questions:

- Are there cost savings to public services in Florida when persons experiencing chronic homelessness who are high utilizers of public services are provided supportive housing and services? If so, what are the savings?
- What are the quantitative and qualitative outcomes of residents' health and well-being over the study period?

Cost/Benefit Evaluation Overview
Research Methods. To carry out cost savings evaluations, the research teams from the three pilots obtained Medicaid and other public cost data from the State of Florida. The teams also obtained information on emergency shelter stays and homeless services data, along with local jail cost data. Duval was also able to obtain arrest data as well as emergency services data from the Jacksonville Fire and Rescue Department. Two of the pilots, Duval and Miami-Dade, also worked with local hospitals and other health care providers to obtain additional health care data for those study participants not on state Medicaid or other public monies reported through state data systems. These two pilots also reported out additional HMIS data or self-collected data on the cost of services related to residents in their pilots. The Pinellas pilot did not collect local health care information for the residents in its research. Residents who participated in the three studies signed consent forms to allow the researchers to collect their health care and other data.

The pilots collected information for survey participants two years prior to move-in and two years post-move-in. Each pilot took a different approach to who was included in this evaluation.

Duval. The study followed 68 consenting participants from the 92 residents either living at the Village on Wiley pilot property, or residents located in existing scattered sites throughout the community. All residents were evaluated together as part of this research.

Miami-Dade. This study followed three different groups. The first group included 21 consenting participants out of the 34 total residents living at the Coalition Lift building financed through this pilot, and

this is the key group in the pilot evaluation. The second group included 11 additional consenting residents living in scattered site housing throughout the Miami area. The two resident groups are not equivalent in terms of ranking or severity issues: 79.5 percent of Lift residents were in the top 150 of high utilizers, compared to 45.2 percent in the scattered site housing. This was done by design, as the severity of challenges presented by individuals higher up on the list meant that traditional community housing programs were usually not a good fit for these individuals.

The third group of 21 consenting individuals passively refused housing offered as part of this pilot (i.e., they didn't act or follow up with appointments with the housing team), so were considered homeless for this study, but participated in the study. The first group residing in Coalition Lift received the most intensive services, while the other two groups received access to more traditional supportive services.

The Miami-Dade pilot focused mainly on the first group, because it comprised residents with the highest needs. However, the pilot included one year of data for the second and third groups in its report, because many types of supportive housing models can result in savings to public systems as long as they are responsive to the level of need of their residents. However, no supportive housing/services costs were collected for a full evaluation.

Pinellas. The study included 22 consenting participants out of 45 residents living at the Pinellas Hope V property financed through this pilot.

Demographic Characteristics of the Pilot Residents, as reported by each pilot—

Duval. Participants ranged in age from 20 to 62 years of age, with 72.8 percent between the ages of 40 and 64 at move-in. Fifty-four percent of participants were female. More than half (55.4%) self-identified as Black, and one self-identified as Latino. More than one-third of participants (37.0%) had a high school diploma or GED. Another 36.1 percent started but did not finish high school, and 5.4 percent had some college education. All study participants had disabilities, which could include intellectual, physical, psychiatric and/or behavioral health diagnoses.

Miami-Dade. Of the 44 total residents living at the Coalition Lift property during the course of the pilot (34 residents were housed at the property at any one time, but an additional eight residents were evicted and another two abandoned their units), the median age was 51.9 years, and 79.5 percent were male. Over 59 percent identified as Latino, and 47.6 percent identified as Black. All of the residents had one or more documented disabilities.

Pinellas. Fifteen out of the 22 study residents entered the property from an emergency shelter, followed by four from a medical respite facility and three from a referral from a social service program. Men and women were equally represented among the 22 participants in the study, with 86.0 percent being White/Non-Latino. Sixty-eight percent were aged 55 or older at move-in. Ninety percent of participants self-identified as having one or more physical or mental health conditions, and 68.0 percent had at least one documented disability.

Cost/Benefit Findings
Detailed cost data is provided in each local pilot report, and a broad summary of the three pilots' data is provided in two tables in **Appendix C**. One table shows total costs and savings, and the other table shows average per person costs across all systems. As stated earlier, each pilot site collected pre- and post-move-in data across three key categories: health care, arrests and incarceration, and emergency shelters and homeless services.

Each pilot compiled its housing and services data somewhat differently. The Duval pilot collected pre- and post-move-in data on housing and services for each of its 68 study participants. But while the Miami-Dade and Pinellas pilots collected public systems service data for the residents in their studies, at post-move-in they reported aggregated housing and housing stability services data across all residents in their housing (not just those in the studies). Because many of the services available at the properties post-move-in were provided to all of the residents, it proved difficult to disaggregate the data just for those who volunteered for the study. As a result, the Miami-Dade and Pinellas pilots chose to extrapolate the public systems cost data (e.g., crisis services, health care) to all of the residents, projecting what the likely costs and savings were for all the residents in those pilots. The summaries below provide extrapolated data for *all* residents.

Duval. The Duval pilot report shows an estimated **$16,541 in total cost savings per person, per year** when all pre-move-in costs are compared to post-move-in costs. This means that when persons who were high utilizers moved into supportive housing, savings to public systems were substantial enough that the cost of housing and services post-move-in was overall less than the cost to public systems (including housing) prior to move-in, for a total estimated two-year savings of more than $2.2 million for 68 residents, as shown in Table 2.

Table 2. Duval Cost/Benefit Summary				
	2 Years Prior to Move-In		2 Years Post-Move-In	
Health Care	$7,222,168	96.3%	$3,826,574	72.8%
Incarceration	$197,703	2.6%	$59,910	1.2%
Shelter & Homeless Services	$83,434	1.1%	$1,382	0.0%
Supportive Housing/Program Costs	$-	0.0%	$1,365,927	26.0%
Total Costs	$7,503,305	100.0%	$5,253,793	100.00%
Total Savings over 2 Years				$2,249,512
Savings Per Person, Per Year				$16,541

- Pre-move-in, total public system costs for the 68 participants were more than $7.5 million, with the largest costs for hospital in-patient stays.

- Health care costs were the highest proportion of costs both prior to and after move-in – over 96 percent of total public system costs prior to move-in.

- Post-move-in, the biggest reduction in costs was in health care, with a 57.6 percent reduction in local hospital costs and a 47.1 percent reduction in all health care costs.

- While overall health care costs decreased, Medicaid billings increased by 42.1 percent post-move-in due to additional residents becoming eligible and accessing care through this benefit.

Miami-Dade. The Miami-Dade pilot report shows an estimated **$10,169 in total cost savings per person, per year** when all pre-move-in costs are compared to post-move-in costs, for a total estimated two-year savings of $691,487 for the 34 residents at the Coalition Lift property, as shown in Table 3.[9]

- Prior to move-in, estimated total costs to public systems was over $3 million.

- Almost 90 percent of pre-move-in costs were for health care, with over half of these for physical health care needs.

- Shelter and homeless services were low because in the two years before move-in many participants were living on the streets and received little in emergency shelter or homeless services.

- Post move-in, the biggest reduction in costs was health services, which overall declined by 64.5 percent. While physical and mental health care costs declined, substance use care increased as residents began taking advantage of recovery programs.

- It is likely that if additional locally provided health care data had been compiled by this pilot, it would have seen additional health care costs both pre- and post-move-in, and likely more savings to report.

Table 3. Miami-Dade Cost/Benefit Summary				
	2 Years Prior to Move-In		**2 Years Post-Move-In**	
Health Care	$2,733,171	89.7%	$970,825	41.2%
Incarceration	$276,857	9.1%	$219,543	9.3%
Shelter & Homeless Services	$37,615	1.2%	$1,426	0.1%
Supportive Housing/Program Costs	$-	0.0%	$1,164,362	49.4%
Total Costs	**$3,047,643**	**100.0%**	**$2,356,156**	**100.0%**
Total Savings over 2 Years				**$691,487**
Savings Per Person, Per Year				**$10,169**

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[9] Data reported for the other groups studied in the Miami-Dade evaluation may be found in that pilot's report.

Table 4. Pinellas Cost/Benefit Summary				
	2 Years Prior to Move-In		**2 Years Post-Move-In**	
Health Care	$739,056	61.3%	$738,035	65.7%
Incarceration	$237,784	19.7%	$4,091	0.4%
Shelter & Homeless Services	$228,537	19.0%	$-	0.0%
Supportive Housing/Program Costs	$-	0.0%	$381,390	33.9%
Total Costs	**$1,205,377**	**100.0%**	**$1,123,516**	**100.0%**
Total Savings over 2 Years				**$81,861**
Savings Per Person, Per Year				**$910**

Pinellas. The Pinellas pilot report shows an estimated **$910 in total cost savings per person, per year**, for a total estimated two-year savings of $81,861 for 45 residents, as shown in Table 4. Note that the pre- and post-move-in cost estimates exclude local health care data, an area of real savings for the other two pilots.

- Pre-move-in costs to public systems were estimated to be just over $1.2 million.

- More than 61 percent of pre-move-in costs were health care related, with 84.1 percent of total health care costs related to physical care.

- Overall health care costs barely changed pre- and post-residency. Mental health crisis services decreased after move-in, but overall mental health care costs increased during this time, reflecting residents' improved access to services. Another likely reason noted above was that no local health care data was collected.

Cost/Benefit Analysis Limitations. While each pilot site collected data across the three general categories outlined above, there were differences in data collection approaches. The most important limitation lies in what health care data was collected, particularly because health care was by far the largest cost center and opportunity for savings. Only two of the three pilots, Duval and Miami-Dade, were able to collect local health care data not provided through state reporting programs (e.g., Medicaid). The Duval pilot collected data across several local hospitals and health centers; Miami-Dade compiled data just from the county's largest public hospital. At move-in many residents were not receiving benefits or insurance; thus, any indigent health care costs resulting from these people using local hospitals and other health care centers are not part of the pre-move-in data. The lack of local health care data in the Pinellas pilot is one likely reason that this pilot shows so little cost savings.

Another reason may be that more Duval and Miami-Dade residents came directly off the street and without resources to protect themselves and may have been more ill/vulnerable at move-in, compared to Pinellas residents who largely had been living in emergency shelters or medical respite beds at the time of move-in and therefore were more stabilized. In addition, the remoteness of Pinellas Hope's location, far from any public transportation lines, might also have had some impact on residents' ability or willingness to seek additional services off site.

Because each pilot's data collection approach was different, comparing results between the three pilots is difficult. While the Duval pilot collected the most

Findings of the Florida High Needs High Cost Pilot

comprehensive locally derived data on health care, most of these local costs are not differentiated by type of health care provided (i.e., physical health, mental health or substance use care). This still allows comparison across the general health care category.

Most importantly, the Pinellas research approach did not include collection of any locally derived health care data, which is a big gap in its data compared to the other pilots. Relying just on state-provided health care data, the Pinellas pilot showed total costs of just 15-20 percent of the other two pilots, as shown in Table 5. Health care costs in the other two pilots were shown to be the greatest overall cost, and the area in which the greatest savings were realized during the pilot period.

Residents' Personal Outcomes Findings

The pilots also evaluated quantitative and qualitative outcomes of residents' health and well-being over the study period. Each site also used different tools and methodologies to evaluate the qualitative changes that occurred as residents stabilized in their housing. Depending on the program, many experienced improved health outcomes and/or residents' perceptions of their quality of life also improved. In some cases, resident incomes increased, and more residents received access to health insurance. The greatest success was resident housing retention – a large majority of residents maintained their homes for the full two years of the study.

Duval. To determine change in resident stability over time, the Duval study assessed perceived quality of life using the Ferrans and Powers Generic Quality of Life Survey. Mental wellness was measured using the Mini-International Neuro-psychiatric Interview (M.I.N.I. 6.0). These surveys were administered with each participant twice, once at move-in and then toward the end of the pilot period.

The Duval pilot also evaluated several socio-economic outcomes, including income, access to disability benefits and access to health insurance.

During the two years post-move-in, there was a 30.9 percent decrease in suicidality, a 20.0 percent decrease in agoraphobia and a 19.9 percent decrease in drug abuse/dependence. Quality of life measures also showed improvement, with over 15.1 percent improvement in perceived overall quality of life, 25.8 percent increase in perceived health, a 20.7 percent increase perceived in psychological/spiritual quality of life and a 20.8 percent increase in perceived family quality of life.

Additionally, the number of those with health insurance (Medicaid, Veterans Administration, Medicare, or the local charity hospital "Shands" card) increased from 36 individuals before housing to 54 post-move-in. Incomes also increased. Before move-in, 53 people had some income; post-move-in, the number increased to 67, and average monthly income increased from $367 to $611.

Miami-Dade. At move-in and then every six months thereafter, Miami participants were interviewed regarding personal outcomes related to medical/primary care. Residents were interviewed and asked to rate their health, and answer questions related to their physical and behavioral health; employment, education and benefits; and social connectedness, such as interacting with families and friends. Researchers used a truncated version of the SAMHSA Government and Performance Results Act "GPRA" National Outcome Measure tool.

This pilot also evaluated socio-economic outcomes, including employment and access to disability benefits. From the initial assessment at move-in to the final assessment, there was a slight increase in the

Table 5. Comparison of Pilots Two-Year Health Care Costs Per Person	Pre-Move-In Per Person	Post-Move-In Per Person
Duval	$106,208	$56,273
Miami-Dade	$80,387	$28,554
Pinellas	$16,423	$16,401

percentage of residents (6.8%) describing their overall health as good, very good and excellent. There was not a significant decrease in the average number of days residents said they experienced depression or anxiety, but residents did have a decrease in the number of days in a month (4.95) they experienced trouble concentrating. There was also an 8.2 percent increase in residents who were less bothered by psychological or emotional problems. The number of those with Medicaid benefits pre-move-in was 22 out of the total of 34 residents at the property, or 64.7 percent; post-move-in, the number increased to 27 residents, or 79.4 percent of total residents.

There was an overall increase among Coalition Lift residents who reported interacting with family and friends from their baseline to final assessment, from 54.8 percent to 70.5 percent, and these residents reported interacting with friends or families on a daily or weekly basis. There was an increase in attendance at self-help or support groups, such as religious and Alcoholics Anonymous/Narcotics Anonymous meetings.

Pinellas. Researchers used two instruments to collect in-depth information about the 22 residents in the study upon move-in and then at 6-month intervals: a customized survey instrument was used initially, and later a simpler tool, the modified World Health Organization Quality of Life-BREF (WHOQOL-BREF) tool was used. Questions related to four quality of life domains – health, psychological, social and environment concerns – were asked of participants.

At baseline, residents described their health as trending toward good; however, by the end of the assessment period, average resident perceptions of health had decreased somewhat. When asked about the quality of their lives at move-in, 18 out of 22 residents indicated that they were mostly satisfied with their lives. By the end of the evaluation period, 21 out of 22 residents reported their lives were good.

The number of those in the study with Medicaid benefits pre-move-in was 11 out of the total of 22 residents in the study, or 50.0 percent; post-move-in, the number increased to 13 residents, or 59.1 percent able to access Medicaid benefits.

Most Formerly Homeless in the Pilot Residents Successfully Retained their Housing. All three pilots showed excellent resident housing retention during the two-year study period. In the Pinellas pilot, 31 residents were either still living at the property or had moved to other permanent housing by the end of the two-year study. Not counting five residents who died or moved into higher care housing situations, this represents a housing retention rate of 77.5 percent. Of the original 34 residents living at the Miami-Dade Coalition Lift property, 24 were still living in housing at the end of the two-year study. The other ten were either evicted or abandoned their units. This represents a housing retention rate of 77.3 percent. And in the Duval pilot, of the original 92 residents enrolled in the study, 77 were still living in housing at the end of the two-year study. Not counting three residents who died and another for whom no information was available, this represents a housing retention rate of 87.5 percent.

Studies Nationally Support these Findings. According to the report called *Penny Wise But Pound Foolish: How Permanent Supportive Housing Can Prevent A World of Hurt*, published in mid-2019:

> Research shows PSH [permanent supportive housing] costs the same or substantially less than leaving people homeless, and only PSH ends their homelessness. No studies found an increase in social service costs associated with PSH, and the cost savings resulting from PSH often exceed the cost of providing PSH. Moreover, no study assesses all or even most of the cost drivers associated with PSH and the cost savings resulting from PSH often exceed the cost of providing PSH. Moreover, no study assesses all or even most of the cost drivers associated with leaving people unsheltered, including but not limited to sweeps, first responders, emergency room visits, hospital stays, psychiatric commitments, outreach workers, lost business, city services, environmental hazards, police time, courts, jail and prison time, probation, lost economic productivity, and the psychological and emotional tolls on homeless people and the surrounding community. So, while existing studies already establish PSH as the most cost-effective solution to chronic homelessness, these studies also vastly underestimate its impact.[10]

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[10] Staten, Lavena, *Penny Wise But Pound Foolish: How Permanent Supportive Housing Can Prevent A World of Hurt*, Sara K. Rankin, editor, Homeless Rights Advocacy Project, Seattle University School of Law, 12 July 2019; at https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3419187.

Findings of the Florida High Needs High Cost Pilot

SUMMARY OF FINDINGS

The three sites in this Florida pilot showed overall savings in community-provided services, some substantial, even after the cost of housing and supports provided to residents was included in our analysis.

- **Supportive housing for persons experiencing chronic homelessness with high needs can save local and state governments money.** The Florida study certainly shows that health care was both the costliest of public systems and the most likely to see savings through this pilot. For savings to be achieved when the objective is to serve high utilizers of public systems, it is critical that programs use effective targeting methods for resident selection, such as data matching and good screening tools, to verify high system use.

- **Moving into permanent supportive housing reduces interaction with the criminal justice system, reducing costs borne by both local and state governments along with attendant costs to move someone through the judicial process.** Fewer people in the justice system not only increases the quality of life for those individuals, the community's quality of life is also positively impacted. Emergency shelter and homeless shelter costs, which are funded by all levels of government, are also decreased.

- **Resident stability in housing usually decreases supportive service costs over time.** While initial costs to assist a new resident with tenancy supports and service coordination may be high, most studies find that as a resident stabilizes in their home, coordination costs and even services costs usually decrease. Even if a resident continues to need services such as behavioral health care, these costs typically are lower than the crisis services often incurred before housing was obtained.

- **Permanent supportive housing is successful in helping persons experiencing chronic homelessness with high needs achieve and sustain housing stability.** In the Florida pilot, these residents were more likely to increase their incomes, obtain health insurance, and show greater satisfaction with their quality of life.

- **Most pilot residents who had formerly experienced chronic homelessness successfully retained their housing.** All three pilots showed excellent housing retention during the two-year study period, with between 77 and 87 percent of residents remaining housed.

The results of the state pilot show that this approach can save money and create strong opportunities for persons experiencing chronic homelessness to succeed in supportive housing. However, Florida does not yet have a robust, integrated housing and services framework in which to promote such programs. When Florida Housing initially sought proposals to fund this pilot, we hoped to fund proposals that showed how well-developed local and regional housing and services partnerships could bring the knowledge, experience and funding to their local pilots. Florida Housing understood that each pilot and its sponsoring organization would need this capacity in order to adapt and forge more sophisticated approaches to successfully serve persons with high needs experiencing chronic homelessness.

Our interviews with pilot leaders both during and after the pilots were completed revealed that pilot successes were based on partnerships heavily reliant on housing providers' own, very specific relationships with local service providers rather than because of systemic housing and services integration. Most often, it was the housing provider in the pilot fostering success and finding opportunities with individual service providers where it could.

While many service providers and funders appear to understand the importance of a home to their consumers' stability, few see their role as developing integrated partnerships with housing providers to support their consumers once in permanent housing. Services offered through both Medicaid and DCF now include housing coordination and tenancy supports; however, guidance documents on housing coordination do not frame coordination activities as part of a broader, integrated system. Services are provided, but any partnership is often reliant on individuals at agencies developing relationships to work together rather than on a formalized state infrastructure that requires providers to work together.

Florida Housing found that the formal partnerships needed to successfully replicate these pilots are currently limited and fragmented. Partnerships generally are not well established and are not consistent in terms of providers, commitments, funding, roles and responsibilities. Access to funding is not aligned and is often unavailable except on a provisional basis, particularly to pay for what all three pilots said was the glue that held their support framework together – highly trained and qualified on-site Resident Services Coordinators with small caseloads.

Limited funding opportunities from federal and state programs exist for this type of staffing. The federal Emergency Solutions Grant can fund housing relocation and stabilization services, and federal CoC funding covers similar supportive services activities. However, federal and state policy drives CoCs to prioritize this funding first and foremost to get people experiencing homelessness into housing, and less to support stability once a person is housed. Based on the results of this pilot, Florida Housing believes that success in housing – creating stability and retention – requires a balanced approach of funding access to housing (for development and operations) as well as services and supports to foster long-term housing stability for individuals with acute service needs.

As a result, all three pilots made varying levels of progress acquiring services funding, and their models reflected the funding each pilot was able to access. Each of them obtained short-term funding that either requires annual renewal or was available one time for their use. One pilot relied on a private sector grant to support its work.

This study made it apparent that Florida does not have the connectivity between housing and services funding that would ease the burden of housing providers working to serve individuals with the highest needs. Joint housing stability and services coordination activities are neither a broadly accepted part of the services continuum of funding in this state, nor are practices consistent when implemented by housing and services providers. Managing Entities and behavioral health care providers report a need for additional funding to pay for more coordination of care services than are currently funded. Hopefully the results of this pilot can assist Managing Entities and Managed Care Plans in developing consistent practices for services to support persons experiencing chronic homelessness to live stably in supportive housing.

Operating assistance for housing to serve residents with extremely limited incomes is also difficult to obtain. Both the Duval and Miami-Dade pilots obtained funding from two sources to fund rental assistance for this purpose. One of those sources, CoC funding, aligned with the pilot requirement to serve persons experiencing chronic homelessness. Future projects that wish to serve non-homeless populations will require a different dedicated source of operating support.

In the Pinellas pilot, Catholic Charities paid for most of the housing costs itself. One-year housing costs reported at that property, including the small amount of rents paid and all additional costs paid directly by Catholic Charities, totaled approximately $3,000 per unit, less than half of the housing costs reported by the other two pilots. In Florida Housing's portfolio management experience, this per-unit funding level is unsustainable over the long term to maintain the property in good condition. As noted earlier, Catholic Charities is working with its local public housing authority to bring in rental assistance to offset some of the property's future costs.

While two of the pilots were able to craft useful partnerships with individual health care providers, these partnerships are single project agreements, and in some cases were only in place because the housing organization itself found the funds to pay the partner. This situation makes the work of serving residents with high needs more strenuous, because each housing organization willing to do this already complex work must also continually work to find funding and forge its own seamless approach to service provision. It also appears from this pilot that there still is a limited understanding by private and public crisis and service providers of the link between cost savings to them and the systems of care when residents with high needs are stably housed and have better personal outcomes.

HOUSING AND SERVICES BEST PRACTICES IN SERVING HIGH UTILIZERS OF PUBLIC SERVICES

The three housing providers in this pilot based their approaches to serve residents on their supportive housing experience and best practices from the national literature. As a result of peer discussions with pilot leaders about their strategies, Florida Housing concludes that the following best practices are important to implement to serve residents with high needs, both to help these Floridians and to create opportunities for cost savings in the state.

Residents' Expectations and Goals. Expectations for residents' optimal stability and quality of life must be based on each person's expectations and goals; their history, abilities, capacities and life skills; and individual milestones specific to their situations. This is an overarching principle and best practice in providing supportive housing and services to residents. Use of the Housing First approach in resident selection where residents first choose their housing and then are offered help to access services tailored to their needs and goals, responds to this person-centered principle.

Housing Stability Supports and Resident Services Coordination. Residents with high needs must have immediate access to supports related to obtaining and maintaining housing stability, addressing trauma and acute issues, accessing coordinated community-based supportive services and health/behavioral health services, peer supports and motivational interviewing. On-site, full-time Resident Services Coordinators should be employed in addition to other staff who may be assigned to assist residents. Because of their on-site, intensive work with residents, coordinators should have low resident caseloads. Coordinators must be well qualified, very skilled and experienced in assisting residents with high needs. Caseload recommendations, training and experience recommendations are described in **Appendix A**. Until this best practice is more universal, Florida Housing believes Resident Services Coordinators should be hired and supervised by the non-profit housing provider with experience in resident services coordination.

- Trauma informed care has come to be more understood as a critical best practice in helping persons coming out of homelessness develop housing stability. Studies, show that an extremely high percentage of adults' mental health or substance abuse issues have reported a history of trauma, often in childhood. This is exacerbated when one experiences homelessness. We know that experiences of trauma impact every aspect of how a person functions, but it can be treated.

- Formal peer support relevant to the resident's needs is a beneficial service for a resident's success. Peer support workers are those who have "lived experience" – i.e., they have been through their own recovery processes and can support residents with similar situations. Peer supports have been found to help residents stay engaged in sustained, successful recovery processes.

- Motivational interviewing is ". . .a collaborative, person-centered approach to elicit and strengthen motivation to change. It offers providers a useful framework for interacting with people who are experiencing homelessness and struggling with mental and/or substance use disorders or trauma," according to SAMHSA. This best practice ". . .is rooted in an understanding of how hard it is to change learned behaviors, many of which have been essential to survival on the streets." This approach works with the idea that ". . .motivation to change should be elicited from people, not imposed on them."[11]

Supportive housing properties financed by Florida Housing currently are required to offer modest services coordination help to all interested residents to assist with referrals to community-based services. However, housing stability services are not required to be part of this service, even for residents with high needs. Florida Housing's coordinator qualifications and experience requirements are not as extensive as those found by pilot leaders to be important. As a result of this pilot, Florida Housing should evaluate its current resident services coordination requirements and consider whether changes are necessary to strengthen coordination particularly for residents with high needs. At a minimum, tenancy support services should be required. See **Appendix A** for a more detailed discussion of the housing stability framework.

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[11] S. Rollnick and J. Allison, *The Essential Handbook of Treatment and Prevention of Alcohol Problems,* and SAMHSA at https://www. samhsa.gov/homelessness-programs-resources/hpr-resources/empowering-change.

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The first 12-24 months are critical. Residents with high needs who have experienced chronic homelessness require intensive resident services coordination particularly during the first 12-24 months after moving into supportive housing. A resident's focus transitions from surviving on the streets to the initial effort of obtaining housing stability, to addressing trauma and deeper emotional and life issues, including survivor's guilt and re-adjusting to more mainstream traditional living arrangements. The pilots found that after this initial intensive phase, many residents' supportive service needs often transitioned into more traditional, less intensive supports, and residents were able to connect to clinic-based services in the community without more individualized, unique supports. After a 24-month stabilization period, most of these residents will continue to need some level of supportive services over many years, and these needs likely will evolve throughout their lives.

> ## Access to services funding to support intensive on-site resident services coordination is crucial.

Experience working with residents with high needs is essential. Experienced mission-focused housing owners and property managers (whether the same organization or separate), as well as highly trained, on-site Resident Services Coordinators, are essential to achieve housing stability, optimal self-sufficiency and improved quality of life for residents with high needs.

- In two of the three local pilots, leaders said that residents benefitted from the mission-based housing provider's ability to control the funding for Resident Services Coordination and manage contracts with the appropriate services coordination providers. This ensured that each of the critical parties on the care team had the requisite knowledge and skills to work closely together to create a more successful housing/services web of support for residents.

- Florida Housing and other housing funders should prioritize applicants for funding that:

  o Bring strong experience providing services or working closely with supportive service providers, and, in particular, on-site, full time, robust resident services coordination with low caseloads;

  o Have a track record of obtaining and managing some type of rental assistance in their units;

  o Are working in communities where data systems and local partnerships are capable of and committed to data sharing to ensure that persons who are high utilizers of public services can be identified for resident selection;

  o Are working in partnership with established, responsive housing funders who can offer operating support, including local housing authorities and CoCs that include a range of capable partners; and

  o Either have a successful internal model of property management with experience implementing a Housing First approach in resident selection or oversee and are involved in resident selection approaches using Housing First principles with an experienced, external property management company. Either approach should include knowledge of and the capacity to understand the residents being served and their needs.

- The concentration of only (or mostly) residents with high needs in one permanent housing setting can be a difficult model to manage/operate and doesn't provide a diversity of residents needed to help individuals with high needs successfully stabilize over time and meet their personal goals. Experienced housing providers should be given a choice about the concentration of residents with high needs in their properties.

Access to services funding is crucial. Housing providers must be able to ensure access to services funding is available to achieve long-term success. In particular, funding to support intensive on-site resident services coordination is important, because there is no established program currently in place where these strategies are regularly funded. And yet these services are arguably the most important to ensure the success of residents with high needs in learning how to live successfully in permanent housing, as well as obtaining the right mix of services to meet their needs over time.

Local or regional administrators of behavioral health services, such as Managing Entities and Managed Care Plans, along with the Agency for Health Care Administration and DCF, are key partners for supportive housing providers. Their policies and funding are crucial in facilitating access to, obtaining and maintaining housing stability for residents with high needs. State and local systems partners must be at the table throughout the process, from program conception to outcomes and impact reporting.

Local partnerships increase the likelihood of success. Established local and regional partnerships with community partners and funders committed to permanent supportive housing are key to any successful supportive housing model but are more critical to success when serving residents with high needs. From a thoughtful coordinated entry process working with the local CoC and member organizations, up to the state/regional level with Managed Care Organizations and Managing Entities, housing providers need access to an integrated services funding model that ensures residents are efficiently supported.

Ideally Managing Entities and Managed Care Plans should be working with housing service providers to clarify roles and responsibilities, and identify how funding can best be used to support residents with high needs. In addition, local governments have much to gain in crisis services cost savings by encouraging strong partnerships, including law enforcement, legal services and other programs to assist residents.

Access to operating assistance for supportive housing that serves residents with high needs will provide for sustainable housing over the long term. The most successful pilots were able to obtain some type of rental assistance. Properties must bring in a certain amount of income, typically from rents, in order to maintain the condition of the housing over many years. Rental and other income is used to maintain the property, from shorter term repainting and replacement of carpeting, to longer term maintenance of the physical plant. Housing that is built with affordable program resources must keep rents below certain thresholds required by the programs funding the housing. While it is possible to maintain properties at these rent levels, rents are generally set at levels higher than

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residents with extremely low incomes can afford, much less households that have not achieved housing stability and are high utilizers of crisis services. Many residents, particularly those with disabilities and co-occurring disorders, will continue to need some level of rental assistance throughout their lives to remain stably housed.

Continued predictability and availability of financing to develop supportive housing must occur. The predictability of housing development funding within an established housing and services infrastructure is important for long-term success. Predictability is an important component to increasing the capacity of the supportive housing industry. It is critical that Florida Housing continues to provide reliable annual funding opportunities for such housing.

Efforts to coordinate housing and services dollars should be made at the state and local level to support housing providers. While this has occurred on a limited basis through demonstrations or among a few formal agreements between a housing provider and Managing Entity or Managed Care Plan, there is no state infrastructure in place where housing and services funding streams merge to assist the hardest to serve. This is particularly true of funding to support comprehensive housing stability strategies. Florida's 1115 Medicaid Housing Assistance Waiver pilot provides services funding and is an excellent start, but the alignment of systems is not yet in place. By this, we mean that housing funding and healthcare and social service funds flow from different sources, on different time frames and often serving only partially overlapping populations. Currently the responsibility for braiding funding most commonly lies with the providers on the ground or with the service recipients trying to navigate multiple systems.

Based on findings from this pilot, interagency collaboration among state policy makers (including Managing Entities and Managed Care Plans) and an emphasis on how funding is prioritized for services and coordination would greatly benefit individuals with high needs. Florida's interagency Council on Homelessness could be a useful starting body for agencies to work together to develop a policy approach, bring funding together and coordinate interagency collaboration to address these issues when serving persons experiencing

> # Efforts to coordinate housing and services dollars should be made at the state and local level.

homelessness. The 1115 waiver services offer the impetus for funders and administrators of Florida's publicly funded housing and services resources to work together to coordinate and pair these resources. If so, it will be critical to follow best practices – what we have already learned works – to provide supportive housing that best helps meet residents' short- and long-term needs and goals.

The Housing Stability Framework discussed in this report[12] **also would be ideal for persons leaving institutionalized settings,** because they need strong supports to live independently. National studies show that savings are garnered from these transitions – supportive housing with a strong housing stability framework is less expensive than institutional settings. In addition, **creating housing stability with intensive wrap-around services for families in the child welfare system** has shown success in pilots around the country.

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[12] Again, see Appendix A.

PILOT PARTICIPANTS AND FUNDERS

Florida Housing wishes to express its appreciation to the housing providers who sponsored each of the pilots and to their partners who stepped up to integrate funding and services to support the residents with high needs who moved into these properties. Because of the commitments from those involved in each of these pilots, residents were given the supports they wanted and needed to help them realize independence and stability in their communities. We also appreciate the funders who stepped up to provide critical resources to help these pilots succeed.

Thanks to the researchers who worked hand in hand with the housing organizations to compile the data to report how supportive housing is a successful model to help people live their best lives.

Our thanks also to the Corporation for Supportive Housing (CSH), a national non-profit with a vision of a future in which high quality supportive housing solutions are integrated into the way every community serves the men, women and children in most need. Throughout the pilot, CSH staff provided expertise and support to Florida Housing Finance Corporation and the three pilots.

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Funders
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Disability Rights Florida

Florida Blue

Lutheran Services of Florida

US Department of Housing and Urban Development

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Funders
Corporation for Supportive Housing

Health Foundation of South Florida

JP Chase Morgan

Miami-Dade County, Public Housing and Community Development

Miami-Dade Homeless Trust

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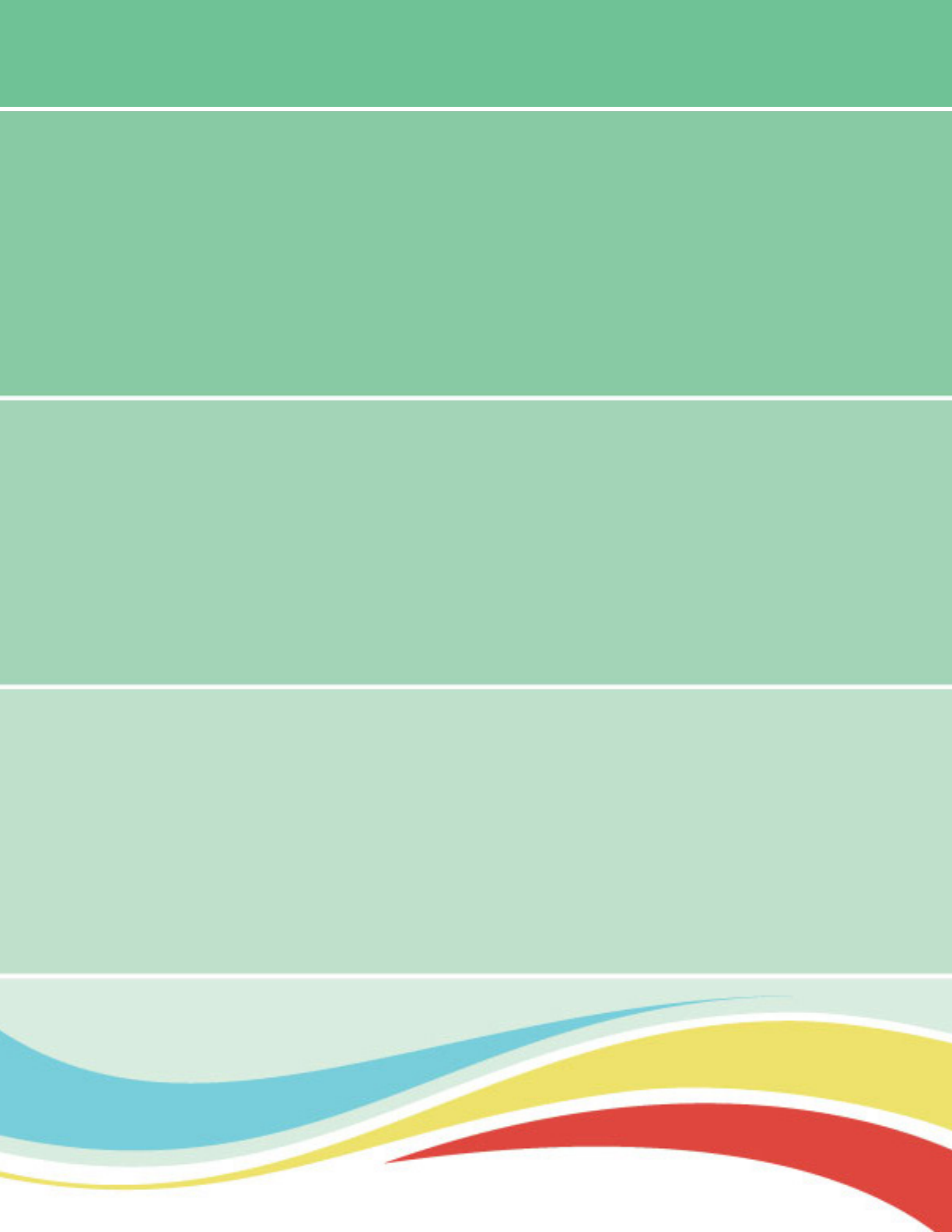
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In the literature, "housing stability" is often referred to as a finite set of activities to help a new resident stabilize in their home. Housing stability is typically discussed as a best practice to support chronically homeless veterans or others who may not be familiar with how to settle into a new home after living on the streets. "Tenancy supports" are those actions taken to promote housing stability.

Through work on this pilot, Florida Housing concludes that housing stability should be thought of as a broader, overarching framework to encourage success for chronically homeless persons moving into supportive housing. The objective of housing stability is to help residents both obtain and maintain permanent homes. To succeed with this deceptively simple objective, however, requires a range of partners (and funding) working hand in hand across a spectrum of housing and community-based services. For a person to maintain true stability in their housing, they must not only understand the basics of keeping house, their personal lives must also be stable, with whatever behavioral and other supports are needed to help them achieve this.

Therefore, Florida Housing believes a housing stability approach should include tenancy supports, traditional community-based supportive services and additional critical supports when working with residents with high needs (in addition to housing). To ensure that these services are provided within an integrated framework, we believe there are key clinical tenets that should be implemented to support these residents. Underlying this entire approach is the notion that these services are resident-centered – that is, the residents being served are equal partners in planning, developing and monitoring these supports and services to help make sure they meet their needs.

These services should also be voluntary. A resident that is in compliance with the lease for their rental housing should not be at risk for not participating in services. But services must always be available and offered to residents so when they are at risk of violating their lease, they have the supports necessary to maintain their housing. The pilot sites found that the control residents have of their participation in services is an important part of the services being person-centered.

This appendix provides a list of common tenancy supports, a list of traditional and more intensive supportive services provided to residents in supportive housing and key tenets in the clinical housing stability framework.

Tenancy Supports

Housing stability work generally begins prior to leasing to assist with eligibility requirements for the housing and prepare people for moving in. No matter what other services are provided at move-in, tenancy supports must begin immediately with an initial needs assessment and development of a Housing Stability Plan within the first 30 days of residency. Tenancy supports generally include:

- Early identification and intervention for behaviors that may jeopardize housing.

- Education about resident and landlord rights and responsibilities.

- Eviction prevention planning and coordination.

- Coaching on developing/maintaining relationships with landlords/property managers.

- Assistance resolving disputes with landlords and/or neighbors.

- Advocacy/linkage with community resources to prevent eviction.

- Training on independent living skills, such as cleaning, laundry, shopping, household budgeting and management, financial literacy, including credit repair.

- Assistance with housing recertification process.

- Review/modification of housing support plan and eviction prevention plan with resident.

- Role modeling in such areas as apartment community living, communication with neighbors, sober fun.

- Home visiting.

Traditional Supportive Services

- Assistance with completing SOAR applications, support to obtain (or reinstate) all eligible entitlement benefits, such as Social Security, VA benefits and food stamps and SOAR case management.

- Referrals to needed services such as mental health, substance use treatment and recovery support, medical and preventive health care and other wellness services.

- Referrals and information about community services such as places of worship, community centers, food pantries, community-based support groups such as NA/AA, and other groups specific to areas of interest.

- Employment services to increase financial independence and increase opportunities for employment.

- Education support services with the focus on completing degree or diploma technical or language skills.

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- Transportation services such as access to transit passes and other personal transport services.

- Community activities designed to decrease isolation, develop community mindset and strengthen "good neighbor" actions and behaviors.

- Re-establishing identity for those who lost identification cards.

- Financial support for medical expenses not covered by insurance or interim assistance pending benefits such as prescriptions and non-durable medical expenses.

- Legal services to assist with outstanding warrants, expunging records and getting residents folks out of jail if arrested.

Additional Critical Supports for Persons Who Are High Utilizers of Public Services

- Health and behavioral health care services, including medication management.

- Nurse case management on site.

- Targeted case management for folks who have Medicaid or other insurance.

- Funding or access to items to meet all personal needs including personal hygiene, clothing, food, essential for household not covered under food stamps.

- Access to crisis intervention teams such as FACT (Florida Assertive Community Treatment) or ACT (Assertive Community Treatment) teams.

- On-site therapeutic services.

Key Tenets in the Clinical Framework for Supporting High Utilizers

When working with residents with high needs, the clinical framework in which these supports are provided includes the following approaches:

Housing Stability Resident Services Coordinators – Housing Stability Resident Service Coordinators work on site with residents to ensure long-term housing sustainability by developing a housing stability plan; focusing on tenancy supports, such as interacting positively with landlords and neighbors; coordinating services to respond to behaviors that may accompany mental illness or substance use so that they don't interfere with success in housing; developing crisis plans as needed; connecting with appropriate community resources; and supporting residents' individual housing goals. Full-time coordinators should have low caseloads – between 15-20 adult residents per coordinator, depending on whether residents have just moved in or are becoming stabilized. If Resident Services Coordinators are to serve residents on site at multiple properties, their caseloads should be no more than one-to-15 residents to ensure adequate resident support. Pilot leaders recommend strong qualifications for these coordinators due to the range of duties they have, as well as knowledge and experience with strategies such as trauma informed care, harm reduction, motivational interviewing, critical time Intervention and Housing First practices. Qualification should include a bachelor's degree in social work, mental health, psychology or related field required, and a minimum of three years related field experience. A detailed position description used by the Miami-Dade pilot based on what was learned in this pilot is provided at the end of this appendix.

Housing First – Under Housing First, permanent housing is provided without conditions. This means that properties accept residents without prior requirements for sobriety, compliance with medications or participation in programs. After the resident has moved in, properties following Housing First limit lease terminations to severe lease violations and only after strenuous efforts to resolve any problems, along with continuing services to assure housing stabilization in the resident's unit.

This approach prioritizes providing permanent housing to people experiencing homelessness, thus allowing people to attend to basic necessities like food and a place to live before attending to anything less critical, such as getting a job, budgeting properly, or attending to substance use issues.

Motivational Interviewing – A counseling method that helps people resolve ambivalent feelings and insecurities in order to find the internal motivation they need to change their behavior, often used to address addiction and the management of physical health issues.

Trauma Informed Care – An approach to supporting clients that is grounded in an understanding of and responsiveness to the impact of past and current trauma that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment.

Recovery Peer Support – Formal peer support workers are people who have been successful in the recovery process who help others experiencing similar situations. Peer support workers help people become and stay engaged in the recovery process and reduce the likelihood of relapse.

POSITION DESCRIPTION
Resident Services Coordinator

Job Summary: The Resident Service Coordinator will provide direct supportive services, employment and training support and appropriate referrals for residents on site at Carrfour Support Housing Programs.

Essential Duties/Expectations:

- Engage with residents to collaboratively complete the initial assessment and develop and implement individualized Housing Stability Plans ("HSP") outlining short term and long-term goals

- Provide services utilizing evidence-based practice in service delivery such as intensive case management, Motivational Interviewing, Harm Reduction, Trauma Informed Care, Critical Time Intervention and Housing First Practices to assist in obtaining/increasing income, promoting self-sufficiency and housing stability

- Coordinate with community providers to offer additional services in the areas of, but not limited to: housing stabilization, money management, community integration, employment and training, benefits establishment, referrals to community providers for substance use, primary and mental health care, and all other services needed to assist client in reaching their housing stability goals

- Facilitate/teach daily living skills and workshops for residents in groups and individually as outlined on each resident's HSP

- Conduct scheduled home visits with each resident at the frequency determined in collaboration with the Program Supervisor

- Work in collaboration with the property manager to establish community building activities (resident council, residents' meetings, etc.), facilitate/supervise workshops, information sessions to meet residents needs and interests to enhance life skills

- Provide crisis intervention as needed under the supervision of the Clinical Director or Program Supervisor

- Maintain all client records and information in accordance with our policies

- Ensure compliance with HMIS and timely data entry into Service Point

- Complete all documentation, paperwork in a timely and efficient manner

- Actively participate in quarterly (at a minimum) staffing to address resident progress towards HSP goals and update as needed

- Actively participate in weekly/monthly supervision

- Attend scheduled workshops, trainings and meetings as required

- Cross train across all programs/departments to ensure success of Carrfour Supportive Services

- Other duties as assigned to support and ensure the success of the program

- Reports to Program Supervisor

Skills:

- Understanding of working directly with formerly homeless individuals and families and at-risk populations by treating all individuals with respect and are able to build rapport by promoting empathy and compassion with patience and consistency

- Pays close attention to detail and demonstrates strong organization skills

- Strong critical thinking skills and ability to problem solve

- Effective communication skills backed by detailed written documentation and comprehensive listening skills

- Maintains a professional demeanor and maturity, good judgment, quick learner, and proactive

- Ability to multi-task, prioritize and manage time efficiently

- Highly proficient in Excel, Adobe, Microsoft programs, Outlook, and understanding of database applications, including the use of formulas, functions, data import/export and creating charts

Minimum Requirements Education/Experience:

- Bachelor's degree in social work, mental health, psychology, or related field required and a minimum of three years related field experience

- Individuals who do not possess a Bachelor's Degree will be required to have a high school diploma or equivalent and a minimum of five years related field experience and may be required to become certified as a Behavioral Health Technician

- Knowledge of community resources

- Must have a valid driver's license and reliable transportation

- Ability to work a flexible schedule and be on-call as needed

- Bilingual (English/Spanish or Creole/English) preferred
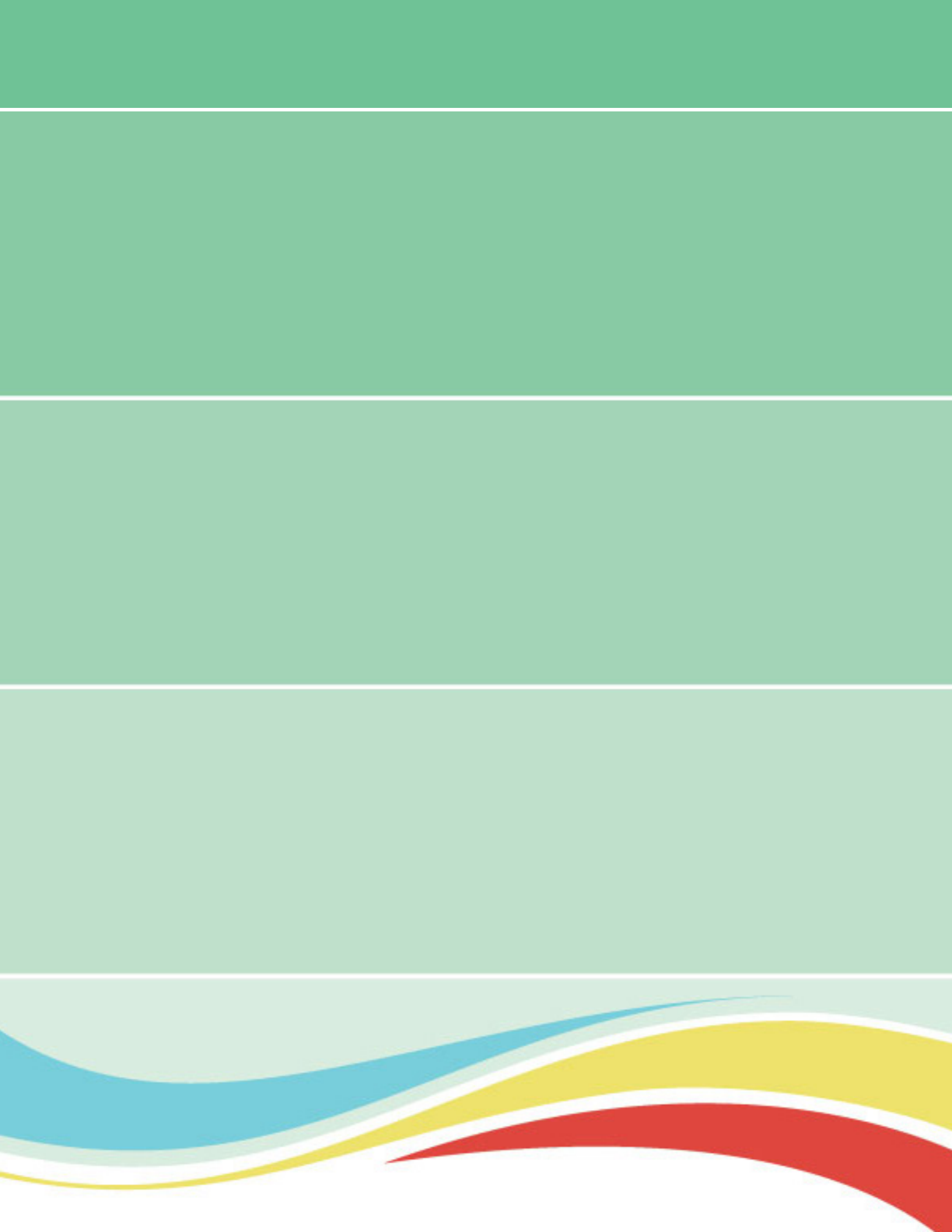
Pilot	Service Model Used by Pilot	Housing Stability Resident Services Coordination	Organization Performing Resident Services Coordination	Housing Stability Resident Svcs Coordination Ratios (Staff to Resident)
Miami-Dade County — Coalition LIFT Carrfour Supportive Housing, Inc	Modified Assertive Community Treatment (ACT) Model	Yes	Carrfour staff	1:17
Duval County — Village on Wiley Ability Housing, Inc	Tenancy Support Model	Yes	Sulzbacher Health Center (FQHC)	1:20
Pinellas County — Pinellas Hope V Catholic Charities, Diocese of St Petersburg	Tenancy Support Model	Yes	Catholic Charities Staff	1:24

Notes:
Local Homeless Continuums of Care (CoCs) get funding from US HUD and state appropriations.
Managing Entities are under contract with the Department of Children and Families to provide funding and oversight for behavioral health services.

Financing Models to Provide Care	Working with Medicaid Managed Care? If so, which MCOs?	Number of Residents that are Medicaid Eligible upon Move-In	Number of Residents that are Medicaid Enrolled after Two Years
Miami-Dade County — Coalition LIFT (out of 35 residents)	No	22	27
Duval County — Village on Wiley** (out of 68 study participants)	No	36*	54*
Pinellas County — Pinellas Hope V (out of 22 study participants)	No	11*	13*

Notes:
* These numbers reflect the proportion of residents in the respective studies rather than all residents at the properties.
** The Duval pilot numbers reflect the number of residents enrolled in Medicaid, Medicare, VA and/or with a local charity hospital "Shands" card.

Funding Source for Resident Services Coordination	Health and Behavioral Health Supports on Site	Linkages to Off Site Clinical Services	Peer Supports	Resident Services on Site	Formal Liasion with the Local Managing Entity	Non Business Hours Staffing
CoC grant obtained by Carrfour	Yes, also a substance abuse recovery group	Yes, Citrus Health primarily, also Camillus Health Center,etc	Yes, 7 days a week	Some	Informal only	Yes
CoC $$, Private grant and Managing Entity funding obtained by Ability Hsng	Partially. Substance abuse recovery svcs onsite; other svcs mainly offsite	Yes, primarily Sulzbacher Health Center; plus others	Yes, part time	Some	ME provided some housing stability case mgt funding	Yes
County $$ obtained by Catholic Charities	Yes, behavioral health; limited nursing available	Yes, mainly for psychiatric/ medication mgt and VA	No	Some	No	No, but limited availability from staff at other parts of campus

COMMUNITY SERVICES

Health Care Services Total
Includes Physical, Mental and Substance Recovery Services below, but cost information from the greyed out categories below does not include all cost data for the Duval County pilot. This summary line is provided b/c a portion of the the Duval healthcare data is not divided into these sub-categories.

Total Physical Health Services
Includes both in-patient and out-patient hospital costs, emergency and ongoing medical svcs, ambulance and non-psychoactive medications; where available, includes local hospital system data.

Total Mental Health Care Services
Includes both crisis care as well as ongoing behavioral health services accessed through DCF/Medicaid systems, including case management and behavioral medications; where available, includes local hospital system data.

Total Substance Recovery Services
Includes crisis and detoxification services as well as ongoing recovery services.

Incarceration Costs
Includes costs related to interacting with the criminal justice system related to jail stays; the Duval pilot also includes the cost of arrests.

Shelter Stays and Homeless Services
Includes the cost of emergency shelter as well as services offered through the shelter or other services pre-move-in recorded in the HMIS (for Duval).

SERVICES TOTAL

HOUSING AND HOUSING STABILITY SERVICES

Housing Operations
Includes publicly and privately paid for costs of utilities, public rental assistance, other operations costs.

Housing Stability Resident Services Coordination
Includes housing stability resident services coordinators, peer supports, nursing case managers where data is available.

Housing Stability Services
Includes many of the services (if delineated) for this purpose, e.g., bus transportation, food, emergency utilities/deposits, life skills, education/employment supports.

HOUSING AND HOUSING STABILITY SERVICES TOTAL

GRAND TOTAL

Miami-Dade County: Coalition Lift			Pinellas County: Pinellas Hope V			Duval County: Village on Wiley		
Pre-Move-In 2 Yrs	Post-Move-In 2 Yrs	Savings/ (Increase) 2 Yrs	Pre-Move-In 2 Yrs	Post-Move-In 2 Yrs	Savings/ (Increase) 2 Yrs	Pre-Move-In 2 Yrs	Post-Move-In 2 Yrs	Savings/ (Increase) 2 Yrs
COSTS ESTIMATED FOR 34 RESIDENTS Service cost data in this report is for 21 residents participating in this pilot study, but here is extrapolated to match the housing data for 34 total residents.			**COSTS ESTIMATED FOR 45 RESIDENTS** Services cost data was for 22 residents participating in this pilot study, but here is extrapolated to match the housing data for 45 total residents.			**COSTS ESTIMATED FOR 68 RESIDENTS** Pilot services and housing data were reported for 68 residents participating in this pilot's survey, so no extrapolation necessary.		
$2,733,171	$970,825	$1,762,346	$739,056	$738,035	$1,021	$7,222,168	$3,826,574	$3,395,594
$2,450,162	$855,508	$1,594,654	$621,218	$559,512	$61,706	$22,772	$79,732	$(56,960)
$280,081	$92,340	$187,741	$97,102	$177,284	$(80,182)	$56,695	$60,460	$(3,765)
$2,928	$22,977	$(20,049)	$20,736	$1,239	$19,497	$20,660	$48,311	$(27,651)
$276,857	$219,543	$57,314	$237,784	$4,091	$233,693	$197,703	$59,910	$137,793
$37,615	$1,426	$36,189	$228,537	$ -	$228,537	$83,434	$1,382	$82,052
$3,047,643	$1,191,794	$1,855,849	$1,205,377	$742,126	$463,251	$7,503,305	$3,887,866	$3,615,439
$ -	$492,876	$(492,876)	$ -	$233,282	$(233,282)	$ -	$1,128,382	$(1,128,382)
$ -	$592,486	$(592,486)	$ -	$148,108	$(148,108)	$ -	$223,369	$(223,369)
$ -	$79,000	$(79,000)	$ -	$ -	$ -	$ -	$14,176	$(14,176)
$ -	$1,164,362	$(1,164,362)	$ -	$381,390	$(381,390)	$ -	$1,365,927	$(1,365,927)
$3,047,643	$2,356,156	691,487	$1,205,377	$1,123,516	81,861	$7,503,305	$5,253,793	2,249,512
Annual per person savings = $10,169			**Annual per person savings = $910**			**Annual per person savings = $16,541**		

COMMUNITY SERVICES

Health Care Services Total
Includes Physical, Mental and Substance Recovery Services below, but cost information from the greyed out categories below does not include all cost data for the Duval County pilot. This summary line is provided b/c a portion of the the Duval healthcare data is not divided into these sub-categories.

> **Total Physical Health Services**
> Includes both in-patient and out-patient hospital costs, emergency and ongoing medical svcs, ambulance and non-psychoactive medications; where available, includes local hospital system data.

> **Total Mental Health Care Services**
> Includes both crisis care as well as ongoing behavioral health services accessed through DCF/Medicaid systems, including case management and behavioral medications; where available, includes local hospital system data.

> **Total Substance Recovery Services**
> Includes crisis and detoxification services as well as ongoing recovery services.

Incarceration Costs
Includes costs related to interacting with the criminal justice system related to jail stays; the Duval pilot also includes the cost of arrests.

Shelter Stays and Homeless Services
Includes the cost of emergency shelter as well as services offered through the shelter or other services pre-move-in recorded in the HMIS (for Duval).

SERVICES TOTAL

HOUSING

Housing Operations
Includes publicly and privately paid for costs of utilities, public rental assistance, other operations costs.

Housing Stability Resident Services Coordination
Includes housing stability resident services coordinators, peer supports, nursing case managers where data is available.

Housing Stability Services
Includes many of the services (if delineated) for this purpose, e.g., bus transportation, food, emergency utilities/deposits, life skills, education/employment supports.

HOUSING AND HOUSING STABILITY SERVICES TOTAL

GRAND TOTAL

Miami-Dade County: Coalition Lift			Pinellas County: Pinellas Hope V			Duval County: Village on Wiley		
Pre-Move-In 2 Yrs	Post-Move-In 2 Yrs	Savings/ (Increase) 2 Yrs	Pre-Move-In 2 Yrs	Post-Move-In 2 Yrs	Savings/ (Increase) 2 Yrs	Pre-Move-In 2 Yrs	Post-Move-In 2 Yrs	Savings/ (Increase) 2 Yrs
Per Person (34 Residents Total)			Per Person (45 Residents Total)			Per Person (68 Residents Total)		
$80,387	$28,554	$51,834	$16,423	$16,401	$23	$106,208	$56,273	$49,935
$72,064	$25,162	$46,902	$13,805	$12,434	$1,371	$335	$1,173	$(838)
$8,238	$2,716	$5,522	$2,158	$3,940	$(1,782)	$834	$889	$(55)
$86	$676	$(590)	$461	$28	$433	$304	$710	$(407)
$8,143	$6,457	$1,686	$5,284	$91	$5,193	$2,907	$881	$2,026
$1,106	$42	$1,064	$5,079	$-	$5,079	$1,227	$20	$1,207
$89,637	$35,053	$54,584	$26,786	$16,492	$10,294	$110,343	$57,175	$53,168
$ -	$14,496	$(14,496)	$ -	$5,184	$(5,184)	$ -	$16,594	$(16,594)
$ -	$17,426	$(17,426)	$ -	$3,291	$(3,291)	$ -	$3,285	$(3,285)
$ -	$2,324	$(2,324)	$ -	$ -	$ -	$ -	$208	$(208)
$ -	$34,246	$(34,246)	$ -	$8,475	$(8,475)	$ -	$20,087	$(20,087)
$89,637	$69,299	$20,338	$26,786	$24,967	$1,819	$110,343	$77,262	$33,081
Annual per person savings = $10,169			Annual per person savings = $910			Annual per person savings = $16,541		

Agency for Health Care Administration (AHCA) – The chief health policy and planning entity for the state. Primarily responsible for Florida's Medicaid program, the licensure of the state's 48,000+ health care facilities and the sharing of health care data through the Florida Center for Health Information and Policy Analysis. Administers contracts with Managed Care Plans through which most Medicaid recipients receive their Medicaid services.

Assertive Community Treatment (ACT) – A team-based treatment model that provides multidisciplinary, flexible treatment and support to people with mental illness 24/7. ACT is based around the idea that people receive better care when their mental health care providers work together. ACT team members help a person address every aspect of their life, whether it be medication, therapy, social support, employment or housing. ACT is mostly used for people who have transferred out of an inpatient setting but would benefit from a similar level of care and having the comfort of living a more independent life than would be possible with inpatient care.

Chronic Homelessness – Refers to a situation in which an individual is experiencing homelessness has: (a) a diagnosable substance use disorder, or (b) a serious mental illness, or (c) a developmental disability, or (d) a chronic physical illness or disability, including the co-occurrence of two or more of these conditions; and meets at least one of the following requirements: (e) has been continuously homeless for one year, (f) has had four periods of homelessness in the last three years, or (g) has had a sustained stay of not less than sixty days and no more than the last two years in an assisted living facility, residential care facility, nursing home, or institution due to a lack of appropriate and adequate supportive housing and services available in the community. An episode of homelessness is a separate, distinct and sustained stay in a place not meant for human habitation, on the streets, in an emergency homeless shelter or in transitional housing.

Continuum of Care (CoC) – a regional or local group organized to carry out a community's goal to end homelessness. CoCs are generally composed of representatives of organizations including: non-profit homeless providers, victim service providers, faith-based organizations, governments, businesses, advocates, public housing agencies, school districts, social service providers, mental health agencies, hospitals, universities, affordable housing developers, law enforcement, organizations that serve homeless and formerly homeless veterans, and homeless and formerly homeless persons. The lead agency of the CoC operates the HMIS, carries out planning for the CoC, coordinates implementation of a housing and service system within its geographic area to meet the needs of the individuals and families who experience homelessness there, and designs and implements the process the allocation of CoC program funds.

Cooperative Agreements to Benefit Homeless Individuals (CABHI) Grant – Competitive grant programs, jointly funded by the SAMHSA Center for Mental Health Services and Center for Substance Abuse Treatment. CABHI programs support state and local community efforts to provide behavioral health treatment and

recovery-oriented services. CABHI's primary goal is to ensure that the most vulnerable people experiencing homelessness and chronic homelessness receive access to housing, treatment and recovery support services.

Coordinated Entry System – A local or regional homeless process designed to quickly identify, assess, refer and connect people in crisis to housing, shelter, resources and services, no matter where they show up to ask for help.

Extremely Low-Income – Refers to the income level of households making 0-30 percent of an area's median income.

Ferrans and Powers Generic Quality of Life Survey – A survey developed by Carol Estwing Ferrans and Marjorie Powers in 1984 to measure quality of life in terms of satisfaction with life. It measures both satisfaction and importance regarding various aspects of life valued by the individual being surveyed, including health and functioning, psychological/spiritual domain, social and economic domain, family and overall.

Florida 1115 Medicaid Housing Assistance Waiver Pilot – With approval from the federal government, Florida's Section 1115 waiver pilot allows participating Managed Care Plans to pay for flexible services for persons with severe mental illness or substance use disorders, including, but not limited to, temporary housing assistance. The goal is to provide additional behavioral health services and supportive housing assistance services for enrollees ages 21 and older with a serious mental illness, a substance use disorder, or both, and who are homeless or at risk of homelessness due to their condition. Ultimately, the goal is to keep these Medicaid recipients in sustainable housing through improved supports.

Florida Department of Children and Families (DCF) – DCF's primary program responsibilities are to assist Florida's most vulnerable residents through adult protective services, family safety and child welfare, substance use disorders and mental health services, and economic self-sufficiency.

Florida Housing Finance Corporation – A statutorily created public corporation of the State of Florida with the mission of financing affordable homeownership opportunities and the development of rental housing using federal and state resources.

Government and Performance Results Act (GPRA) National Outcome Measure Tool for SAMSHA – Provides ten domains for National Outcome Measures (NOM) that measure outcomes for people who are receiving care via SAMSHA funding. The NOMs matrix provides a state-level reporting system that assists in reporting a national picture of substance use disorders and mental health services.

Homeless Management Information System (HMIS) – A local information technology system used to collect client-level data and data on the provision of housing and services to individuals and families experiencing homelessness and persons at risk of homelessness. Each Continuum of Care is responsible for selecting an HMIS software solution that complies with the US Department of

Housing and Urban Development's data collection, management and reporting standards.

Housing First – Under Housing First permanent housing is provided without conditions. This means that properties accept residents without prior requirements for sobriety, compliance with medications or participation in programs. After the resident has moved in, properties following Housing First limit lease terminations to severe lease violations and only after strenuous efforts to resolve any problems, along with continuing services to assure housing stabilization in the resident's unit.

Housing Retention – the ability of residents to successfully remain in their housing. Success of housing retention at a property serving persons who formerly experienced homelessness is typically evaluated by reporting the percentage of residents at the property retaining their housing over a period of time.

Housing Stability – The extent to which an individual's access to affordable housing of reasonable quality is secure. Housing stability actions help a resident stabilize in their home. Housing stability is typically discussed as a best practice to support chronically homeless veterans or others who may not be familiar with how to settle into a new home after living on the streets.

Housing Stability Framework – A broad, overarching framework that provides the necessary supports to help residents at risk of losing their housing with supports to help them manage the issues they are confronting that might cause them to lose their housing. The objective of housing stability is to help residents both obtain and maintain permanent homes. To succeed with this deceptively simple objective requires a range of partners (and funding) working hand in hand across a spectrum of housing and community-based services. For a person to maintain true stability in their housing, they must not only understand the basics of keeping house, but their personal lives must also be stable with whatever behavioral and other supports are needed to help them achieve this.

Managed Care Plans – In Florida, most Medicaid recipients are enrolled in the Statewide Medicaid Managed Care program. AHCA contracts with a number of Managed Care Organizations to provide Managed Care Plans for the delivery of Medicaid health services.

Managing Entities – The Florida DCF contracts for behavioral health services through seven regional systems of care called Managing Entities. These entities do not provide direct services; rather, they work with service providers to allow DCF's funding to be tailored to the specific behavioral health needs in the various regions of the state.

Mini-International Neuro-psychiatric Interview – A short, structured diagnostic interview, developed jointly by psychiatrists and clinicians in the United States and Europe, for DSM-IV and ICD-10 psychiatric disorders. With an administration time of approximately 15 minutes, this test was designed to meet the need for a short but accurate structured psychiatric interview for multicenter clinical trials and epidemiology studies and to be used

as a first step in outcome tracking in non-research clinical settings.

Motivational Interviewing – A collaborative, person-centered approach to elicit and strengthen motivation to change. It offers providers a useful framework for interacting with people who are experiencing homelessness and struggling with mental and/or substance use disorders or trauma. This best practice is rooted in an understanding of how hard it is to change learned behaviors, many of which have been essential to survival on the streets. This approach works with the idea that motivation to change should be elicited from people, not imposed on them.

Operating Assistance – Payments typically made monthly or annually to owners of housing developments to cover a portion of the ongoing costs of operating the property and to make the housing more affordable to residents who may be unable to afford some or all of their rent.

Peer support – Peer specialists are those who have "lived experience" – i.e., they have been through their own recovery processes and can support residents with similar situations. Formal Peer support positions have been found to help residents stay engaged in sustained, successful recovery processes.

Project-Based Vouchers – Federal law allows a public housing authority (PHA) to use a portion of its Housing Choice Voucher funds (also known as tenant-based vouchers, which are provided to households through a contract with the PHA) to provide operating assistance for a certain number of units at a specific affordable rental property through a contract with the property owner. PHAs enter into initial contracts for 15-20 year terms and may agree to extend the initial or renewed HAP contract for an additional period. In Florida most of project-based vouchers are attached to properties serving persons with special needs or serving residents who were formerly homeless. After living at the property for twelve months, tenants may request tenant-based rental assistance from the PHA to move from the property. If a family chooses to move, the PBV assistance remains with the building, to be used by the next occupant, for the length of the contract between the PHA and the landlord.

Public Housing Authority (PHA) – Chartered under state law (in Florida, Ch 421,F.S.), a public housing authority is an autonomous, not-for-profit public corporation at the city, county or regional level with their boards of directors appointed by the city mayor or governor, depending on the PHA. Although housing authorities have a strong relationship with local, state and federal governments, they are independent agencies designed to used federal and other funding to provide affordable housing opportunities for residents. They may do this by managing public housing, providing vouchers to assist with rent payments, developing and managing additional rental housing, and running programs to assist residents with economic self-sufficiency and other objectives.

Rental Assistance – Programs that provide households with short- or long-term assistance to pay rent. Such programs may be local, state or federally funded, and may be temporary programs to address one event (e.g., impacts of losing a home in a hurricane or

an economic event) or longer term to assist very low income persons who qualify for assistance with help to pay rent. In the federal Housing Choice Voucher rental assistance program, households are issued a housing voucher and authorized to find a housing unit that meets the needs of the family and requirements of the program.

Resident Services Coordinator – As defined in this pilot, Resident Service Coordinators work on site with residents where they live to ensure long-term housing sustainability by developing a housing stability plan; focusing on tenancy supports, such as interacting positively with landlords and neighbors; coordinating services to respond to behaviors that may accompany mental illness or substance use so that they don't interfere with success in housing; developing crisis plans as needed; connecting with appropriate community resources; and supporting residents' individual housing goals. Full-time coordinators should have low caseloads – between 15-20 adult residents per coordinator.

Residents Who Are High Utilizers – As a result of often acute, unresolved health care and other concerns that persons experiencing homelessness have, these people may rely heavily on public crisis services. This report refers to persons in these situations as "high utilizers."

Residents with High Needs – Refers to the panoply of services and supports that such a resident needs in order to become and remain stably housed, typically as a result of conditions many persons experiencing chronic homelessness have, including physical, behavioral and/or developmental/intellectual disabilities, and a history of trauma.

SSI/SSDI Outreach, Access, and Recovery (SOAR) – A national program funded by SAMHSA designed to increase access to the disability income benefit programs administered by the Social Security Administration for eligible adults and children who are experiencing or at risk of homelessness and have a serious mental illness, medical impairment, and/or a co-occurring substance use disorder.

Substance Abuse and Mental Health Services Administration (SAMHSA) – Established by Congress in 1992 as the agency within the US Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance use disorders and mental illness on America's communities. SAMSHA makes federal grants to various agencies (including DCF in Florida) to prevent and treat addictive and mental disorders and furthers its work through public campaigns, system reform, policy and program analysis.

Supportive Housing – Combines permanent affordable rental housing with community-based services to help people maintain a stable home. It is a proven model to help people who are not stably housed or who are experiencing homelessness, as well as persons with disabilities who can live independently in the community with supportive services. Provides residents with housing for an indefinite length of stay as long as the tenant complies with lease requirement and has no limits on length of tenancy related to the provision or participation in supportive services.

Supportive Services – Services provided by a service provider to help residents enhance their way of living and achieve self-sufficiency. Such services may be provided directly by the services department of a housing provider or through coordination with existing service agencies and may be delivered through a combination of both on- and off-site service delivery mechanisms, typically with the provision of on-site service coordination.

Tenancy Supports – These services orient and support residents in the basics of what goes into living independently and successfully in a home, such as housekeeping, coaching on developing relationships with property managers and neighbors, directly interfacing with property managers as needed to assist with issues residents may have, and banking and shopping for necessities.

Trauma Informed Care – a critical best practice in helping persons coming out of homelessness develop housing stability. Studies show that an extremely high percentage of adults' mental health or substance abuse issues have reported a history of trauma, often in childhood. This is exacerbated when one experiences homelessness. We know that experiences of trauma impact every aspect of how a person functions, but it can be treated.

VI-SPDAT – The Vulnerability Index–Service Prioritization Decision Assistance Tool is a pre-screening triage tool to quickly assess the health and social needs of persons experiencing homelessness and match them with the most appropriate support and housing interventions that are available. The VI-SPDAT allows homeless service providers to similarly assess and prioritize the universe of people who are homeless in their community and identify whom to treat first based on the acuity of their needs.

World Health Organization Quality of Life-BREF (WHOQOL-BREF) Tool – A quality of life assessment tool developed through the World Health Organization that measures an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns.

Permanent Supportive Housing Property Photos