Statewide Supportive Housing Workgroup

Statewide Supportive Housing Workgroup

Mission

The Statewide Supportive Housing Workgroup has been identified as a group of policy makers for the purpose of developing a statewide Action Plan that will bring together State Agencies for the purpose of identifying efficiencies, improving existing efforts, and charting a course of future collaboration and coordination.

History

Last year, the Florida Supportive Housing Coalition hosted a Policy Day in Tallahassee. Representatives from the Executive Office of the Governor, multiple State Agencies, and other key stakeholders gathered to discuss supportive housing and the households served. The group discussed the need to increase production of housing units for persons with special needs, how to improve access, coordination and funding for supportive services, and the importance of creating data-driven solutions that cross State Agencies and systems of care.

This group examined data from a recently completed statewide needs assessment and worked to identify and outline short- and long-term strategies to address the needs of households that require supportive housing services.

At this Policy Day, the Governor's Office recommended establishing a statewide workgroup consisting of State Agency leadership to identify housing and supportive services policies and actions that can be implemented to best address the needs of our most vulnerable neighbors.

FLORIDA SUPPORTIVE HOUSING COALITION
ADVOCATE EDUCATE COLLABORATE

Supportive Housing for Persons with Special Needs
May 5th Policy Day Report

Florida Supportive Housing Coalition State Agency Briefing

RELEASED: June 13, 2022

CONTACT: Shannon Nazworth, FSHC Policy Committee, Chair
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On May 5, 2022, the Florida Supportive Housing Coalition (FSHC) convened the Executive Office of the Governor, nine State Agencies and other key stakeholder organizations to hold a strategic dialogue regarding statewide supportive housing issues. The facilitated meeting explored common purpose, traced the history of Florida's supportive housing policy and examined how best to:

- Increase production of housing units for special needs populations
- Improve access, coordination and funding for supportive services
- Create data-driven solutions across multiple State Agencies and systems of care

Participating Organizations

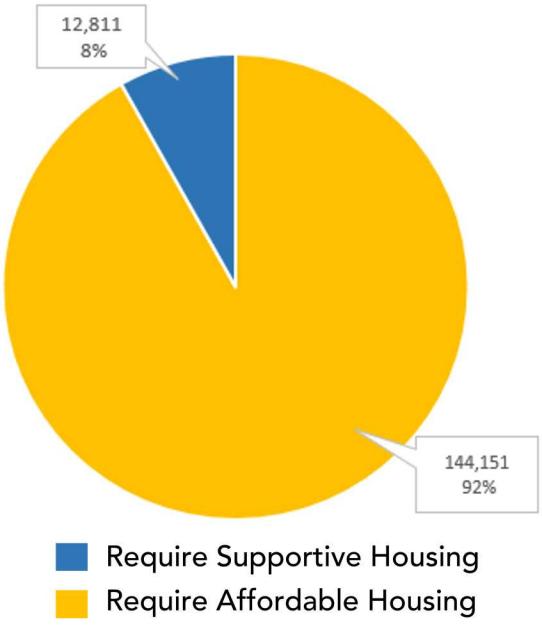
- Agency for Health Care Administration
- Agency for Persons with Disabilities
- Executive Office of the Governor
- Florida Association of Managing Entities
- Florida Coalition to End Homelessness
- Florida Department of Children and Families
- Florida Department of Elder Affairs*
- Florida Department of Veterans' Affairs
- Florida Housing Finance Corporation
- Sunshine Health*
- UF Shimberg Center*
- UnitedHealth

*Agencies invited, but not in attendance

An Achievable Goal

12,811

To meet the need of homeless and special needs households, Florida needs an estimated 156,962 units of affordable and supportive housing. Only 12,811 (8%) need supportive housing; the remaining 144,151 (92%) need affordable housing



Current Inventory of Supportive Housing

- Florida Housing Finance Corporation (FHFC) has supported the production of 2,271 units of supportive housing that are 97% occupied
- FHFC will award $60 Million in 2022 dedicated to the production of additional Supportive Housing

Supportive housing is a proven solution that combines affordable housing with individualized services that help people with the most complex challenges live with stability, autonomy and dignity. It reduces homelessness and avoids the unnecessary institutionalization of people with disabilities. Among those that may need supportive housing are: persons experiencing chronically homelessness, persons with severe behavioral health disorders, homeless youth, youth aging out of the foster care system and survivors of domestic violence. Learn more about Supportive Housing by clicking this link: https://fshc.org/wp-content/uploads/2021/02/FSHC-Educational-Brochure.pdf

Actionable Strategies

Together attendees identified a broad range of recommendations to advance supportive housing statewide:

Immediate Strategies

- Foster interagency information and data sharing to maximize and leverage resources
- Coordinate and align resources for greater efficiency and impact
- Build a statewide database for optimizing access to information on available units
- Convene quarterly State Agency working group
- Use the FSHC 2022 Supportive Housing Summit in October to examine:
    1. Pay For Success/Social Impact Bond strategies
    2. "Speed Dating" to promote sharing knowledge amongst state agencies
    3. Standardized use of service fee structures and performance metrics

Long Term Strategies

- Expand Medicaid eligible services to promote housing and tenancy supports
- Generate new sources of revenue
    1. Enlist health systems and insurance companies to invest in supportive housing
    2. Implement a Pay For Success or social impact model
    3. Work to create a Supportive Housing Trust Fund
- Improve alignment of resources for the development and operation of supportive housing
- Conduct 'Education and Awareness Campaign' to highlight supportive housing and its residents

Key Policy Day Achievement

- ***The Executive Office of the Governor*** proposed developing a Supportive Housing State Plan

- ***Florida Housing Finance Corporation will be the lead*** agency coordinating the state agency collaborative effort to develop the Plan

The Florida Supportive Housing Coalition is deeply grateful to all those that participated in the Supportive Housing Policy Day and for the expertise, dedication and enthusiasm of state agency leadership. We look forward to working alongside you so that together we may create a "road map" of dignity and success for the benefit of persons with special needs.

We invite you to join us at the Florida Supportive Housing Coalition's

2022 Supportive Housing Summit

October 26th and 27th

Hilton St. Petersburg Bayfront

Click below for more infromation

Summit 2022 - Florida Supportive Housing Coalition (fshc.org)

FLORIDA SUPPORTIVE HOUSING COALITION

ADVOCATE ⅄ EDUCATE ⅄ COLLABORATE

Outcomes Report
Policy Day Sept. 7, 2022
FSHC Statewide Policy Summit Conference
Oct 26 -27, 2022

Florida Supportive Housing Coalition State Agency Briefing

RELEASED: December 6, 2022
CONTACT: Shannon Nazworth, FSHC Board; Policy Committee, Chair 904.359.9650 x. 106 snazworth@abilityhousing.org

Policy Day, September 7, 2022

Florida Supportive Housing Coalition (FSHC) re-convened the Executive Office of the Governor, six State Agencies and other key stakeholder organizations to continue a strategic dialogue on supportive housing in Florida. This meeting reviewed and flushed out previously identified key strategies that should be incorporated in a State Supportive Housing Action Plan.

Key Outcomes:

- Executive Office of the Governor designates Florida Housing Finance Corporation as "lead agency" to bring together state agencies to develop a State Supportive Housing Action Plan
- State Action Plan that includes recommendations for implementation to be completed by September 30, 2023
- State Plan to Prioritize
  - State agency leadership engagement
  - Local stakeholder engagement
  - Interagency communication, coordination and resource leveraging
  - Data sharing and data-driven decision making
  - Long-term sustainable funding / creation of a Supportive Housing Trust Fund
  - Streamlined access to housing navigation and supportive housing units
  - Agency and stakeholder capacity development
- Budget Proviso proposed for consideration in 2023 Legislative Session to support State Action Plan

Participating State Agencies and other Stakeholder Organizations

- Agency for Health Care Administration
- Agency for Persons with Disabilities
- Executive Office of the Governor
- Florida Association of Managing Entities
- Florida Coalition to End Homelessness*
- Florida Department of Children and Families
- Florida Department of Elder Affairs
- Florida Department of Veterans' Affairs*
- Florida Housing Finance Corporation
- Sunshine Health*
- UF Shimberg Center*
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Supportive housing is a proven solution that combines affordable housing with individualized services that help people with the most complex challenges live with stability, autonomy and dignity. It reduces homelessness and avoids the unnecessary institutionalization of people with disabilities. Among those that may need supportive housing are: persons experiencing chronically homelessness, persons with severe behavioral health disorders, homeless youth, youth aging out of the foster care system and survivors of domestic violence. Learn more about Supportive Housing by clicking this link: https://fshc.org/wp-content/uploads/2021/02/FSHC-Educational-Brochure.pdf

2022 FSHC Supportive Housing Summit

October 26 - 27, 2022

"Integrating Health, Housing and Services"

This year's FSHC Supportive Housing Summit showcased strategies for advancing and providing supportive housing and offered extensive opportunities for policy leaders, advocates and service providers to advance industry knowledge and expertise. The Summit also reported on results of FSHC's Policy Day and State Agency Planning Session previously held in Tallahassee (May 5/September 7, 2022).

Key Summit Highlights:

- Federal updates on supportive housing, including disaster response and recovery
- Florida Housing Finance Corporation reported State Agency Working Group will develop State Supportive Housing Action Plan, in four upcoming public planning meetings to be held in Tallahassee
- Agency for Health Care Administration and FHFC provide updates on state pilots; noting housing stability retention rates of 85%+
- AHCA, DCF and FHFC now entering into interagency agreements
- FSHC sets policy agenda for 2023 Legislative Session including outreach to stakeholders through community dialogues, and listening sessions
- FSHC celebrates 25th Anniversary and honors the Coalition's founder, Maria Barcus

Summit Presentations by:

Federal

- U.S. Department of Health and Human Services; Substance Abuse and Mental Health Services Administration
- U.S. Department of Housing and Urban Development
- U.S. Department of Veteran Affairs
- U.S. Interagency Council on Homelessness

National

- Center on Policy & Budget
- Community Solutions
- Corporation for Supportive Housing

State

- Agency for Health Care Administration
- Agency for Persons with Disabilities
- Department of Children and Families
- Florida Housing Finance Corporation

The Florida Supportive Housing Coalition is deeply grateful to all who participated in Policy Day and the Statewide Policy Summit. We look forward to working with lead agencies to create a State Action Plan and "road map" of dignity and success for persons with special needs.

Summary of the Estimated Supportive Housing & Affordable Housing Unit Need for All Subpopulations Examined in the Needs Assessment

Subpopulations Assessed	Estimated SH Unit Need (households)	Estimated AH Unit Need (households)	Unit Need Totals (SH+AH)
Individuals Experiencing Chronic Homelessness	4,664	518	**5,182**
Individuals Experiencing Non-Chronic Homelessness	1,580	13,866	**15,446**
Families Experiencing Homelessness*	296	913	**1,209**
Families Living Doubled Up or in Hotels/Motels	1,346	43,508	**44,854**
Individuals Exiting Prison	319	1,278	**1,597**
Youth Aging Out of Foster Care	625	1,875	**2,500**
Homeless Individuals with Severe and Persistent Mental Illness (SPMI) and/or Substance Use Disorder (SUD) in Residential or Inpatient Treatment Settings**	726	1,742	**2,468**
Persons with Intellectual/Developmental Disabilities (I/DD) Requiring Independent Living Services	995	1,990	**2,985**
Survivors of Domestic Violence	80	1,520	**1,600**
Child Welfare-Involved Families with an Adult with Special Needs.	2,180	***	**2,180**
Individuals and Families Receiving SSDI, SSI, or Veterans Disability Benefits	****	76,941	**76,941**
State Totals	**12,811**	**144,151**	**156,962**

Table Note: This table provides a summary of the overall estimated unit need for SH and AH for the subpopulations assessed in this analysis. Duplication across subpopulations has been accounted for in the methodology and removed wherever possible, but the potential for some duplication may continue to persist in the totals listed above. See Methodology section for more details. Numbers reflected in this report may be off +/- 1 due to rounding.

*Chronically Homeless Families make up less than 10% of the chronically homeless population and a small percentage of families experiencing homelessness. As such, this category includes both non-chronic family households and those with a chronically homeless adult with a disability. HUD defines a Chronically Homeless family as a family with an adult head of household who meets the definition of a Chronically Homeless individual.

**Assessment of need for individuals for whom no subsequent residence has been identified upon discharge.

***This category assessed child-welfare involved families where one or more adults in the household who have a Special Need. A rate of 18% was applied to the total number of child-welfare involved families to estimate the share with Special Needs. This estimated number was allocated to a supportive housing intervention. Child welfare involved families without Special Needs may likely have affordable housing needs, but are expected to be captured in other assessment categories and were not assigned to an AH value here to minimize duplication.

Refer to the Methodology section of this document for further details on determination of rates of need.

****In order to further prevent duplication, households in this group that would need supportive housing are assumed to be captured by other systems due to service needs and the high probability of duplication with other subpopulations in systems assessed for this report. This is not intended to indicate that there is never a need for a particular intervention for the specified subpopulation, or that overlap is 100%.

FLORIDA ASSESSMENT OF HOUSING FOR SPECIAL NEEDS AND HOMELESS POPULATIONS

2021

CSH

30 Years of Supportive Housing Solutions

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ABOUT CSH AND FLORIDA HOUSING

Founded in 1991, CSH's mission is to advance solutions that use housing as a platform for services to improve the lives of the most vulnerable people, maximize public resources and build healthy communities. For 30 years, CSH has been the national champion for supportive housing, demonstrating its potential to improve the lives of at-risk individuals and families in desperate need of homes and services. Our efforts have helped house over 385,000 people nationwide. CSH has earned an award-winning reputation as a highly effective, financially stable CDFI, with strong partnerships across government, community organizations, foundations and financial institutions. CSH engages broader systems to fully invest in solutions that drive equity, help people thrive, and harness data to generate concrete and sustainable results. By aligning affordable housing with services and other sectors, CSH helps communities move away from crisis, optimize their public resources, and ensure a better future for everyone. Learn more at www.CSH.org.

Founded more than 40 years ago, Florida Housing Finance Corporation (Florida Housing) is a public corporation of the State, administering federal and state housing programs with a mission to assist in providing a range of affordable housing opportunities for the state's residents. Florida Housing provides financing for both homeownership and rental housing, including permanent supportive housing, working with private and nonprofit developers, lenders, local governments and others to serve Floridians.

ACKNOWLEDGEMENTS

CSH wishes to express sincere thanks to those who contributed to this needs assessment, in particular; Bill Aldinger, Nancy Muller, Elaine Roberts, Zach Summerlin and Kevin Tatreau, of the Florida Housing Finance Corporation; the Florida Needs Assessment Advisory Group members including; Teresa Berdoll, Florida Department of Children and Families, Substance Abuse and Mental Health; Edwin DeBardeleben, Agency for Persons with Disabilities; The Honorable Michael Gottlieb, Florida House of Representatives, District 98; Richard Horner, NAMI Broward Advocacy Group; Susan Morgan, Florida Supportive Housing Coalition; Shannon Nazworth, Florida Council on Homelessness; Anne Ray, The Shimberg Center for Housing Studies; Amanda Rosado, Florida Housing Coalition; Leeanne Sacino, Florida Coalition to End Homelessness; Jim Whittaker, ARC of Florida; and Mark Wickham, Youth and Family Alternatives, Inc., as well as the Florida Department of Children and Families, the Florida Department of Corrections and numerous developers and providers across the state who engaged in conversations to help inform the data acquired through this effort.

EXECUTIVE SUMMARY

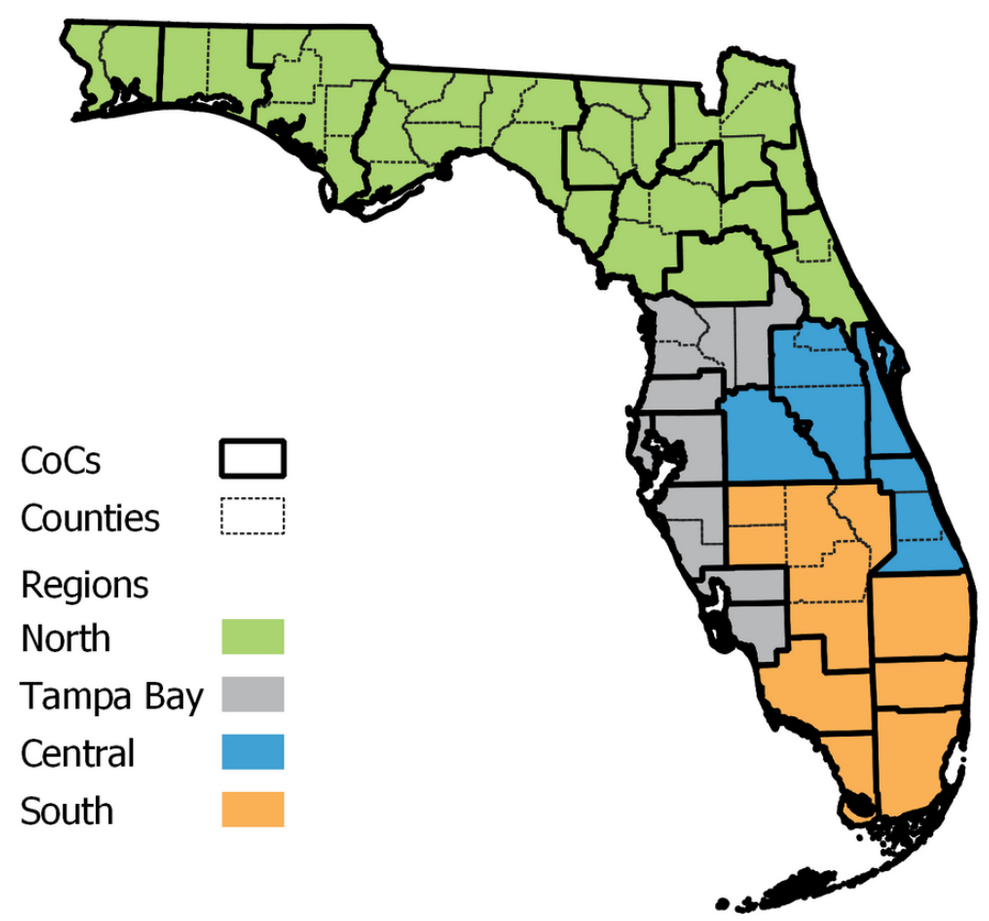
Background and Methodology

In September 2020, Florida Housing Finance Corporation (Florida Housing) contracted with Corporation for Supportive Housing (CSH) to develop a state-level housing needs assessment designed to identify the supportive and affordable rental housing needs of Special Needs and Homeless populations with incomes at or below 60% of area median income (AMI). This effort also included financial modeling to estimate the number of units required to meet the various housing needs of the specified populations in Florida, as well as the costs associated with meeting that need. These costs specifically include the capital costs of financing unit development to meet the rental housing need; operating costs and replacement reserves to maintain that housing; and an analysis of funding support needed to lower barriers to entry to housing.

This report defines the populations and subpopulations specific to this effort describes the methodology(1) utilized to determine the affordable and supportive rental housing needs of those populations, details the assumptions utilized in the analysis, and presents the resultant projected need, as well as the costs associated with meeting that need. The findings presented herein are designed to clearly summarize the results of this effort, with more extensive methodology and reference information provided in the Appendix. Data utilized in this analysis is provided with this report via supplemental Excel tables that can be found on Florida Housing's website.

As utilized throughout this report, the term "Rate of Need" refers to the share of a specified population that, based on the analysis of state and regional data and national research, is assumed to have needs that are consistent with supportive housing. To that end, this analysis grouped housing need into two "buckets" of rental housing types: Supportive Housing, (SH) and Affordable Housing (AH), and grouped populations into Homeless Households and Persons with Special Needs, although this assessment must acknowledge there is overlap between these two broad populations.

The analysis of the need for SH and AH among Homeless Households and Special Needs populations are informed by CSH's National Needs Assessment(2) and refined utilizing extensive state and regional data tailored to the specific subpopulations and geographies assessed in this project. In many instances, Point-in-time(3) or census-style data was utilized to assess the housing need across multiple sectors while seeking to avoid duplication, or double-counting, of individuals and households wherever possible.



Florida Housing divides the state into four regions, North Florida, Central Florida, South Florida and Tampa Bay, in order to allocate financing for homeless housing; this report aggregates the cumulative need for housing into those same regions. Costs associated with developing housing in each of the four regions were applied to the cumulative need, providing a cost summary that reflects the nature of housing development in different parts of the state. The following key findings summarize the housing need, and the costs to meet that need, among the analyzed populations.

(1) Detailed Methodology is available in Appendix I.
(2) https://cshorg.wpengine.com/supportive-housing-101/data/
(3) Refers to a snapshot of the size of a given population at a particular point in time.

Key Findings Summary

Statewide Perspective

- In Florida, an estimated 156,962 homeless and/or Special Needs households have a need for either supportive or affordable housing.
- In total, of the 156,962 households in this analysis with a housing need, 12,811 (8%) require SH, while the remaining 144,151 households (92%) require AH. Of these, 104,894 (67%) are comprised of one- or two-person households and 52,068 (33%) are households of three or more.
- One- and two-person households account for 95,745 (66%) of the 144,151 AH unit need, and households of three or more persons account for 48,406 units (34%).
- Of the one- and two-person households with AH needs, 63% fall within the 0-30% AMI range and 37% fall within the 30.01-60% AMI range.
- Households of three or more persons with AH needs are evenly split between the 0-30% and 30.01-60% AMI ranges.

Homelessness

- An estimated 70,756 households experiencing homelessness in Florida need either supportive or affordable housing.
- Of those, 8,931 (13%) have a need for SH, while 61,825 (87%) have an AH need.
- Individuals experiencing Chronic Homelessness who need supportive housing amount to 4,664 persons, constituting the largest share (52%) of SH need out of all homeless subpopulations. Families experiencing Chronic Homelessness make up just under 10% of the Chronic population in Florida.

Special Needs

- There are an estimated 86,206 Special Needs households in Florida in need of either supportive or affordable housing.
- Of that total, 3,880 households (5%) are estimated to need SH, while the remaining 82,326 (95%) need AH.
- Child Welfare-involved families with one or more adults with a Special Need comprise the largest share of SH need among the Special Needs subpopulations examined in this assessment; 2,180 (56%) of the 3,880 Special Needs households in need of SH are Child Welfare-involved families.
- Of note, Severe and Persistent Mental Illness (SPMI) and/or Substance Use Disorder (SUD) is a contributing factor to housing instability across all subpopulations, including Homeless, assessed in this analysis.
- During Q2 of the fiscal year 2021, 45,723 Floridians utilized Substance Abuse and Mental Health Services. Of those, 2,685 were identified as homeless, 8,291 were independent living settings with either relatives or non-relatives, and 702 were in correctional facilities.

Cost of Housing

- It would cost $36.32 Billion (B) to develop enough new construction units of Supportive Housing and Affordable Housing to meet the estimated need.
- Of that cost, $3.24B is required to develop sufficient SH to meet the need, and the remaining $33.08B reflects the development cost to offset the deficit in AH for these populations.
- Operating costs for all units of supportive and affordable housing, after accounting for tenants' ability to contribute rent, amounts to $21.9B over 15 years. Replacement Reserve costs, which are a component of operating costs, to maintain all units in good condition total $706.3 Million (M) over 15 years.
- ·An additional $219.6M over 15 years is needed to lower cost barriers to entry, such as application fees and security deposits, for homeless and special needs households.

The following table summarizes the estimated need for SH and AH for subpopulations examined in this analysis. Please note that throughout this report, numbers reflected may be off by +/- 1 due to rounding.

Figure 1: Summary Table Detailing the Estimated SH and AH Unit Need for All Subpopulations Examined at the Time of This Analysis.

Subpopulations Assessed	Estimated SH Unit Need (households)	Estimated AH Unit Need (households)	Unit Need Totals (SH+AH)
Individuals Experiencing Chronic Homelessness	4,664	518	**5,128**
Individuals Experiencing Non-Chronic Homelessness	1,580	13,866	**15,446**
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**Assessment of need for individuals for whom no subsequent residence has been identified upon discharge.
***This category assessed child welfare involved families where one or more adults in the household have a Special Need. A rate of 18% was applied to the total number of all child-welfare involved families in the state to estimate the share with Special Needs.

INTRODUCTION

Overview

The purpose of this assessment is to project the scale of need for supportive and affordable rental housing for both Homeless Households and Persons with Special Needs and to model the capital and operating resources necessary to meet that need, as well as examine the costs to lower barriers to entry to housing. While it is important to acknowledge that supportive services comprise a necessary and substantive additional cost to sustain supportive housing, an assessment of those costs was outside of the scope of this analysis.

Of note, in April of this year, Florida Housing released a report on the findings of the **Florida High Needs High-Cost Pilot**(4), which performed a comparative analysis of costs to public systems, both pre-and post-housing, for extremely low-income persons experiencing chronic homelessness who were high utilizers of publicly-funded crisis services. The findings of that report illustrated the effectiveness of Supportive Housing (SH) in maintaining housing stability for high acuity populations.

In Florida, a variety of interventions exist to support individuals and families facing a housing crisis who are experiencing homelessness and/or have special needs that require unique approaches to ensure housing stability. Because the nature of the crisis and the level of support varies on a case-by-case basis, it is essential for an efficient and well-functioning system to understand the appropriate mix of interventions to meet those needs. While examining those types of interventions and services was not a part of this assessment, we recognize the inherent value of supportive services in ensuring housing stability for at-risk populations.

Every three years, on behalf of Florida Housing, The Shimberg Center for Housing Studies at the University of Florida produces a statewide Rental Market Study(5) which includes evaluations of needs for Special Needs and Homeless populations. However, no similar effort existed to assess how much of the total affordable need is comprised of supportive housing specifically for Homeless Households and Special Needs populations and the specific subpopulations examined in this analysis or to model the development and operating costs to meet the identified need. Accordingly, this report is not intended to replace or duplicate the Rental Market Study rather, CSH coordinated with the Shimberg Center and Florida Housing to examine the data utilized in that study in order to further inform the targeted goals of this assessment.

Currently, no single statewide dataset exists that comprehensively captures the supportive and affordable rental housing needs across systems, and the costs to develop units to meet that need, specifically for the subpopulations examined through this effort. Florida's twenty-seven Continua of Care (CoC's) provide an annual count of sheltered and unsheltered homeless persons and collect client-level data on the provision of housing and services to persons experiencing homelessness via HMIS. However, these data sources often exclude many other unstably housed and vulnerable sub-populations. Florida Housing and CSH recognized that this undertaking would entail an alternate approach to gathering and analyzing the data necessary to create projections of both the affordable and supportive housing needs in the state for specific populations experiencing homelessness and/or with special needs.

CSH proceeded to address this challenge by adapting and applying methodologies from our National Needs Assessment, in consultation with Florida Housing and the Florida Needs Assessment Advisory Group. We then analyzed and incorporated regional and state data sets, including HUD Annual Homeless Assessment Reports (AHAR), Annual Performance Reports (APR), Point in Time (PIT) Counts, Housing Inventory Charts (HIC), Florida Department of Education (FDOE) homeless student data, as well as county-level data from other systems - including child welfare and SAMHSA(6)-that serve the target populations. This process also included collaborating with relevant state and local agencies in order to provide

(4) https://www.floridahousing.org/programs/special-programs/report-on-the-findings-of-the-florida-high-needs-high-cost-pilot-april-2021
(5) https://www.floridahousing.org/press/publications/2019-rental-market-study
(6) https://www.samhsa.gov/

affordable and supportive rental housing projections for the populations and areas of need specified by Florida Housing for this effort.

Additionally, it is important to recognize that mental health challenges, particularly Severe and Persistent Mental Illness (SPMI) and Substance Use Disorders (SUD), are exacerbating factors contributing to housing instability and homelessness across all systems of care in the state, as well as across all subpopulations assessed in this effort. In this analysis, as in our national needs assessment, CSH utilizes extensive research and data to develop rates of need that take this population into account across systems, while minimizing duplication wherever possible. See the Methodology Appendix for more details on how data, or the lack thereof, was utilized to address this population.

While stakeholders in Florida have long known that there is a pressing need for more affordable housing – indeed, this is true of virtually every community and state in the country at present – the effort that produced this report uniquely estimates how much of that need should be directed toward supportive and affordable housing for Special Needs and Homeless Populations and models the cost to meet that need. Ultimately, this assessment strives to provide additional and more differentiated datasets of specific subpopulations, as well as an estimate of costs to develop and support the operation of needed affordable and supportive rental housing for the specified populations.

Definitions

Numerous state systems engage with Floridians who may experience housing instability or homelessness, or who have special needs. It is common in Florida – indeed, in all states – for different systems to deploy separate definitions for homelessness, or to categorize needs according to their specific areas of expertise. Thus, it is important to clearly define homelessness and special needs in the context of this assessment. Florida Housing provided CSH with specific definitions for Supportive and Affordable Housing, as well as **Homeless Households** and Persons with Special Needs, for the purposes of this analysis. Below, we define these terms both broadly, and in the scope provided for this effort.

Supportive Housing

Supportive Housing (SH), also commonly referred to as Permanent Supportive Housing (PSH), is a housing model that pairs affordable housing with community-based services and supports, including case management and/or service coordination designed to assist Persons with Special Needs or Homeless Households to achieve housing stability. For this assessment, Florida Housing defines SH as "housing paired with community-based services with onsite case management and/or service coordination to assist Persons with Special Needs or Homeless Households achieve housing stability that allows an indefinite length of stay as long as the tenant complies with lease requirements and has a lease with a minimum of seven months with no requirements related to the provision of or participation in supportive services. Permanent Supportive Housing shall facilitate and promote activities of daily living, access to community-based services, and inclusion in the general community. It is possible that Permanent Supportive Housing units may be embedded in a broader Affordable Housing property."

While there are a variety of models of supportive services and housing assistance that fall under the umbrella of SH, not all households that utilize services and have an affordable housing need would be said to have a specific need for SH. The distinction can be blurry, but SH is targeted towards the higher need individuals and involves integrated housing and services, while other less robust interventions might involve non-integrated housing and services. A key factor in supportive housing is the integration of services alongside housing, as opposed to households that reside in affordable housing and receive other community-based services which are not coordinated with their housing.

Individuals and families in need of SH frequently encounter,

and may reside in, a variety of institutions and systems. The homeless system accounts for some, but not all, of the need for SH in any given jurisdiction. People with needs consistent with SH may reside in foster care homes, carceral settings(7), behavioral health institutions, and/or facilities providing housing for individuals with Intellectual and Developmental Disabilities (I/DD) and other challenges. In addition, Persons with I/DD may be residing in family homes due to a lack of access to independent SH.

Affordable Housing

As defined by Florida Housing for this analysis, Affordable Housing is; "general occupancy rental housing financed with public programs such that rents are restricted to serve households with incomes at or below 60% AMI; in which an individual in a unit may or may not have supportive services unrelated to the unit lease, and that has no time limit on residency assigned to it."

Homeless Household

Florida Housing defines a homeless household as; "an individual or family who lacks a fixed, regular and adequate nighttime residence, including an individual/family who is sharing the housing of other persons due to loss of housing, economic hardship or a similar reason; is living in a motel, hotel, travel trailer park or campground due to a lack of alternative adequate accommodations; is living in an emergency or transitional shelter; has a primary nighttime residence that is a public or private place not designed for, or ordinarily used as, regular sleeping accommodation for human beings; is living in a car, park, public space, abandoned building, bus or train station, or similar setting; or is a migratory individual/family who qualifies as homeless because he, she or it is living in circumstances described above. The term does not refer to an individual imprisoned pursuant to state or federal law or to individuals or families who are sharing housing due to cultural preferences, voluntary arrangements or traditional networks of support. The term does include an individual who has been released from jail, prison, the juvenile justice system, the child welfare system, mental health and developmental disability facility, a residential addiction treatment program or a hospital, for whom no subsequent residence has been identified, and who lacks the resources and support network to obtain housing. Note that this definition includes people living in motels because they have no other affordable place to live."

The above-mentioned homeless definition is from the 2019 Florida Statutes. The Legislature updated this language during its 2020 legislative session to conform with the HUD definition of homelessness. However, Florida Housing asked CSH to use the more expansive 2019 definition as the basis for collecting and analyzing data, because it captures additional populations which are served under Florida Housing's own homeless housing programs, specifically:

1. Persons released from justice systems, child welfare systems, developmental disability settings, or a residential treatment program or hospital for whom no subsequent residence has been identified and who lack the resources and support network to obtain housing; and
2. Persons sharing the housing of other persons or doubled up in motels due to loss of housing, economic hardship, or a similar reason.

Person with Special Needs

For this analysis, Florida Housing describes special needs populations as defined in s. 420.0004(13), Fla. Stat., "an adult requiring independent living services in order to maintain housing or develop independent living skills and who has a disabling condition; a young adult formerly in foster care who is eligible for services under s. 409.1451(5), Fla. Stat.; a survivor of domestic violence as defined in s. 741.28, Fla. Stat.; or a person receiving benefits under the Social Security Disability Insurance (SSDI) program, the Supplemental Security Income (SSI) program, or from veterans' disability benefits." For the purposes of this Needs Assessment, this definition also includes families with children at risk of separation because one or more adults in the household have Special Needs.

(7) Relating to a jail or prison.

While Florida Housing and the Shimberg Center have relied on a variety of datasets, including homeless information, to estimate need, all too often, communities rely solely on data from homeless system reporting to create the yardstick against which they measure progress. A growing effort to examine data across health, mental health, homeless, justice, and other systems shows that people who experience homelessness also use these other systems. For example, youth in foster care often have needs consistent with supportive housing but may not have utilized the homeless services system. Thus, it is critical to gather data as "upstream" as possible, to look at the housing needs for people in advance of a crisis experience of homelessness, along with the current populations of Floridians experiencing homelessness. This assessment takes a broad perspective and models need across a variety of systems in an effort to provide the State of Florida with a more comprehensive view of both the types and affordability levels of housing needed across the state.

FINDINGS

Need and Cost Summary

Overall, among homeless and special needs populations, this analysis projects that there is an estimated unmet need for 12,811 units of SH, for which approximately 9,149 units are needed for individuals and 3,662 units for families. The same populations present a need for 144,151 units of affordable housing, which includes 95,745 units for individuals and 48,406 units for families. The costs associated with developing units through new construction to meet the SH need the amount to $3.24B, and the costs associated with developing the total needed AH amount to $33.08B.

This section will elaborate on the housing need for the primary categories requested by Florida Housing for this assessment: Homeless Households and Persons with Special Needs. In addition, we will examine the subpopulations specified by Florida Housing within those categories and model the costs to develop supportive and affordable rental housing to meet that need.

Homeless Households

The subpopulations examined in this category consist of:

- Individuals Experiencing Homelessness
- Families Experiencing Homelessness
- Families Living Doubled-Up or in Hotels/Motels
- Individuals exiting Prisons
- Homeless Individuals with SPMI/SUD in Residential or In-Patient Treatment Settings

The following paragraphs elaborate on how rates of need were determined for the subpopulations assessed in the Persons Experiencing Homelessness category. We know that there is some overlap between these categories, but as mentioned earlier, persons with SPMI/SUD are prevalent across all subpopulations, and that has been taken into account in assumptions utilized to assess the rates of need for housing interventions.

Individuals Experiencing Homelessness: Homelessness is primarily tallied by means of an annual PIT count, where a count and survey of sheltered and unsheltered people experiencing homelessness are conducted on a single night in January. The PIT classifies individuals into different types of homelessness, including their sheltered/unsheltered status, and by chronicity. HUD defines Chronic Homelessness, essentially, as a single individual (or head of household) with a disabling condition who has been homeless for a year or more(9). This analysis differentiates homeless individuals by chronicity in order to determine groups with differing rates of need for supportive housing – individuals experiencing chronic homelessness are more likely to need supportive housing than those experiencing shorter-term homelessness, as are persons with SPMI and other special needs.

Families Experiencing Homelessness: Homeless families are also accounted for during the annual PIT count. The definition of homelessness employed by HUD results in discounting some families that experience homelessness because they are living doubled-up, or in hotels/motels. These families are accounted for through a Florida Department of Education (FDOE) survey of homeless students which disaggregates homeless families by living situation, allowing the analysis to avoid duplicating families already counted under the Federal definition of homelessness wherever possible. It is important to note that, as the FDOE homeless survey relies on self-reporting, an undercount is also likely in this category. Chronically Homeless Families make up less than 10% of the overall chronically homeless population, and a small percentage of families experiencing homelessness. As such, for the purposes of this analysis, both non-chronic family households and those with a chronically homeless adult with a qualifying disability are included in the Families experiencing Homelessness category and the need for SH was apportioned accordingly. HUD defines a Chronically Homeless family as a family with an adult head of household with a qualifying disability who meets the definition of a Chronically Homeless individual (10).

Families Living Doubled-up or in Hotels/Motels: For the

(8) Unit numbers reflected in this report may be off by +/- 1 due to rounding.
(9) https://www.hudexchange.info/homelessness-assistance/resources-for-chronic-homelessness/
(10) https://files.hudexchange.info/resources/documents/Flowchart-of-HUDs-Definition-of-Chronic-Homelessness.pdf

3% of families living doubled-up or in hotels/motels were assumed to have a need for SH. This assumption is based on the nature of these households' housing instability, which is generally inconsistent with the populations targeted for SH. It is likely that some of these households may have a need for services alongside affordable housing, but that model of housing and services differs from SH, as described in the Supportive Housing definition previously. It is also assumed that families in this subpopulation are likely to be captured in other systems in this analysis, such as in the annual PIT counts in the homeless system, in the child welfare system, and/or with those receiving SSI/SSDI or veteran's benefits. In consideration of the data captured in other systems, data analyzed by CSH on a national scale, discussion with Florida Needs Assessment Advisory Group, and in order to avoid potential duplication, the SH need for this subpopulation was assumed to be a very low percentage.

Of note, over 77,000 students in Florida live without stable housing, either doubled-up or in hotels/motels. Based on student data from the FDOE, approximately 91% of Florida's homeless students live with families. This rate, combined with assumptions on the average family size from the US Census, suggests that there are an additional 37,917 households with housing needs unaccounted for under the federal definition of homeless. For this assessment, CSH utilized the assumption that 3% of these households have a need for SH, as previously described.

CSH maintains a national supportive housing needs assessment(11) applying research-backed rates of need across systems to estimate the number of people in each system who have a need for supportive housing. These national rates were adjusted for this assessment based on Florida specific data and experience. See the Methodology Appendix for more details on the assumptions utilized to determine the rate of need.

The resulting baseline assumptions utilized to determine rates of need for supportive housing (SH) among homeless individuals and families were:

- 90% of chronically homeless individuals have a need for SH
- 10% of non-chronically homeless individuals have a need for SH
- 16% of all homeless families have a need for SH
- 3% of families living doubled up or in hotels/motels have a need for SH

(11) https://www.csh.org/data/

These assumptions result in an estimated need for SH and AH for Homeless Households as illustrated in the two following tables :

Figure 2: SH Need by Region for Individuals and Families Experiencing Homelessness.

Region	Chronically Homeless Individuals with SH Need	Non-Chronically Homeless Individuals with SH Need	Homeless Families with SH Need	Households Doubled Up and in Hotels/Motels with SH Need	Regional Totals
North FL	1,124	433	58	**436**	**2,051**
Tampa Bay	1,448	412	58	**262**	**2,180**
Central FL	610	226	92	**314**	**1,241**
South FL	1,482	510	88	**333**	**2,414**

Figure 3: AH Needs by Region for Individuals and Families Experiencing Homelessness.

Region	Chronically Homeless Individuals with AH Need	Non-Chronically Homeless Individuals with AH Need	Homeless Families with AH Need	Households Doubled Up and in Hotels/Motels with AH Need	Regional Totals
North FL	124	3,841	165	14,104	**18,233**
Tampa Bay	158	3,591	141	8,467	**12,356**
Central FL	70	1,968	346	10,158	**12,543**
South FL	166	4,466	261	10,780	**15,673**

Of note, the PIT counts include homeless individuals and families that are survivors of domestic violence. Because survivors of domestic violence are identified as a separate Special Needs population, individual survivors of domestic violence are ultimately subtracted out from the non-chronic individuals count, and family households fleeing domestic violence are subtracted from the homeless families count. The tables above reflect the PIT numbers without survivors of domestic violence included. See the Persons with Special Needs subpopulation description of survivors of domestic violence for more details regarding that population. Additionally, the AH need in North Florida may be impacted by ongoing displacement due to Hurricane Michael in 2018.

Individuals exiting Prisons: In addition to assessing homeless populations accounted for in the CoC homeless and FDOE systems, CSH examined the likelihood of individuals exiting the prison system who have a need for supportive or affordable housing. Data from the Florida Department of Corrections suggests that 5.56% of individuals exiting the prison system exit to homelessness. Of these, we estimate that 20% have a need for SH and the remainder have a need for AH.

(12) Numbers reflected throughout this report may be off +/- 1 due to rounding.

Homeless Individuals with Severe and Persistent Mental Illness (SPMI) and/or Substance Use Disorder (SUD) in Residential or Inpatient Treatment Settings: The SAMHSA N-SSATS(13) Statewide totals reflect the statewide count of individuals receiving substance use treatment, as well as mental health services, in residential treatment programs at a given point in time. The survey assesses all facilities that provide substance use services, the majority of which also offer other types of mental or behavioral health services. Based on the average rate of homelessness among recipients upon entry, CSH utilizes an estimate that 10% of individuals in these settings have needs consistent with SH, and an additional 24% have an AH need. Because these numbers are reported at the state level, totals were apportioned to counties based on population. Patients receiving mental health services in facilities that do not also offer substance use treatment would be missed in this count, suggesting that the total assessed population will be an undercount.

Individuals with SPMI and/or SUD constitute an overwhelming share of the supportive housing need in Florida, and across the country. Across all systems assessed, the prevalence of SPMI alongside housing instability was a primary driver in estimating the rates of need for supportive housing. Due to a lack of centralized and focused treatment settings for individuals with SPMI, assessing the total scale of need for individuals receiving mental health care is challenging.

As of December 2020, Florida's managing entities under contract with the Department of Children and Families (DCF) operated 183 beds in Community Inpatient Psychiatric Hospitals, and an additional 866 beds in Crisis Stabilization Units (CSUs) or Integrated CSU and Addiction Receiving Facilities (CSUARFs). Daily census data from the managing entities shows that between July 1st and December 31st, 2020, an average of 57 indigent clients were served in Psychiatric Hospitals daily, and an additional 413 indigent clients were served in CSUs and CSUARFs(14).

A larger swath of Floridians encounters the broader Substance Abuse and Mental Health (SAMH) system overseen by DCF. During Q2 of the fiscal year 2021, 45,723 Floridians utilized SAMH services. Of those, 2,685 were identified as homeless, 8,291 were independent living settings with either relatives or non-relatives, and 702 were in correctional facilities. While the data does not disaggregate by type of SAMH services or severity of diagnosis, it is clear that there is a strong linkage between mental health and housing instability.

While the SAMHSA N-SSATS data and associated supportive housing, estimates reflect a portion of Floridians with mental health and substance use disorders needing supportive housing, it does not reflect the full extent of overlapping mental health and supportive housing need in the state. Households with mental health needs overlap all of the populations assessed in this report.
The following table illustrates the SH need for individuals exiting prisons, persons with SPMI/SUD in residential treatment programs:

Figure 4: SH Needs for Individuals Exiting Prisons and in Residential Treatment Programs.

Region	Individuals exiting prisons with SH Need	Individuals in Residential Treatment Programs with SH Need	Regional Totals
North FL	114	160	**275**
Tampa Bay	80	189	**269**
Central FL	65	142	**207**
South FL	60	234	**294**

Persons with Special Needs: This analysis also considers Persons with Special Needs, as defined by Florida Housing, while acknowledging overlap between this category and the category of Homeless Households. This overlap is accounted for in determining rates of needs to avoid duplication wherever possible.

(13) https://www.samhsa.gov/data/data-we-collect/n-ssats-national-survey-substance-abuse-treatment-services
(14) Data from the Florida DCF, Substance Abuse & Mental Health Dashboard, Acute Care Services Utilization Reports, 2020

Furthermore, as is the case with the category of Homeless Households, a considerable share of individuals meeting the definition for Special Needs also have Severe and Persistent Mental Illness and/or Substance Use Disorders. Data on the prevalence of SPMI and SUD inform the rates of need for supportive housing for each subpopulation in the Special Needs category. Many individuals with SPMI and/or Special Needs are not homeless but do experience deep housing instability or rely on natural supports such as familial help in order to maintain housing. The reliance on natural supports to maintain housing while faced with the challenges of SPMI and/or SUD underscores the demand for affordable housing with integrated support services for this population.

The subpopulations examined in this category, as specified by Florida Housing, consist of the following, recognizing that persons with mental illness are dispersed throughout all subpopulations:

- **Persons with I/DD**
- **Survivors of Domestic Violence**
- **Child Welfare-involved Families with an Adult with Special Needs**
- **Youth Aging out of Foster Care**
- **Individuals and Families Receiving SSDI, SSI, or Veterans Disability Benefits**

Persons with I/DD: To assess the needs for SH among individuals with I/DD requiring independent living services, the analysis leveraged the Florida waitlist for these services, disaggregated by living situation. This population has historically had high rates of extended family caretaking and institutional placement, even when such living situations were not ideal or not preferred. Thus, the movement to provide access to independent, supportive housing situations for this population is nascent, and data on the transition to supportive and affordable housing in this population is limited.

The 35,000+ persons with I/DD in Florida with Medicaid services waivers have Person-Centered Support Plans which indicate whether they would like to live independently or in supported living, both of which for this Needs Assessment fit into our definition of affordable or supportive housing. Of these waiver holders, 876 people have indicated their wish to live independently or in supported living.

There are an additional 22,718 persons with I/DD on a waiting list to receive these Medicaid waivers. Out of this total, 518 already are living independently or in supported living. Another 9,794 are under age 21 or would be coming out of situations where their needs are too great to live independently. This leaves a subtotal of 12,406 on the waiting list. To estimate how many of these people might want to live independently, information was gleaned from the National Core Indicator project(15) which carries out consumer surveys of persons with I/DD receiving services. The surveys ask these consumers about their involvement in and satisfaction with decisions related to various aspects of their lives, particularly their living situations and services. One question asks whether the survey respondent "wants to live somewhere else," and in the most recent available survey (2017-18), 17% of Floridians stated they would like to live somewhere else. While this question does not indicate whether they would like to live independently per se, it serves as the best available measure of a desire for this type of home. Seventeen (17) percent of the 12,406 persons on the I/DD waiting list, or 2,109 persons, are estimated to be interested in living independently. Adding those with services desiring to live independently (876) with those on the waiting list who may desire this type of home (2,109), yields a total of 2,985 estimated as needing affordable or supportive housing. The Rate of Need for SH for Persons with I/DD applied in this analysis is 33%.

Survivors of Domestic Violence: According to the National Network to End Domestic Violence's (NNEDV) Domestic Violence Counts report which examines a point-in-time count of domestic violence services recipients, 1,601 survivors of domestic violence received housing assistance through DV providers on a given day in Florida. Based on census data and data from NNEDV, CSH assumes that 5% of

(15) https://www.nationalcoreindicators.org/states/FL/report/2017-18/ National Core Indicators® (NCI®) is a collaborative effort between the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Services Research Institute (HSRI). The purpose of the program, which began in 1997, is to support NASDDDS member agencies to gather a standard set of performance and outcome measures that can be used to track their own performance over time, to compare results across states, and to establish national benchmarks.

DV survivors receiving housing assistance have a need for SH, and the remainder has needs for AH. Trends in the distribution of adult and child recipients of DV services alongside data on the average number of children per family suggest that approximately 60% of households receiving DV services are adult and child households, and the remaining 40% are comprised of individuals.

Child Welfare-involved Families with an Adult with Special Needs: At the national level, among families that have experienced a child removal, CSH estimates that 18% have a need for SH. This data is based on national research, drawing on a combination of the prevalence of homelessness among child welfare-involved families, rates at which housing is a contributing factor preventing family reunification, and the prevalence of co-occurring conditions indicative of SH need, such as mental health, substance abuse, and intellectual or developmental disabilities, in child welfare-involved families. In Florida, available data only includes children already in out-of-home placement. The lack of data on families with special needs that have not yet experienced a child removal but are at risk of child removal means that the analysis for this population likely undercounts the total need. Data was not available regarding families at risk of separation, but where children had not been removed from the home. Consequently, the estimate for total need is based on the calculated number of families that have experienced a child removal. To reduce the risk of duplication with other categories, the total need of 2,180 units resulting from this approach was assumed to have supportive housing needs and no affordable housing need was assessed. This does not mean that there is not a need for affordable housing among child-welfare involved families or families at risk of separation, only that that need is assumed to be captured elsewhere in the methodology and may still present an undercount.

Youth Aging out of Foster Care: Youth Aging out of Foster Care (YAFC) were assessed based on the number who are receiving Aftercare, Extended Foster Care, and Postsecondary Education Services. These totals were provided at the state level and were apportioned to counties based on the distribution of youth in out-of-home foster care. CSH estimates that 25% of youth receiving these services have a need for SH and that the remainder has an AH need. For the purposes of this assessment, YAFC were classified as individuals; we recognize that some YAFC may also have children and/or siblings, but existing data is insufficient to separate YAFC individuals from YAFC who have families.

Individuals and Families Receiving SSDI, SSI, or Veterans Disability Benefits: Individuals and families receiving SSDI, SSI, or Veterans Disability Benefits constitute the final Special Needs category. Affordable housing needs for this group were determined based on the subset of households that fell at or below 60% AMI, experienced a rent burden of greater than 40% of their income and had a person(s) with a disability.

Because SH constitutes a subset of AH, the SH needs for Special Needs populations that might overlap with this category are likely to be captured in other subpopulations (child welfare, youth aging out of foster care, adults requiring independent living services) that have already been assessed. To minimize duplication, no rate for SH need was assigned to this group. The result is an estimate of AH need that minimizes (but does not completely foreclose) duplication. It is possible that a portion of the individuals in this category have needs for housing and services but did not fit into the other Special Needs categories, suggesting that the SH need in this population may be an undercount.

The following charts illustrate the SH need for households in Special Needs subpopulations:

Figure 5: SH Unit Need by Region for All Households in Subpopulations With Special Needs.

Region	Child Welfare Involved Families with SH Need	Persons with I/DD and SH Need	Survivors of Domestic Violence with SH Need	Youth Aging out of Foster Care with SH Need	Regional Totals
North FL	656	288	18	156	**1,118**
Tampa Bay	748	199	21	119	**1,087**
Central FL	393	198	16	93	**700**
South FL	383	310	26	257	**976**

Figure 6: SH Needs by Region for Family Households in Subpopulations With Special Needs.

Region	Child Welfare Involved Families with SH Need	Survivors of Domestic Violence with SH Need (Families)	Regional Totals
North FL	656	11	**667**
Tampa Bay	748	13	**761**
Central FL	393	9	**402**
South FL	383	16	**399**

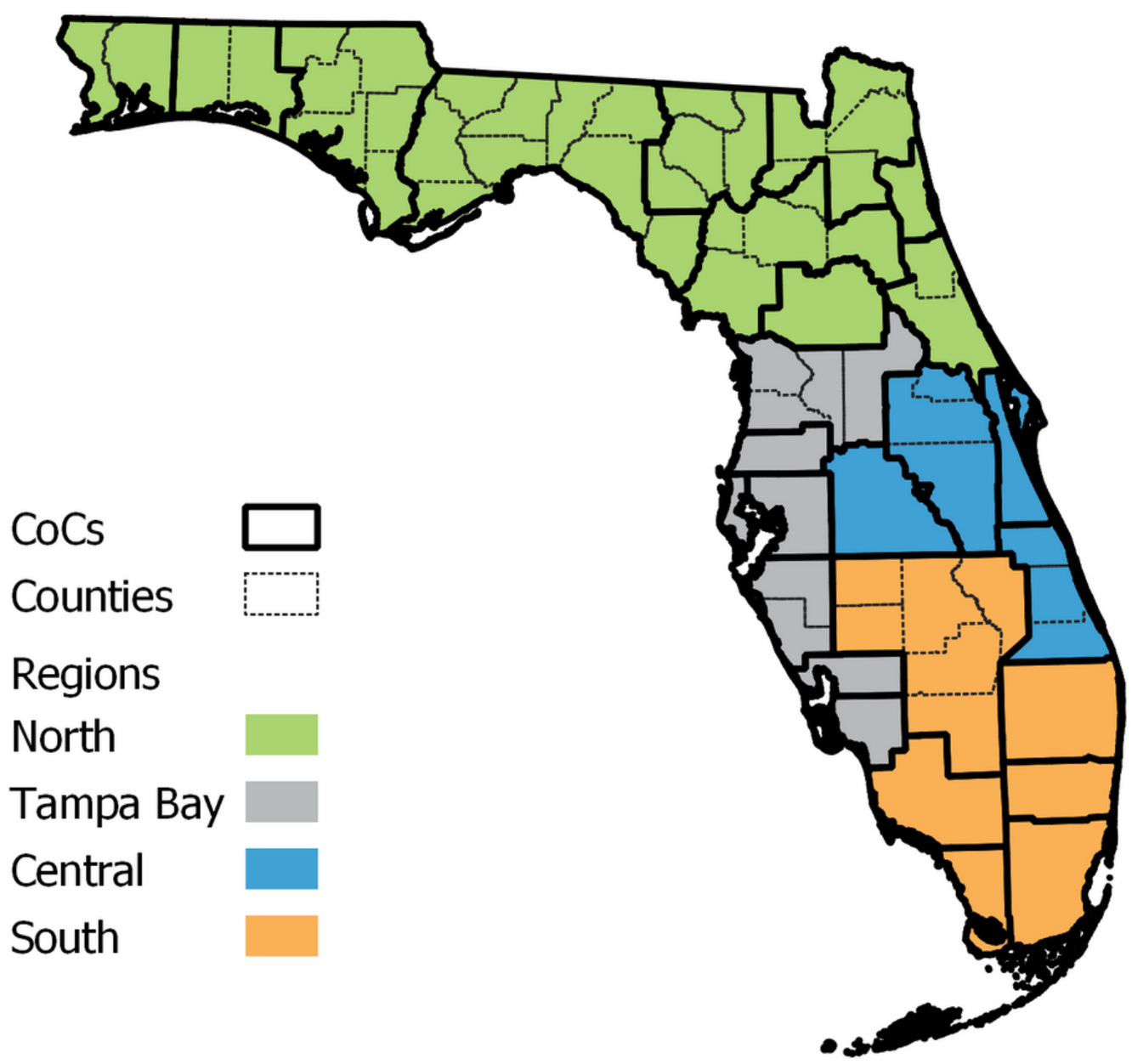
Figure 7: SH Needs by Region for Individual Households in Subpopulations With Special Needs.

Region	Persons with I/DD with SH Need	Survivors of Domestic Violence with SH Need (Families)	Youth Aging out of Foster Care	Regional Totals
North FL	288	7	156	**451**
Tampa Bay	199	8	119	**326**
Central FL	198	7	93	**298**
South FL	310	10	257	**577**

Total Need in Florida

For the purpose of this analysis, the need for supportive and affordable rental housing for Homeless Households and Special Needs populations in Florida was distributed into four primary regions: North Florida, Central Florida, Tampa Bay and South Florida.

Where available, data was collected at the county level. Utilizing this regional methodology allowed county-level data to first be aggregated into CoCs catchment areas and finally into the four specified regions, as illustrated in the image below.



The resultant data on total need were then modelled onto individual and family households. For the purpose of this analysis, individual and adult-only family household need was separated equally into 0-bedroom and 1-bedroom units. For family households, including adults and children, the need was separated into 2-, 3-, and 4-bedroom units. Seventy percent of family households were assigned two 2-bedroom units, 25% were assigned to 3-bedroom units, and 5% were assigned to 4-bedroom units, as illustrated in the charts on the following page:

Figure 8: Total Unit Needs by Region for Individual and Family SH and AH.

Total Unit Need by Region	Individual SH	Family SH	Individual AH	Family AH	Regional Totals
North FL	2,350	1,093	23,635	14,541	**41,618**
Tampa Bay	2,496	1,040	25,823	9,876	**39,236**
Central FL	1,388	760	16,426	11,527	**30,100**
South FL	2,915	769	29,861	12,463	**46,008**

Figure 9: SH Unit Need by Region and Unit Mix.

SH Unit Need by Region and Unit Mix	0-bdrm	1-bdrm	2-bdrm	3-bdrm	4-bdrm	Regional Totals
North FL	1,175	1,175	769	273	50	**3,442**
Tampa Bay	1,248	1,248	727	261	52	**3,537**
Central FL	694	694	533	189	37	**2,148**
South FL	1,458	1,458	541	191	36	**3,684**

Figure 10: AH Unit Need by Region and Unit Mix.

AH Unit Need by Region and Unit Mix	0-bdrm	1-bdrm	2-bdrm	3-bdrm	4-bdrm	Regional Totals
North FL	11,817	11,817	10,177	3,636	728	**38,175**
Tampa Bay	12,911	12,911	6,914	2,469	493	**35,699**
Central FL	8,213	8,213	8,070	2,881	576	**27,953**
South FL	14,931	14,931	8,723	3,116	624	**42,324**

Financial Modeling

In order to assess and model costs over time, Florida Housing provided projected costs associated with developing different types of housing through new construction based upon data on the most recent cost information available(16). These costs were then applied to the assessed need for SH and AH. For financial modeling charts broken out by AMI, region and unit mix, see the Supplemental Data Tables Excel document provided with this report. Costs illustrated below provide estimated Total Development Costs (TDC) for SH and AH units, based on today's costs to develop. Capital costs, Operating costs, Replacement Reserve costs and Costs to mitigate barriers to housing entry are also provided over a 15-year period(17). Replacement reserves are a component of operating costs. All costs are broken out by region and by unit mix in the following tables:

Total Development Costs

Figure 11: Estimated Total Development Cost (TDC) for SH per Unit, by Region and Unit Mix.

Data: 2019-2020 Estimated SH Costs Per Unit (PU)					
Avg. TDC Per Unit (PU)	**North FL Region**	**Central FL Region**	**Tampa Bay Region**	**South FL Region**	**Statewide Average**
0-bdrm	$154,600	$167,500	$159,600	$223,500	**$176,300**
1-bdrm	$214,600	$222,800	$214,300	$272,400	**$231,025**
2-bdrm	$370,700	$305,400	$291,400	$418,500	**$346,500**
3-bdrm	$377,900	$352,700	$392,000	$503,700	**$406,575**
4-bdrm	$441,700	$433,700	$481,600	$623,800	**$495,200**

(16) Florida Housing used construction cost data from developments recently awarded financing. But because 2021 has seen such extraordinary cost increases in building materials and labor, for this assessment Florida Housing added 15% to the construction cost data to bring estimated costs in line with today's costs. Florida Housing believes this increased rate will shortly slow down to a more normal 3-5% increase per year, but the 15% increase puts these estimates more in line with what Florida Housing is now seeing.
(17) In underwriting, the financial feasibility analysis looks at the ability of a new property to be successful over 15 years. However, in exchange for favorable, low-cost financing, most housing financed by Florida Housing is expected to remain affordable for 30-50 years. These cost projections do not evaluate the costs of rehabilitation, recapitalization or operations beyond 15 years.

Figure 12: Estimated Total Development Cost (TDC) for AH per Unit, by Region and Unit Mix.

Data: 2019-2020 Estimated AH Costs Per Unit					
Avg. TDC Per Unit (PU)	**North FL Region**	**Central FL Region**	**Tampa Bay Region**	**South FL Region**	**Statewide Average**
0-bdrm	$135,200	$147,500	$152,700	$201,700	**$159,275**
1-bdrm	$183,200	$200,100	$207,300	$246,200	**$209,200**
2-bdrm	$256,900	$267,500	$286,200	$348,500	**$289,775**
3-bdrm	$305,900	$325,600	$358,400	$442,800	**$358,175**
4-bdrm	$351,600	$393,800	$433,800	$522,000	**$403,967**

Capital Costs

Capital development costs to meet the assessed need entirely through new construction by region and unit mix for SH and AH, consecutively, are shown in the tables below:

Figure 13: Capital Development Costs for New Construction of SH by Region and Unit Mix.

SH Capital Costs	SH 0-BDRM	SH 1-BDRM	SH 2-BDRM	SH 3-BDRM	SH 4-BDRM
North FL	$181,626,522	$252,115,469	$285,108,690	$103,235,391	$22,277,738
Tampa Bay	$199,194,615	$267,464,950	$211,832,049	$102,444,432	$25,075,741
Central FL	$116,250,021	$154,629,879	$162,748,926	$66,799,383	$16,167,845
South FL	$325,801,102	$397,083,760	$226,528,822	$96,438,314	$22,514,168
State Totals	**$822,872,260**	**$1,071,294,058**	**$886,218,487**	**$368,917,520**	**$86,035,491**

Figure 14: Capital Development Costs for New Construction of AH by Region and Unit Mix.

AH Capital Costs	AH 0-BDRM	AH 1-BDRM	AH 2-BDRM	AH 3-BDRM	AH 4-BDRM
North FL	$1,597,721,082	$2,164,959,336	$2,614,364,929	$1,112,294,564	$255,904,173
Tampa Bay	$1,971,576,939	$2,676,541,581	$1,978,833,250	$885,012,774	$213,806,458
Central FL	$1,211,414,596	$1,643,417,360	$2,158,597,119	$938,114,294	$226,843,481
South FL	$3,011,484,946	$3,675,892,879	$3,039,835,901	$1,379,611,105	$325,900,563
State Totals	**$7,792,197,562**	**$10,160,811,156**	**$9,791,631,199**	**$4,315,032,738**	**$1,022,454,675**

Figure 15: Total Capital Costs for SH and AH by Region and State.

Total Capital Costs			
Region	**SH**	**AH**	**Regional Totals**
North FL	$844,363,810	$7,745,244,084	**$8,589,607,894**
Tampa Bay	$806,011,785	$7,725,771,003	**$8,531,782,789**
Central FL	$516,596,054	$6,178,386,851	**$6,694,982,905**
South FL	$1,068,366,165	$11,432,725,392	**$12,501,091,558**
State Totals	**$3,235,337,815**	**$33,082,127,330**	**$36,317,465,145**

Operating and Replacement Reserve Costs

It is important to recognize the value of estimated operating costs, including replacement reserves, as it is extremely difficult for households in the 0-30% AMI range to pay enough rent to enable a property to remain in good condition over time. Operating costs in this analysis reflect the gap between the total costs associated with operating a property and the income received by collecting rent. Thus, housing providers serving these populations regularly apply for project-based rental assistance and other supports from sources such as Public Housing Authorities, CoC's and HUD funding sources to help maintain their properties.

Figure 16: Operating Costs Over 15 Years for SH and AH by Region and Unit Mix.

Operating Costs	1BR SH	2BR SH	3BR SH	1BR AH	2BR AH	3BR AH
North FL	$119,304,845	$107,905,524	$46,466,956	$1,255,370,695	$1,324,575,196	$624,114,804
Tampa Bay	$159,304,346	$128,979,332	$53,679,340	$1,652,741,683	$1,126,013,858	$509,180,417
Central FL	$88,339,409	$92,015,684	$38,018,687	$1,046,716,717	$1,274,983,357	$585,851,335
South FL	$214,295,670	$119,551,219	$47,018,890	$2,242,167,929	$1,656,548,696	$779,332,697
State Totals	**$581,244,270**	**$448,451,759**	**$185,183,873**	**$6,196,997,024**	**$5,382,121,108**	**$2,498,479,252**

In the interest of space, only one-, two-, and three-bedroom units are illustrated in this table. Refer to Supplemental Data Tables on the Florida Housing's website for Costs for all unit mixes and modeling over time. The statewide total for operating costs, including all unit types over 15 years is $21.9b.

Mitigating Cost Barriers to Entry

Cost Barriers to Entry (CBE) include items such as rental deposits, utility deposits and applications fees, the costs of which would pose a barrier to entry to housing for low-income households in the 0-30% AMI range in need of either SH or AH. Housing providers often identify additional resources or assist tenants to do so, in order to cover these costs. Florida Housing has worked with stakeholders and property managers to lower such fees, particularly for extremely low-income households. However, even these lower costs can be barriers to households moving into such housing. For this analysis, CBE was modeled to account for a $300 utility deposit and $35 application fee, as well as two months' worth of rent based on the average Fair Market Rent per unit type in a given region.

Figure 17: Costs to Mitigate Barriers to Entry by Region and Unit Mix for All Homeless and Special Needs Individuals and Families With a Housing Need, and Who Fall Within the 0-30% AMI Range.

Costs to Mitigate Barriers to Entry						
Region	**0-bdrm**	**1-bdrm**	**2-bdrm**	**3-bdrm**	**4-bdrm**	**Regional Totals**
North FL	$14,837,552	$15,841,483	$12,537,848	$5,732,909	$1,319,459	**$50,269,251**
Tampa Bay	$19,928,248	$21,126,630	$11,336,812	$5,209,786	$1,221,877	**$58,823,352**
Central FL	$12,675,808	$13,582,801	$12,493,706	$5,723,294	$1,336,485	**$45,812,094**
South FL	$21,606,311	$23,265,514	$12,662,528	$5,810,334	$1,343,292	**$64,687,978**
State Totals	$69,047,919	$73,816,427	$49,030,894	$22,476,323	$5,221,112	**$219,592,675**

CONCLUSION AND RECOMMENDATIONS

Throughout this assessment, data was collected from a variety of systems aligning with the specified target populations. Wherever possible, a point-in-time type approach was taken to minimize duplication, or double-counting, of individuals and families that have engagements with multiple systems.

Additionally, for each subpopulation, a rate of need for PSH was estimated and applied where applicable. System data was then scaled to the four regions defined by Florida Housing. Data at the county and CoC level was aggregated into the specified regions, and data at the state level was apportioned based on population distribution.

Needs for supportive and affordable rental housing were separated into individual and family households based on the population and data elements reflecting household size, and household types were linked to housing units based on household size and unit mix. The resulting matrices for SH and AH need by region and unit mix were combined with regional cost data provided by Florida Housing to estimate the total costs associated with developing and maintaining additional SH and AH to meet the calculated need.

Among homeless and special needs populations, there is an unmet need for 9,149 units of SH for 1-2-person households and 3,661 units of SH for households of 3 or more. The same populations present a need for 95,745 units of AH for 1-2-person households, and 48,406 units of AH for households of 3 or more. This is a portion of the total need for general affordable housing in the state. The Shimberg Center for Housing Studies found in the 2019 Rental Market Study that there was a deficit of 356,808 affordable and available units for renters in the 0-30% AMI range, and a deficit of 547,624 affordable and available units for renters in the 0-60% AMI range.

The total costs associated with developing new units to meet the need in Florida for Homeless Households and Persons with Special Needs amount to $36.2B, with $3.24B needed for SH, and $33.08B needed for AH development. The 15-year operating costs for the SH units necessary to meet this need total $1.74B, while the 15-year operating costs associated with affordable housing for this population total $20.13B. A further $219.6M is needed to mitigate cost barriers to entry for Homeless Households and Persons with Special Needs. This highlights the critical need for operating assistance in order for developments to effectively maintain the condition of properties over time, while still keeping rents affordable, particularly for low-income households who fall within the 0-30% AMI range and are homeless, have special needs or are experiencing housing instability.

Over the last 10 years, Florida has made progress to minimize the risks of housing instability and reduce the number of people experiencing homelessness through increased collaboration and commitment by leadership within state-governed housing agencies, Homeless CoCs, community service providers, and Advocates for the deployment of evidenced-based permanent housing solutions. However, due to ongoing challenges in the U.S. economy - including rises in costs of goods, low wages, lack of affordable housing inventory, impacts of the global pandemic and the impact of systemic racial inequities around housing, health and income - there remains a prevailing and critical need for additional permanent affordable and supportive rental housing within each of the four regions of the state examined in this analysis.

Recommendations

For consideration as Florida Housing examines strategies to increase unit production to meet the need across the state, CSH offers the following recommendations to enhance efforts to; increase the pipeline of quality, affordable and supportive housing; lower cost barriers to entry to housing; identify sources for acquisition, capital, operating and reserve funding; and improve housing stability for Homeless Households and Persons with Special Needs.

Centering Racial Equity & Amplifying the Voices of People with Lived Experience in Housing Design & Pipeline

Development. Significant new funding from the federal government to increase unit development and access to housing comes with an increased responsibility to purposefully and strategically utilize funding to maximize impact and ensure that unit production efforts are targeted to remediate historic inequities, and not inadvertently further burden/intensify disparities experienced by Black, Indigenous and People of Color (BIPOC) and marginalized communities (e.g., LGTBQ+ people with disabilities). Systemic inequity is further exacerbated by the current health crisis and global pandemic, particularly for persons experiencing homelessness and/or with special needs. It is imperative to examine data(18), identify the most appropriate housing models for various communities and center equity in universal design features. Florida Housing currently has a strong universal design/visibility approach in its Requests for Applications (RFAs) for housing development and would benefit by applying an equity analysis to review and revise existing aspects of unit design. People with Lived Experience (PWLE) are critical stakeholders, and their voices are invaluable to provide insight into various aspects of unit development and design. Thus, it is critically important to examine ways to meaningfully incorporate PWLE and BIPOC into statewide stakeholder groups and planning efforts.

Implement a statewide training initiative to build the capacity for the development and operations of high-quality Supportive Housing. Strengthening the capacity of developers and provider partners to successfully apply for and secure Florida Housing funding to develop and maintain quality SH is critical to expand the pool of knowledgeable and effective SH developers in the state. Consider developing a strategy to implement a capacity-building process in Florida.

Throughout this effort, CSH talked with a variety of stakeholders, including developers and providers at the state and local level, to obtain deeper context to challenges surrounding assisting target populations in obtaining and sustaining housing stability. Despite the existing innovative housing programs and resources in Florida to support special needs and homeless households, the overall consensus of those interviewed was frustration around the lack of enough affordable housing and service resources to effectively meet the need. Additionally, they expressed a need for improved coordination and partnership between housing providers and community-based programs to better serve residents most in need, as well as connect them to permanent housing quickly and ensure housing stability.

Approaching the challenge of building capacity, partnerships and knowledge around the implementation of quality SH and services as a statewide effort could potentially have a tremendous impact in increasing access to quality affordable housing.

Prioritize and target existing and new federal funding, including the American Rescue Plan Act (ARPA) and other CARES Act funding, to jump-start the development of new units by financing capital and operating costs. Newly appropriated ARPA funding, including HOME-ARP(19) and State/Local Fiscal Recovery Funds, is eligible for new unit development use. Additionally, HOME-ARP can be utilized for acquisition/conversion to SH and may also be used for capital and operating reserves. Medicaid/HCBS, HRSA and SAMHSA funding in the ARP include eligible uses for supportive and other services to improve housing stability, as well as to address cost barriers to entry. This surge in funding can be creatively utilized for upfront investment in unit creation and capacity building.

The state, Local jurisdictions and communities should examine efforts to braid this funding to meet the need for SH unit development as well as provide for needed service coordination to ensure housing stability. Of note, as the services funding timeline for HOME-ARP is shorter than the affordability compliance period and the period from which capitalized operating reserve can be drawn down, HOME-ARP should be viewed as a supplementary or bridge resource for supportive services.

(18) https://www.csh.org/2020/04/advancing-equity-through-data/
(19) https://www.hud.gov/program_offices/comm_planning/home-arp

To further the reach and impact of this influx of funding, Florida Housing should consider identifying opportunities to coordinate with local jurisdictions and developers to braid and leverage ARPA funding with the Low-Income Housing Tax Credit (LIHTC) program, National, State and Local Housing Trust Funds, Community Development Block Grants (CDBG), and/or even additional ARPA resources such as the State and Fiscal Local Recovery Funds provides an opportunity to maximize it for supportive housing development. In addition, continue to maintain and increase the availability of incentives to develop affordable housing for people with household income at or below 30% AMI (60% AMI).

HOME-ARP is targeted for individuals and families who are homeless, at risk of homelessness, fleeing or attempting to flee domestic/dating violence or human trafficking, or when additional supportive services or assistance would prevent homelessness or help those at risk of housing instability. However, when utilized for capital costs, only 70% of the units developed must be occupied by those individuals. The remaining 30% of the units may be occupied by low-income households more generally to help sustain the financial feasibility of the development project. HOME-ARP projects have a minimum affordability compliance period of 15 years.

Recommended HOME-ARP activities for **capital funding**, including acquisition, construction and rehabilitation, include:

- Supplementing 9% LIHTC projects to finance more applicants during the 2022 cycle,
- Financing 9% LIHTC projects that did not receive awards in previous years due to limited funding amounts, and
- Pairing with 4% LIHTC and tax-exempt bonds for the cost of construction and/or the permanent financing of a project(20).

Recommended use of HOME-ARP for **operating funding** includes creating a capitalized operating reserve that is held in an interest-bearing account that can be drawn down to cover operating deficits of the supportive housing units in the development. The capitalized account can be maintained for a period of up to 15 years, allowing the ability to drawdown these funds over the minimum affordability compliance period. Of note, capitalized operating reserves from HOME-ARP may only be used for developments that also financed construction cost, at least in part, with HOME-ARP as well.

In addition, locally, the new Emergency Housing Vouchers (EHV)(21) offer an opportunity for jurisdictions to provide long-term rental subsidies and opportunities to:

- Assist residents living in SH who could benefit from rental assistance but no longer require intensive services, which in turn supports the transition of other residents (unsheltered, disabled) into open SH units,
- Assist residents housed using time limited Rapid Rehousing resources who, but for the assistance, would be unable to afford housing,
- Provide sustainable rental assistance for victims of domestic violence or human trafficking, seniors, families, veterans, and individuals and families at risk of or experiencing homelessness, and
- Prioritize permanent housing resources to meet the housing needs of those most highly impacted by COVID-19, people living with chronic health conditions or disabilities, at-risk families and youth, seniors/older adults and those living in unsheltered conditions.

Statewide, Public Housing Authorities (PHAs) in Florida received 24,981 EHVs in the initial ARP allocation. This presents an incredible opportunity for local communities to engage PHAs across the state in strategies to increase access to housing and lower cost barriers to entry.

Additionally, Florida recently received $1,273,479,128 in HOME-ARP funding and Fiscal Recovery Funds in the amount of $8,816,581,838.70 for the State, $11,867,310,184 for metro cities, $17,089,135,281 for counties, and $1,416,425,123.00 for non-entitlement areas. To fill the gap for needed services and supports, including lowering cost barriers to entry, additional funding is also available through

(20) Decisions on how to best apply HOME-ARP to a 4% LIHTC project may depend on the bond volume cap in the state. In states that are near their volume cap, HOME-ARP can be used as a permanent funding source if the state is conserving the bonds by using them for construction costs only. Otherwise, HOME-ARP can be used both for construction and permanent financing. Additional information on financing supportive housing with tax-exempt bonds and 4% LIHTC can be found here: https://www.csh.org/resources/financing-supportive-housing-with-tax-exempt-bonds-and-4-low-income-housing-tax-credits/

(21) https://www.hud.gov/ehv

the ARPA awards through the Health Resources & Services Administration (HRSA)(22), the Community Mental Health Block Grant Program ARP Supplemental Awards(23) and the Substance Abuse Prevention and Treatment Block Grant Program ARP Supplemental awards(24) through the Substance Abuse and Mental Health Services Administration (SAMHSA).

Develop a statewide strategy to identify and invest in opportunities for the acquisition and rehabilitation of abandoned or under-utilized buildings to preserve and expand affordable housing stock. The lack of affordable housing is a national crisis, and the same can be said for the state of Florida. Now more than ever, considering the uncertainty of the long-term scope and impact of the Coronavirus pandemic, it is critical to creating new and preserve existing housing stock to meet the growing need, particularly for low and extremely low-income households with special needs and/or who are facing a homeless crisis. One option that is being successfully implemented across the country is hotel/motel conversion to permanent housing. As hotels/motels throughout the state are being utilized for short-term pandemic housing or abandoned altogether due to significant reduction in use, they are becoming increasingly attractive for acquisition. In the **From Hotel to Home** series(25), CSH discusses cost-effective strategies for the acquisition, quality conversion and funding of hotels/motels and other real estates. In Florida, for example, Alachua County recently approved the purchase of a 36-unit motel to convert into 36 units of affordable permanent housing, partnering with the local PHA for property management. Similar projects are cropping up around the country and present an opportunity to preserve and improve existing housing stock at a much lower cost per unit than new development, bearing in mind potential issues around quality, location and access to amenities that may impact cost-effectiveness.

In California, with one of the highest costs of living in the nation, Project Homekey(26) is an excellent example of the cost savings that upfront investment and coordinated acquisition can accomplish. In this project, for which the California Department of Housing and Community Development (HCD) made available $550 million in Coronavirus Relief Funds (CRF) and other state general and other funding to purchase and rehabilitate housing, including hotels, motels, vacant apartment buildings, and other buildings and convert them into long-term housing. The average CRF cost per unit acquired was $127,254, compared to an average of over $500k per unit for typical new PSH development. The program has been so successful and cost-effective, that in September of this year, the Governor announced an additional investment of $2.75B to expand the program to purchase and rehabilitate properties to convert into up to 14,000 housing units.

Additionally, local governments are often more supportive of this type of affordable housing for vulnerable populations due to the additional incentive of removing blight and improving the quality of neighborhoods.

Coordinate and improve statewide data collection to include persons with mental and behavioral health challenges across systems. While Florida Substance Abuse and Mental Health (SAMH) and the homeless system currently collect and report on subpopulations with SPMI and/or SUD by the living situation, other systems, including child welfare and justice systems, would benefit from including the collection of this data point. Further, the Agency for Persons with Disabilities collects data on its clients by the living situation and would benefit by merging that living situation data with information on the co-occurrence of SPMI and/or SUD. Recognizing that mental illness doesn't discriminate, and affects persons of all ages, genders, races and economic status, improving data collection at a statewide level would greatly increase Florida's ability to mitigate the effects of mental illness on housing stability.

Utilize the findings and lessons learned from the Florida High Need High-Cost Pilot(27) report to effectively

(22) https://bphc.hrsa.gov/program-opportunities/american-rescue-plan/awards
(23) https://bphc.hrsa.gov/program-opportunities/american-rescue-plan/awards
(24) https://www.samhsa.gov/grants/block-grants/mhbg-american-rescue-plan
(25) https://www.csh.org/hotel-to-home/
(26) https://www.hcd.ca.gov/policy-research/plans-reports/docs/hcd100_homekeyreport_v18.pdf
(27) https://www.floridahousing.org/programs/special-programs/report-on-the-findings-of-the-florida-high-needs-high-cost-pilot-april-2021

advocate for the crucial need for increased supportive services funding targeted to support the housing stability of Homeless Households and Persons with Special Needs throughout the state. Notably, the analysis of results from the three pilot sites, all located in metropolitan areas of the state, found:

- Notwithstanding the costs of housing and supports, all three sites showed overall savings in supportive services provided to those experiencing chronic homelessness and cycling through expensive crisis systems, illustrating that SH does indeed provide a cost benefit to local and state governments by allowing the reinvestment of cost savings back into the community,
- Housing stability provided by SH reduces interaction with the criminal justice system and decreases the use and cost of supportive services over time, and
- SH successfully helped high acuity residents to increase their income, obtain health insurance and improve their quality of life, as well as achieve and sustain housing stability over the two-year period of the study.

In closing, our final recommendation above serves to tie together a critical component of successful SH for the focus populations of this analysis: supportive services. Services are the "support" in supportive housing that help people remain successfully housed. While Florida does offer robust services through a variety of funding sources, often they are tied to specific subpopulations with eligibility requirements, and housing providers are left to cobble together funding from a variety of sources with mixed results as the study demonstrated. In addition, as SH and AH inventory increases to meet the need, it will be critical for Florida to invest in resources for service coordination commensurate with unit production in order to ensure housing stability for at-risk populations.

Without an intensive and collaborative focus at the state level on securing increased funding for services and service coordination, as well as the development of strategies to build the capacity of state and local organizations to provide needed services, it will continue to be challenging for the tens of thousands of individuals and families in Florida who are at risk of or experiencing homelessness, and those with special needs, to secure, maintain and retain safe and affordable housing. By exploring innovative strategies to increase the affordable and supportive rental housing pipeline, as well as braid together funding for both unit development and service coordination, Florida will be more effectively equipped to ensure housing stability for populations with the greatest need.

APPENDIX I. METHODOLOGY

Research Design, Data Collection and Financial Modeling
For this effort, CSH worked closely with Florida Housing to identify data contacts for key systems. The CSH data team engaged in discussions with agency data contacts to determine the types and format of available data along with the method of transmission. Publicly available data sources and reports were also collected and analyzed, and data was sorted and divided by county and divided based on county population size into the regions defined by Florida Housing.

CSH modeled costs for developing sufficient units to fill the deficit in supportive and affordable housing. Costs are modeled to reflect the capital development costs for developing new units, operating costs, and reserve requirements. Capital costs to develop new units were provided by Florida Housing, broken out by SH or AH, bedrooms per unit (unit mix) and region. CSH's standard model for calculating operating costs assumes that for a given unit, total costs to operate the unit in good condition are equal to 70% of the unit's Fair Market Rent (FMR). In calculating operating costs, for the purpose of this assessment, it is assumed that tenants in the 0-30% AMI range do not contribute the full cost of rent from income. As mentioned in the report, it is important to recognize the value of estimating operating and replacement reserve costs, as it is extremely difficult for households in the 0-30% AMI range to pay enough rent to enable a property to remain in good condition over time. Operating costs in this analysis reflect the gap between the total costs associated with operating a property and the income received by collecting rent. Thus, housing providers serving these populations regularly apply for project-based rental assistance and other supports from Public Housing Authorities, CoC's and HUDs to help maintain their properties.

Cost barrier assumptions are based on an analysis of county-level data of Fair Market Rents (FMR), average statewide utility costs and average application fees; assumed to include two months' rent, $300 utility deposit and $35 application fee per unit. These costs reflect estimates of what is needed to assist households to move into housing, recognizing that housing providers who serve these populations frequently work with other organizations to obtain funds or in-kind donations to cover all or part of these costs in order to mitigate barriers to entry. Turnover costs were not factored into estimates for this analysis.

The Shimberg Center for Housing Studies at the University of Florida makes available current FMRs for each county in Florida. For subpopulations where data was available at the county level, FMRs were applied directly to the assessed unit need by unit mix. For subpopulations that did not have data available at the county level, the unit need was apportioned to counties based on population distribution, and FMRs were applied to the apportioned totals.

For each subpopulation in the analysis, available data was collected, and the total households accounted for in each system was assessed, broken out by the geography in which that data was originally collected, organized, and made available. For many subpopulations, this aggregation takes place at the county level, while for others separate jurisdictions are used, such as the CoC, for data on homelessness.

Additionally, a rate of need (defined here as
the share of a specified population that, based on local data and national research, is assumed to have a need for SH) for supportive housing was established and applied in order to calculate the estimated supportive housing need for each subpopulation at the original data's geographic scale, aggregated up to the state level. These rates are determined by combining research and evaluation conducted at the national level with data collected by Florida's administrative systems that describe the housing and service needs of their constituents and informed by the Florida Needs Assessment Advisory Group and stakeholder interviews with experts in each subpopulation.

In some instances, numbers between total need and specific

need by unit type may be off by one or two units. This is due to rounding where the total need is distributed across unit types and the result is rounded to the nearest whole number. For example, a population may have a need for 201 individual units of SH. This would be distributed to 100.5 0BD and 1BD units each, which are rounded up to show 101 units of each type.

Assumptions Utilized in the Analysis

CSH utilized numerous data sources to develop need and cost projections, these sources and data are detailed in the Supplemental Data Tables Excel document provided with this report.

CSH has maintained a national supportive needs assessment since 2018 that utilizes research-backed percentages to estimate the cross system need for supportive housing. At the state level, these estimates may vary and for this reason, after creating estimates based on the source data we vetted, reviewed and revised assumptions with key stakeholders. The resultant need and cost projections are estimates based on the best data available today and may be further refined by stakeholders as additional data becomes available in the future.

The projections show the minimum estimated unmet need for supportive and affordable housing among Homeless Households and Persons with Special Needs.

No single data set captures the specific need for supportive and affordable housing as intended in this assessment. As such, numerous assumptions around the distribution of the need for housing interventions and costs must be made. Key assumptions include:

General Assumptions

- SH is primarily intended as an intervention for households with the highest level of needs. Accordingly, this assessment assumes that 100% of 0-30% AMI households who are homeless or have special needs are initially targeted for SH.
- Census data reflecting cost burden (i.e., paying more than 40% of a household's income for rent and utilities) among households receiving SSI, SSDI, or VA benefits shows that 63% of one- and two-person households requiring affordable housing fall in the 0-30% AMI range and 37% of those households requiring affordable housing fall in the 30.01-60% AMI ranges(28). Households of 3 or more persons are evenly split between the 0-30% and 30.01-60% AMI ranges. These ratios were applied to the affordable housing estimates in this assessment.
- One- and two-person adult-only households, excluding those households that are known to be adult-and-child households, are projected to require an even split of 0- and 1-bedroom units.
- Of 3+ person households, 70% are projected to require 2-bedroom units, 25% are projected to require 3-bedroom units, and 5% are projected to require 4-bedroom units.

Rates of Need

"Rate of Need" for SH is defined as the share of a given subpopulation that is estimated to have needs that are consistent with supportive housing. Each subpopulation is assigned a Rate of Need-based on a variety of data, including the Centers for Medicare and Medicaid Services and the US Census Bureau(29), which includes the prevalence of co-occurring conditions associated with SH, rates of the housing crisis, and more. In some instances, the rate of need for a specific subpopulation in this analysis is reflected as Not Applied, due to the high probability of duplication with other subpopulations in systems assessed for this report and is not intended to indicate that there is never a need for a particular intervention for the specified subpopulation, or that overlap is 100%.

Where a strict **Rate of Need for SH** was applied for a subpopulation, the rates utilized in this assessment are:

• Chronically Homeless Individuals: 90%
• Non-Chronically Homeless Individuals: 10%
• Homeless Families(30): 16%
• Homeless Individuals Exiting Prisons: 20%
• Families and Individuals Living in Hotels/Motels or

(28) Note that these estimates are for affordable housing generally and do not attempt to discern whether the household might be more stable in SH.
(29) https://www.csh.org/data/ See the Data Reports by Population section near the bottom of CSH's Data webpage for detailed information on rates of need assumptions for specific subpopulations.
(30) Chronically Homeless Families make up less than 10% of the chronically homeless population and a small percentage of families experiencing homelessness. As such, this category includes both non-chronic family households and those with chronically homeless adults with a disability. HUD defines a Chronically Homeless family as a family with an adult head of household who meets the definition of a Chronically Homeless individual.

Doubled-Up: 3%

- Homeless Individuals Receiving Residential or Inpatient Behavioral Health Services: 10%
- Youth Aging Out of the Foster Care System: 25%
- Survivors of Domestic Violence: 5%
- Persons with I/DD: 33%
- Child-Welfare Involved Families with an Adult with Special Needs: 18%(31)
- Households Receiving SSI, SSDI, or Veterans Benefits: Not Applied(32)

As a starting point, rates of need were utilized from CSH's National Needs Assessment and modified based on Florida-specific data wherever possible and available, as well as through intensive discussion with Florida Housing and the Advisory Group. For detailed methodology on the assumptions for rates of need in CSH's National Needs Assessment, how they were determined, and trends over time, please see www.csh.org/data and refer to the section entitled Data Reports by Population near the bottom of the page.

Summary of Data Methodology for Populations and Subpopulations

Homeless Households and Persons with Special Needs

As described previously, for the purposes of this assessment, Homeless Households were broadly defined as those:

- Experiencing homelessness as defined in the 2019 s. 420.621(5), Fla. Stat., which refers to an individual or family who lacks a fixed, regular and adequate nighttime residence as defined under "homeless" by the U.S. Department of Housing and Urban Development (HUD) (24 CFR s. 578.3); or an individual or family who will imminently lose their primary nighttime residence as defined under the HUD guidance; or
- Persons released from justice systems, child welfare systems, developmental disability settings, or a residential treatment program or hospital, for whom no subsequent residence has been identified and who lacks the resources and support network to obtain housing; or
- Persons sharing housing of other persons or doubled up in hotels/motels due to loss of housing, economic hardship, or a similar reason.

Many systems collect data on the population described above, but no dataset exclusively captures those individuals and families meeting the above definition. Consequently, a variety of data from different institutions have been analyzed and deployed in such a way as to minimize duplication while capturing the best possible estimate for homelessness in Florida. This includes Point-in-Time Count data from HUD, data on families and unaccompanied youth living in motels/hotels or doubled up, state prison rolls, and more.

Because members of the included subpopulations may have contact with a variety of systems over the course of a year, census-type or point-in-time data is leveraged to assess the scale of each subpopulation while minimizing (but not necessarily eliminating) duplication. In some instances, because of how the available data is collected, there is potential for duplication (e.g., a student is identified as homeless by the local school system while living in a motel, and their family later meets the federal definition of homelessness and is captured in the PIT count).

However, available data for some subpopulations does not capture the entire universe of households meeting the definitions of homeless and special needs (e.g., FDOE data that only identifies doubled up students but does not identify adult individuals living doubled up), resulting in a likely undercount. Refer to Appendix II for specific datasets utilized.

As is the case with the homeless definition, no single data source provides counts of households meeting the special needs definition utilized. Therefore, a variety of data sources were deployed to estimate a special needs population that meets the defined criteria while avoiding duplication. The American Community Survey provides a strong basis for these estimates, and other data sets used to supplement

(31) A rate of 18% was applied to the total number of child-welfare involved families to estimate the share with Special Needs. This estimated number was allocated to a supportive housing intervention. Child welfare involved families without Special Needs may likely have affordable housing needs, but are expected to be captured in other assessment categories and were not assigned to an AH value here to minimize duplication.

(32) To minimize duplication, the supportive housing needs for Youth Aging Out of the Foster Care System, Persons with I/DD, and Child-Welfare Involved Families are assumed to overlap to some extent with the broader population of households receiving SSI, SSDI, or Veterans benefits. Because PSH constitutes a subset of AH, the PSH need for those subpopulations is removed from the total AH needs in the SSI/SSDI/VA population, as that need is assumed to ultimately be captured in other systems.

and enhance those assumptions include data on services provided to subpopulations in the Special Needs category, such as youth in foster care settings, census counts of survivors of domestic violence receiving housing services, and more.

For clarity, throughout this assessment the cohorts defined above were disaggregated by subpopulation and simplified as follows in order to assess the need for supportive and affordable rental housing:

- Homelessness:
  1. Individuals experiencing chronic homelessness
  2. Individuals experiencing non-chronic homelessness
  3. Homeless families(33)
  4. Families and unaccompanied youth living in hotels/motels or doubled up
  5. Homeless individuals exiting the state prison system
  6. Homeless Individuals with SPMI/SUD receiving residential or hospital inpatient treatment

- Special Needs:
  1. Persons with I/DD
  2. Youth aging out of foster care
  3. Survivors of domestic violence
  4. Persons with SSDI, SSI, or Veterans Disability Benefits
  5. Child Welfare-involved families with an adult with Special Needs

The methodology used in this assessment is designed to minimize duplication wherever possible but cannot entirely eliminate it. There is potential overlap between the Homeless and Special Needs populations across systems, as well as the potential overlap between the subpopulations in each category, particularly as it applies to persons with mental and behavioral health challenges. In Florida, there is not sufficient data collected across systems that provides an accurate count of persons with mental illness that also describes their living situation, outside of those who are receiving in-patient or residential treatment, other than the annual PIT count conducted by CoCs. CSH recognizes that mental and behavioral health challenges are a special need and mitigating factor in those experiencing homelessness and housing instability, as well as recognize the importance of addressing the housing and service needs for this group. In future data collection efforts, Florida would benefit from collecting mental health data across all systems to provide a more accurate assessment of the true housing need in the state for Persons with SPMI/SUD.

Subpopulations

Data used to model the need for SH and affordable housing in these subpopulations are summarized below and detailed in the Supplemental Data Tables Excel document that can be found on Florida Housing's website.

Individuals and Families Experiencing Chronic and Non-Chronic Homelessness:
The 2019 PIT reports the number of individuals and families experiencing homelessness on a given night and is required by the U.S. Department of Housing and Urban Development (HUD) for a Continuum of Care (CoC) to apply for McKinney Vento Act homeless assistance funds. While there are methodological challenges related to the PIT approach, it is the best available data describing the population experiencing homelessness under the HUD definition.

Families and Unaccompanied Youth Living in Hotels/Motels or Doubled Up:
The Florida Department of Education (FDOE) 2018-2019 homeless student count is based on data submitted by homeless liaisons for all Florida school districts and are made available through the Shimberg Center's Data Clearinghouse. The report includes students identified as homeless during the 2018-2019 school year and categorizes students by place of nighttime residence and by accompaniment status. To minimize duplication with other homeless data, CSH filtered this data to only those students residing in hotels/motels or doubled up. Accompaniment data is used to determine the share of students that are in families and is adjusted to account for the likelihood that multiple children belong to the same family.

(33) Chronically Homeless Families make up less than 10% of the chronically homeless population and a small percentage of families experiencing homelessness. As such, this category includes both non-chronic family households and those with chronically homeless adults with a disability. HUD defines a Chronically Homeless family as a family with an adult head of household who meets the definition of a Chronically Homeless individual.

This data only captures families and youth that are identified as homeless in the school system and does not count homeless adult individuals or adult families or families with children that are not yet school-aged. It is likely that this is an undercount of the actual hotel/motel and doubled up the homeless population. Further, because the FDOE data describing this population captures all student households that are identified as homeless at their first presentation, it is possible that those with deeper housing and service needs may, over the school year, develop deeper housing needs meeting the federal definition of homelessness, and also may be captured in the PIT Count.

Homeless Individuals Exiting Prison:
The Florida Department of Corrections (FDC) provided data directly to Florida Housing and CSH, which counts the annual releases from prison by county. FDC further provided data describing the rates of homelessness among individuals being released on a per-year basis, from the fiscal year 2015/2016 through the fiscal year 2019/2020. In FY 2019/2020, 5.56% of individuals released were homeless. Rates of homelessness increased in each reporting year, with FY 2019/2020's 5.56% rate of homelessness being the highest in the 5-year span. This dataset only reflects the prison population and is does not count the broader justice-involved category, such as releases from local jails.

Homeless Individuals with SPMI and/or SUD Receiving Residential or Hospital Inpatient Treatment:
The U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) collects data from treatment facilities in the United States, both public and private, that provide substance abuse in addition to mental and behavioral health treatment through the **National Survey of Substance Abuse Treatment Services** (N-SSATS)(34). The N-SSATS are the best currently available dataset that captures this inpatient population with any degree of accuracy while avoiding duplication. Data collected in NSSATS, in addition to a point-in-time style count of persons residing in such facilities, also examines topics including, but not limited to; services offered; the primary focus of treatment (substance abuse, mental health, both, general health, other); counseling and therapeutic approaches; and type of treatment provided. The survey is utilized to generate SAMHSA's Inventory of Behavioral Health Services (I-BHS)(35), which is a nationwide electronic inventory of Behavioral Health facilities. The format of published data changes from year to year, and the most recent version that contains client counts by service setting at the time of this analysis is the 2017 N-SSATS. The 2017 N-SSATS reports a one-day, census-type count of individuals receiving services in residential facilities. These counts were conducted on March 31st, 2017 and were filtered to reflect only individuals in residential or hospital inpatient settings. Facilities providing mental health treatment, but specifically excluding substance abuse treatment, and facilities that did not respond to the survey may not be captured in this dataset, suggesting that the assessment for this population is most certainly an undercount.

It is important to note that some individuals experiencing mental and behavioral health challenges in need of housing, but not residing in a facility, are captured in other datasets, such as the homeless CoC PIT count and the dataset of individuals receiving SSI/SSDI or VA benefits. However, due to a lack of data on individuals in need of housing but not meeting the federal definition of homelessness, there is potential for an undercount in this population. Data from Florida's Managing Entities (MEs) and the SAMHSA system make it clear that there is an extensive need for mental health services in Florida, and that there is considerable overlap between households with mental health needs and housing instability. Due to the overlapping nature of needs and systems, and because the methodology focuses on systems that serve individuals in a given residential or institutional setting at a point in time, incorporating ME data alongside other systems data introduces considerable duplication issues. The SAMHSA N-SSATS dataset, while not comprehensively reflecting the total extent of Floridians with

(34) https://www.samhsa.gov/data/data-we-collect/n-ssats-national-survey-substance-abuse-treatment-services
(35) https://wwwdasis.samhsa.gov/dasis2/isatsonline.htm

SPMI or other mental health needs, is utilized due to the combination of its point-in-time data type and coverage. The prevalence of SPMI among households served in other systems is a driving factor in estimating each system's rate of supportive housing need. This method aims to capture the overlapping needs of housing unstable households with mental health needs, but risks hiding the extent of mental health needs as clients are suffused across other systems. The need for mental health services for housing unstable Floridians is considerably higher than the SAMHSA N-SSATS data alone would suggest.

Persons with I/DD:
The Florida Agency for Persons with Disabilities (APD) provided data directly to Florida Housing and CSH which counts the number of adults per county on the waiting list for services by Priority Category and by Living Setting. These counts were filtered to reflect individuals who are not already residing in an Independent or Supported Living setting. Data reflecting those receiving services and those who express a desire to live independently were also considered. The data received reflected counts as of December 1st, 2020.

Youth Aging out of Foster Care:
CSH utilized data from the Count of Children in Out of Home Care Data Table and filtered for children under 17 to minimize duplication when modeling transition-aged youth aging out of foster care. For the purposes of this assessment, YAFC were classified as individuals; we recognize that some YAFC may also have children and/or siblings, but existing data is insufficient to separate YAFC individuals from YAFC who have families.

Survivors of Domestic Violence
The National Network to End Domestic Violence (NNEDV) conducts an annual Domestic Violence Counts Report with data for each state. This report is an annual, census-style report counting unduplicated adults and children seeking services from U.S. domestic violence shelter programs during a single 24-hour period. The 15th annual count which was used for this assessment was conducted on September 10th, 2020. The count breaks out utilization by individuals and family households and identifies the share of individuals receiving housing. CSH adjusted the counts of adults and accompanied children based on average family size to estimate the number of family households served.

Persons with SSDI, SSI, or Veterans Disability Benefits:
The Shimberg Center for Housing Studies at the University of Florida provided to CSH an analysis of U.S. Census Bureau 2019 American Community Survey Public Use Microdata Sample data that identifies the number of renter-occupied households for which at least one of the following is true:

- One or more members of the household is 18+, reports a Census disability, and receives SSI;
- One or more members of the household is 18-64, reports a Census disability, and receives Social Security; or,
- One or more members of the household is age 18+ and has a VA service-connected disability rating of 10% or higher.

This count was then filtered to reflect those households with a 40% or greater cost burden and was disaggregated by household size and by Area Median Income category.

To allocate the statewide count across regions, CSH also employed the Shimberg Center's Special Needs data on Disability and Housing Need, available on the Shimberg Center's Florida Housing Data Clearinghouse. The statewide need identified in the above criteria was apportioned at the county level based on the distribution of need identified in the Disability and Housing Need dataset.

Child Welfare-involved Families with an Adult with Special Needs:
The Florida DCF publishes data on the counts of children in an out-of-home placement through their Placement in Out-of-Home Care Data dashboards. At the time of analysis, the most recent published data was extracted on December 10th, 2020. This reflects a point-in-time count of children in out of home placement as of the extraction date. These counts were adjusted to estimate the number of households based on average children per household. Data was not available regarding families at risk of separation, but where children had not been removed from the home.

(1) Detailed Methodology is available in Appendix I.
(2) https://cshorg.wpengine.com/supportive-housing-101/data/
(3) Refers to a snapshot of the size of a given population at a particular point in time.

RESULTS OF THE FLORIDA HIGH NEEDS HIGH COST PILOT 2021

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Pilot Questions

Can Florida save money by providing supportive housing with services to high utilizers of crisis services who were experiencing chronic homelessness?

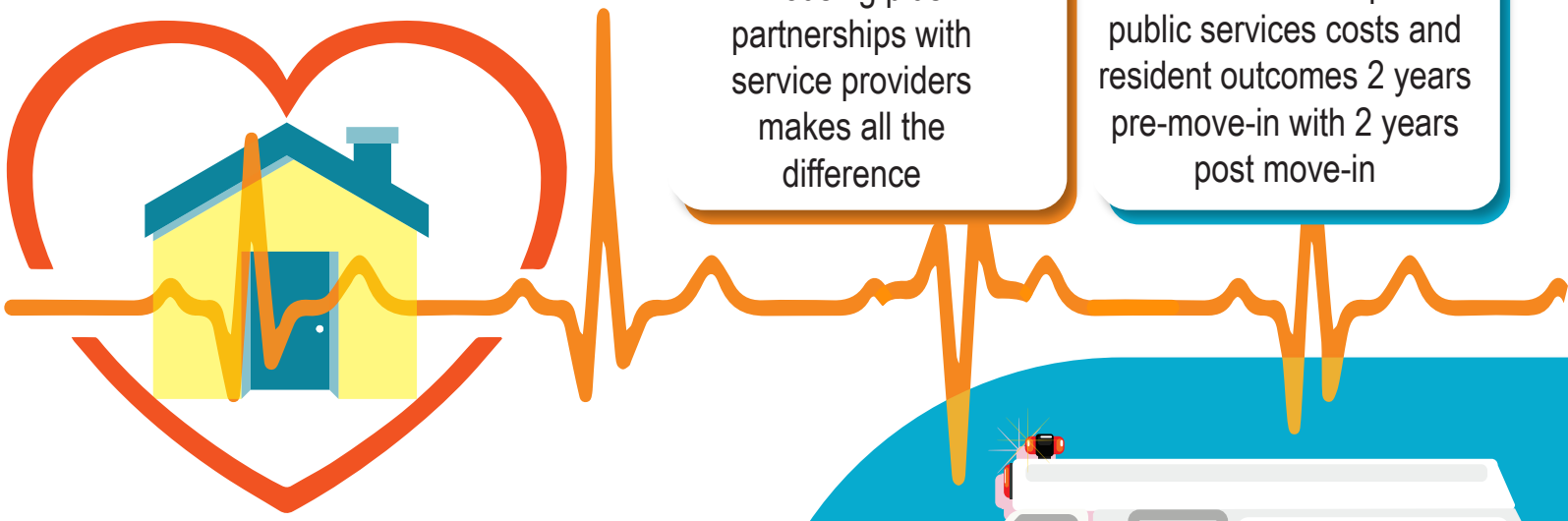
Will these residents' personal outcomes be improved?

3 properties financed in Duval, Miami-Dade and Pinellas together serving 122 residents

Nonprofit developers with experience serving these populations built and manage the housing

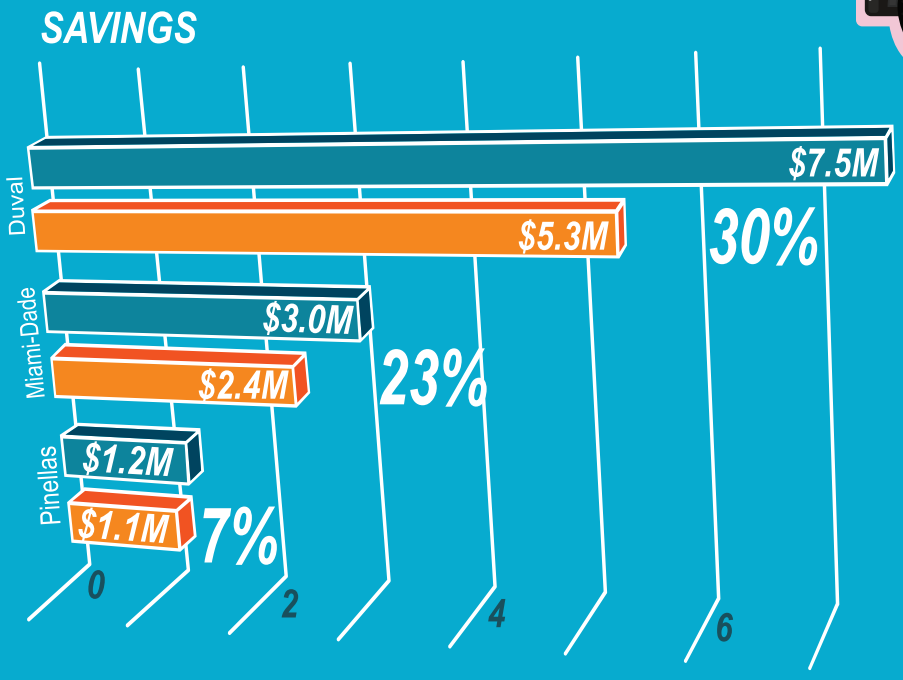
Housing plus partnerships with service providers makes all the difference

Researchers compared public services costs and resident outcomes 2 years pre-move-in with 2 years post move-in



KEY OUTCOMES

Cost benefit analysis found SAVINGS in health care and community service costs



Health Care costs were the greatest expense pre-move-in and showed the greatest decrease after move-in

Two of the pilots reported a 58% to 65% decline in health care costs*

Other costs lowered: criminal justice, shelter & homeless services

*Pinellas's health care costs did not include local care costs pre-move-in; thus, the comparison was incomplete.

RESULTS OF THE FLORIDA HIGH NEEDS HIGH COST PILOT 2021

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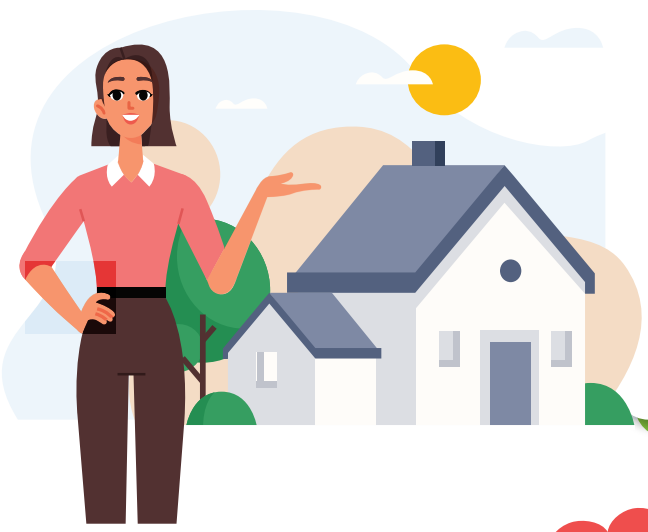
QUALITY OF LIFE AND PERSONAL HEALTH



Most residents retained their housing – between 77% and 87% remained successfully housed

Residents' personal health overall better at the end of 2-year pilot

Health insurance participation increased; incomes increased

Supportive Services over the 2-Year Pilot

Individually tailored services to meet resident goals, with intensive, onsite services coordination

Tenant support services to train and provide support to residents in how to maintain their homes, manage landlord relationships, utilities, and daily living skills

Treatment and recovery support in the home and in groups; facilitated AA and other programs on site

Expedited access to detox and residential treatment

SOAR case management/Medicaid application

Nursing case management

Employment and training services

Social activities and community events

Services provided by multidisciplinary team of recovery support coaches, LMCH/LCSWs, case managers, peer supports; access to care through partnerships with FQHCs, community mental health centers and other free/low-cost local providers

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

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ACKNOWLEDGMENTS

Florida Housing Finance Corporation (Florida Housing) wishes to express its gratitude to the people involved in the three local pilots that were part of this effort. At any successful supportive housing property, many people are involved in coordinating housing and services supports for residents, and coordinating these supports takes constant attention and creativity to meet residents' needs.

But for this pilot, these three non-profit organizations and their partners not only provided housing and access to services, they also worked with researchers from the start of their projects to design the evaluations, compile cost and resident outcome data and prepare their interim and final evaluation reports.

Florida Housing also appreciates the partnership we have with our sister agencies at the state level, particularly their work in reviewing initial methodologies and helping each pilot resolve service issues as they arose.

Florida Housing received critical assistance and perspective from the Corporation for Supportive Housing to help us manage peer discussions with the pilots and researchers, problem solve with each pilot and interpret the results of the pilots' evaluations.

Florida Housing also thanks the pilot funders and many other subject matter experts who helped us think about this pilot and its results. This was a labor of love for many participants. It is impossible to mention all of them here by name, but this pilot would not have been possible without their hard work over many years.

A list of key participants and funders involved in each pilot is provided at the end of the report.

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.

[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:

o 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.

o 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.

o 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 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.

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

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.

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**

[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

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]

[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.

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.

[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.

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

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 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.

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

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.

[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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Disability Rights Florida

Florida Blue

Lutheran Services of Florida

US Department of Housing and Urban Development

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APPENDIX A: HOUSING STABILIZATION: A FRAMEWORK TO

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.

- 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.

CARRFOUR
supportive housing

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

APPENDIX B: PILOT SERVICES MODELS QUICK COMPARISON

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

APPENDIX C: THE COST/BENEFIT OF SUPPORTIVE HOUSING

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

AND SERVICES IN EACH PILOT

	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**		

APPENDIX C: THE PILOTS' PER PERSON COST/BENEFIT

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

AVERAGED ACROSS RESIDENTS IN EACH PILOT

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**		

APPENDIX D: GLOSSARY OF TERMS

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.

Overview of Housing & Services Pilot for High Utilizers of Publicly Funded Behavioral Health Services

In August 2022, Florida Housing Finance Corporation's (Florida Housing) Board of Directors awarded financing to three Permanent Supportive Housing (PSH) properties that will include a 3-year pilot. Twenty (20) percent or a minimum of 15 units in each of the new properties will house "High Utilizers" – individuals that are high users of public behavioral health crisis services or a high priority for diversion from acute behavioral health care services and institutional settings. The focus of this new pilot is on those High Utilizers who are facing housing instability due to their behavioral health care situation.

Overview of the pilot

- In an earlier pilot, Florida Housing focused on braiding together housing and services funding for individuals experiencing chronic homelessness. In this new pilot, Florida Housing continues this work, with a focus on those who are unable to meet literal homeless eligibility requirements and thus are unable to move through the local Continuum of Care system to access housing and services through that portal.
- The long-term objective of the pilot is to create a collaborative approach to state-administered funding for both housing and services to build a replicable model for the future.
- Helping High Utilizers in the behavioral healthcare system who face housing instability, but are not literally homeless, requires blending a different set of funding strategies to help them gain independence and stability in their communities.
- In the first pilot, the three participating housing providers had to fundraise or pay for services staffing on their own. Not only did they have the job of setting up their pilots and managing the tenant referral process and the property itself; but the housing providers were also responsible for ensuring intensive supports and services were in place and funded for the pilot in addition to the complex work of financing and constructing a multifamily apartment project. This new pilot seeks to develop partnerships between housing providers and behavioral health Managing Entities to ensure that housing providers can focus on development of the housing, property management and coordination of services, with assistance from the Managing Entity partner.
- For this pilot, Florida Housing has awarded approximately $40 million through a competitive solicitation to develop and operate permanent supportive housing, with units set aside for varying household income levels (from extremely low income up to 60% of an area's median income). These requirements will be in place for up to 50 years. The three-year pilot period will begin once the units set aside for High Utilizers are fully occupied.

Three pilot developments:

- **Apollo Gardens** – 84 units in Brevard County
  - Housing Provider: Carrfour Supportive Housing
  - Managing Entity: Central Florida Cares Health System
- **Jersey Commons –** 68 units in Polk County
  - Housing Provider: Blue Sky Communities/Community Assisted and Supported Living/Tri-County Human Services
  - Managing Entity: Central Florida Behavioral Health Network
- **Village at Cedar Hills** – 90 units in Duval County
  - Housing Provider: Ability Housing
  - Managing Entity: Lutheran Services of Florida

Current status of the pilot

- Each partnership is memorialized through a Memorandum of Agreement between the housing provider, Managing Entity, and Florida Housing.
- Each development is currently in the credit underwriting phase and will move to construction next. It is estimated that developments will enter the lease-up in the next 24 months. Florida Housing is preparing for delays due to the current construction environment and supply chain issues.
- Each partnership is currently working to finalize plans for the tenant referral process, the supportive services access and working with Florida Housing to develop the performance outcomes for the pilot.

Next phase: setting up the pilot

- Florida Housing is working with each partnership to develop performance measures and identify indicators to monitor over the 3-year period.
- Each partnership has developed a Housing Stability Services Coordination Plan which includes the funding and payment approach that will be used by the Managing Entity to provide eligible housing stability services to High Utilizers at the property.
- Each partnership is working to establish the Managing Entity's tenant referral process, which prior to the lease-up stage will be used to identify the High Utilizer criteria for pilot participants.
- In each partnership the housing provider is leading the effort to identify and establish the necessary supports to ensure housing stability and supportive services are provided. In prior pilots, Florida Housing determined in some cases that housing stability services begin before a new resident moves in, thus services must be available and key staff hired prior to lease-up.

Collaborative Efforts: Managing Entity assistance

- The Managing Entity will partner with the housing provider to assist with obtaining eligibility determination documentation for referred consumers, particularly documentation related to meeting the High Utilizer status.
- The Managing Entity will assist the housing provider with early and ongoing support through a contract to provide housing stability services activities. Each development site is required to have a full-time, on-site coordinator at each property, with additional services as appropriate such as peer specialists, etc.
- On an as needed basis, the Managing Entity will ensure its service network is available to support the High Utilizers at the property and work with the housing provider to problem solve to meet tenant needs.

Pilot engagement

- Each partnership is engaging in local conversations about the development of the required pilot components as well as engaging with Florida Housing and other pilot partnerships on a quarterly basis to discuss progress, implementation issues, and solutions.
- Each partnership will be required to develop first year, second year and final reports after pilot completion, including annual monitoring of progress on performance measures.

Commission on Mental Health and Substance Abuse
Legislative Report
January 1, 2023

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Acknowledgments

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Chair, Governor Appointee

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President of the Senate Appointee

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Message from the Chair

As a society, we do not view behavioral health crisis services as an essential community service, as we view police, fire, emergency medical services (EMS) and emergency medical care. Communities are further recognizing that failure to respond properly to these crises is dramatic in its personal, social, and economic cost, resulting in incarceration, devastation, homelessness, and death. When people are in a mental health crisis, what to expect at the basic level of treatment and services before, during and after the crisis should not be a mystery.

Many individuals are unable to access care in the community. Some are unable to access care due to financial limitations, travel time and distance to available services, and/or no available space. There are not enough resources (services) for all who need it, and many find themselves on a waiting list for services (see Appendix 6).

Not only is there a shortage of MH professionals, but community-based organizations cannot attract MH clinicians and compete with the private sector. The only option is to access care through some of the most costly and inefficient points of entry into the health care delivery system including emergency rooms, acute crisis services and, often, the juvenile and criminal justice systems.

There is an equally if not more compelling need to invest in prevention and treatment at the front end so that the demand for more inefficient services will be reduced.

- Programs to prevent individuals from inappropriately entering the justice and forensic mental health systems.
- Programs to stabilize these individuals and link them to recovery-oriented services in the community that are responsive to their unique needs.
- Mechanisms to quickly identify individuals with mental illnesses who do become inappropriately involved in the justice system.
- Lack of community/based care for reentry. It is imperative that the efforts being undertaken to enhance community re-entry from jails and prisons include the establishment of comprehensive and competent services in the community targeted toward the needs of this high-risk population.

18% (1 in 5) of the population in the U.S. has a diagnosable mental illness. 1 in 17, or 6% of the population, suffer from a serious mental illness (Key Substance Use and Mental Health Indicators in the United States: Results from the 2020 National Survey on Drug Use and Health, 2020). An estimated 20 million Americans have a substance use disorder and 8 million suffer from both Mental Health and Substance Use disorders.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), last year alone, more than 56% of all adults living with serious mental illness and about 62% of all children living with severe emotional disturbances in need of treatment in the public mental health system had no access to care. Our geriatric population is also lacking in providers, needed care, and medication.

It is estimated that somewhere between 13%-20% of adolescents suffer from a mental health disorder, most starting around age 14. It is said that 37 out of 100 children suffer from Acute Childhood Experiences (ACE's). Trauma affects the brain. It is important that those who work

with children, such as school officials, have training in ACEs, calming techniques, and de-escalation. The earlier the diagnoses, and treatment is provided, the better the outcome for the individual.

As identified in the Marjory Stoneman Douglas High School Public Safety Commission, there are issues transitioning from the juvenile system of care into the adult system. Many reaching adulthood are left out on their own and/or now can just choose to stop treatment, which can have devastating effects. Those who find themselves in the criminal justice system will receive services through the Department of Juvenile Justice (DJJ), but once released from their supervision, there are no referrals and/or follow up care.

There are six state mental health hospitals and three private facilities in Florida. In fiscal year 2021 the Department of Children and Families (Department) funded 2,677 beds through the state mental health treatment facilities. Additional beds are contracted annually through the managing entities, including residential programs, in patient programs and psychiatric hospitals. The number varies and only represents patients paid for by the Department. Using the 2020 provisional population numbers for adults in Florida, 17,358,504, the ratio of beds per 1,000 adults is 0.154. There are just not enough long-term and short-term residential treatment beds in the State to address the need. In addition, counties in the State are not created equal and lack access to care for their residents.

In FY 2021, the Department's clients presented with 997 different mental health diagnoses in FY2021. These were the top 10 most common.

ICD10	Dx	Number of clients
F32.9	Major depressive disorder, single episode, unspecified	14,923
F33.1	Major depressive disorder, recurrent, moderate	14,055
F11.20	Opioid dependence, uncomplicated	10,389
Z91.89	Other specified personal risk factors, not elsewhere classified	10,336
F41.1	Generalized anxiety disorder	9,919
F31.9	Bipolar disorder, unspecified	9,724
F43.10	Post-traumatic stress disorder, unspecified	9,554
F25.0	Schizoaffective disorder, bipolar type	9,236
F20.9	Schizophrenia, unspecified	9,147
F10.20	Alcohol dependence, uncomplicated	8,624

Below is a breakdown of Department clients served in FY2021 by program area. This only represents the clients paid for through Department funding and does not represent the entire population of individuals with mental health and substance abuse disorders.

Program Area	Number of clients
Adult Mental Health	152,565
Adult Substance Abuse	43,470
Child Mental Health	34,595
Child Substance Abuse	6,976

Here are the number of admissions meeting criteria for Baker Act and Marchman Act for the last five years.

	Baker Act Admissions	Marchman Act Admissions
FY 2020-2021	14,043	1,125
FY 2019-2020	27,576	2,235
FY 2018-2019	37,722	2,907
FY 2017-2018	38,385	2,995
FY 2016-2017	36,676	2,639
Note: FY 2016-2017 and 2017-2018 are from SAMHIS; FY 2018-2019, 2019-2020, and 2020-2021 are from FASAMS.		

It is not possible to go to one specific source to obtain this data. There is no interoperability between various systems (public providers, private providers, primary care, DCF, DJJ, DOH, DOE, DJJ, VA, criminal justice system). Deinstitutionalization has resulted in a fragmented continuum of care that has failed to adequately integrate services, providers, and systems; leaving enormous gaps in treatment and disparities in access to care.

Individuals can and do, move through community-based providers, the criminal justice system, private providers, emergency rooms, schools, etc., receiving a diagnosis, treatment, and medications in each without anyone being the wiser. Not even our state organizations (DFC, AHCA, DOH, DOC, DJJ, DVA, etc.) share information. We must connect the dots between all the service providers, both public and private, to make sure everyone is sharing information about a single client and preventing silos of information from existing.

While a portion of crises are unpredictable and unavoidable even in the perfect overall behavioral health delivery system, many behavioral health crises are a direct result of inadequate performance by the rest of the behavioral health delivery system and other human service systems such as justice, housing, immigration and child or adult protective services. Common behavioral health system causes of behavioral health crises include inadequate access to routine services, premature discharge from treatment programs and inadequate attention to patient engagement.

In many communities, it is difficult for individuals to flow smoothly to higher or lower levels of service intensity as their needs change. Even more problematic, many individuals in crisis, their families and support systems, experience multiple disjunctions and transitions in care during the crisis episode at a time when they are most vulnerable and distressed. These transitions are often associated with multiple repetitive assessments, changes in diagnosis and variations in treatment plan from one day to the next or one program to the next. This lack of continuity through the crisis episode results not only in diminished experience of care for primary customers but can lead to poorer outcomes because the information often does not flow efficiently as the client moves through the continuum.

For these reasons, continuity of care through the crisis episode and facilitation of smooth transition through different levels of service intensity in the crisis continuum are both essential elements of an ideal crisis system. In Florida's system of care, the money follows individual

programs and not the individual. As the needs of the individual change, protocols and funding should be in place that make it easy for them to be transitioned through the appropriate levels of care in the crisis continuum. These vertical transitions through the continuum should occur as smoothly as possible to meet individual needs and be associated with continuity of care by a crisis intervention team or crisis intervention coordinator that is usually based in the crisis hub and has a care coordination function throughout the continuum of services.

In addition, we sperate mental health and substance abuse disorders (SUD). SUDs are included in the DSM V manual as a mental health disorder. There is a need for seamless flow between various types of co-occurring capable mental health and SUD services for individuals with co-occurring mental health and SUD. Many crisis programs and crisis systems create distinct detox capacity and crisis bed capacity. This often results in impediments to both individual client flow and flexible utilization of limited resources. Individuals with co-occurring conditions in crisis who need help with withdrawal management can receive such support in a crisis bed. Individuals who present with requests for assistance with SUD often have co-occurring mental health conditions as well.

Further, individuals with active SUD who need a safe place to stop using, to address mental health and social concerns and to consider the next steps in recovery should not be required to present with intoxication to access the support services labeled as detox. Therefore, within the bounds of state regulations, efforts in the ideal crisis system should be made to eliminate the artificial distinction between crisis beds and detox beds in favor of a more fluid system that meets the needs of all individuals with any combination of mental health and substance use needs.

Our system is complicated and administratively burdensome, not just for the individual and their families, but the providers. MH/SUD clinicians are inundated with paperwork for various funding sources and programs. Where does this paperwork go and what is it used for? Hours of paperwork equals time a MH/SUD professional could be working with clients. Reporting is necessary in tracking outcomes but can be streamlined to what data is necessary for treatment and for guiding the system of care throughout the State of Florida.

Community providers often find it difficult to meet mandatory performance standards. These high standards disincentivize providers from taking on those high-risk individuals, who are harder to treat, and are more likely to provide services to those not requiring acute care. There are financial deterrents for programs to take on those requiring acute care services. Behavioral health systems cannot meet the mandatory performance standards by taking on those who need the services the most. There are also no protections for the community-based providers and all liability falls on them and premiums continue to rise.

A continuum of services is needed as an individual navigates through the MH/SUD system. Case workers and peer support members are also paramount to keep the individual on track and circumnavigate through this very complex system, assuring they receive the care they need and the funding to support the treatment. The individual should navigate through the system based on their needs not by what the funding source dictates.

In the level of expenditures on front-end community-based services intended to promote recovery, resiliency, and adaptive life in the community, Florida is often ranked near the bottom. In 2021, $769,723,025 was allocated to the managing entities. $61,483,010 was unexpended due to unused ***program*** funds. This is just funding provided through the managing entities. There are also funds from other local and private entities that are returned for this same reason.

The Funding is not flexible. Rules are very strict and cannot be used universally. It was indicated that there is not enough funding, but if funding was more portable, it might address the areas where funding is short, making the system more effective and efficient.

In this first report, you will find recommendations the Commission believes will begin to make the system better. But we still have much work to do as we continue to take a deeper dive into all aspects of our system of care. We are tracking the funding, where it's going, how it's being expended, and the reporting and accountability requirements. We are looking at data collection and sharing, how to make this happen among all stakeholders, and most importantly, how to make Florida's system of care work for all.

William Prummell, Sheriff
Commission on Mental Health and Substance Abuse, Chair

Executive Summary

In 2021, the Florida Legislature passed legislation, which Governor Ron DeSantis subsequently signed into law, to establish the Commission on Mental Health and Substance Abuse (Commission). Composed of 19 members, the Commission's tasks are to review and evaluate the current effectiveness of such services in the state, identify barriers to care, and make recommendations regarding policy and legislative action to implement improvements. In addition to conducting a review of the State's behavioral health and substance abuse systems of care, the Commission is also responsible for assessing priority population groups that can benefit from publicly funded care and proposing recommendations for the creation of a single, permanent State agency that will manage the delivery of these services. Other tasks the Commission must perform include identifying gaps in behavioral health care and assessing current staffing levels and availability of services across Florida. Also, the Commission is responsible for submitting two reports to the Governor, President of the Senate, and Speaker of the House of Representatives. The first, which is due on January 1, 2023, is an interim report that precedes a final one due on September 1, 2023. This is the Commission's interim report on the status and recommendations for Florida's mental health and substance abuse services.

To complete its review, the Commission established four subcommittees and tasked them with evaluating specific aspects of the State's behavioral health and substance abuse systems of care. In addition to holding regular meetings, each prepared reports proposing recommendations. Focusing on their assigned areas, the following subcommittees developed strategies and ideas based on their assessments of how Florida delivers behavioral health services:

- **Subcommittee on Business Operations:** This team dedicated itself to evaluating how Florida's State agencies approached behavioral health services and where they could implement improvements to streamline delivery and reduce wasteful practices.
- **Subcommittee on Criminal Justice:** Tasked with reviewing the Baker and Marchman Acts, this subcommittee worked on recommendations to improve services related to restoring competency, jail diversion, and reducing recidivism.
- **Subcommittee on Data Analysis:** All State agencies and entities engaged in delivering behavioral health services perform data collection. This team focused on methods to improve and enhance data collection and reporting, and devised strategies for alignment and storage.
- **Subcommittee on Finance:** Funding for behavioral health services comes from myriad payers, including Medicaid, federal grants, private insurance, and state and local revenues. This subcommittee explored current obstacles to funding, in addition to identifying potential new sources.

These recommendations correlated to the subcommittees' respective areas and included proposals to improve access to care, divert those with behavioral health needs from the criminal justice system, gather and report data, and discover novel means to fund these services. Each recommendation builds upon existing State programs and will enhance behavioral health care across Florida, if implemented. It is important to note that while the recommendations in this report were agreed upon by the majority of the Commission members, there are some recommendations for which there was not consensus, specifically in the Access to Care section.

As the Commission continues its work, these subcommittees will refine their proposals in the final report.

Focusing on how to improve access to behavioral health services, the Subcommittee on Business Operations identified several approaches that can connect individuals to appropriate care when necessary. These consist of the following measures:

- Establishing a master client index that will collect demographic and diagnosis information: If implemented, such an index can identify those who would benefit the most from enhanced care coordination to reduce the likelihood of utilizing higher levels of services (e.g., crisis stabilization units, inpatient hospitals).
- Conducting an explorative study to better understand the perceived gaps in behavioral health care to determine if modifying Medicaid eligibility criteria would make a difference.
- Initiating uniform quality metrics for all publicly funded behavioral health and substance abuse care in Florida: Currently, programs such as Medicaid and the Department use similar but varying metrics that can prevent accurate measures of performance. A uniform set will provide a more accurate account on the effectiveness of services delivered statewide.
- Creating a coordinated community behavioral health approach for public school students utilizing a single organization, and amending Section 1006.05, F.S

The above recommendations can increase access to behavioral health care for individuals of all ages. Having the ability to see the right provider at the right time can help reduce overutilization of intense services, as well as mental health and substance abuse crises. Among the most intense behavioral health services in Florida that result in heavy costs for the State are involuntary examinations conducted under the Baker and Marchman Acts. In addition, competency restoration following arrest and indictment compounds these costs. Furthermore, the State's jails and prisons have become residences for those who would be better served by behavioral health and substance abuse service providers. To improve these issues, the Subcommittee on Criminal Justice proposed modernizing the Baker and Marchman Acts, making improvements to how Florida approaches competency restoration, and implementing jail diversion programs. Regarding the two acts, the subcommittee recommended legislative action that will amend the existing statutes to better serve the populations that require them and reduce unnecessary involuntary examinations. For competency restoration, proposed actions consist of reducing the number of offenses where such action is necessary for an individual to stand trial. This is needed to alleviate the burden on state mental health hospitals, which have insufficient capacity to meet this demand. The subcommittee also cited jail diversion programs as critical in reducing the number of inmates contending with serious mental illness who would benefit from behavioral health interventions. All of these recommendations can contribute to reducing costs by lowering recidivism rates and utilization of intense levels of care.

Measuring the outcomes of new measures and programs is impossible without data. To determine actions to improve this area, the Subcommittee on Data Analysis proposed the following three goals that will align and centralize Florida's behavioral health and substance abuse data:

- Goal One: Create a coalition of key stakeholders to identify the best data sources across the state and determine outcomes for their use.
- Goal Two: Establish a single repository for behavioral health and substance abuse data which can allow for accurate collation and reporting. The subcommittee proposed establishing one point for all state agencies to submit their data.
- Goal Three: Use collected data to provide information on behavioral health provider availability to aid individuals with the highest risks.

These improvements can aid the State in increasing access to services, achieving better outcomes, and ensuring appropriate levels of care are utilized. Regarding funding opportunities, the Subcommittee on Finance is in the process of reviewing whether there are untapped sources of revenue or areas that could generate additional funds. As the subcommittee completes its evaluations, it will prepare its recommendations for the final report in September 2023.

Data Transparency

Having data available upon which to make informed decisions and address persistent behavioral health problems is critical to having a robust and effective system of care. On that basis, the Commission has composed several recommendations to improve data collection, storage, and transparency that will improve how the State uses information when evaluating performance, individual outcomes, and identifying issues. The Commission proposes the development of a master client index to reduce duplication of effort and better integrate delivery of care between various public funders of behavioral health services. The Commission further proposes the development of a de-identified data warehouse to analyze trends, prevalence, and outcomes in behavioral healthcare in Florida. The following outlines the Commission's proposed actions to make these improvements.

Recommendation 1

Develop a pilot Master Client Index to yield the following results:

1. Public Funders of Behavioral Health Services would be required to upload limited scope, client specific information and service type or program into a non-transactional data warehouse/repository at a specified frequency.
2. The data would be submitted in a universal file format
3. The data fields would be limited to the most commonly collected information. For example:
    a. First Name
    b. Middle Initial
    c. Last Name
    d. Date of Birth
    e. Social Security Number
    f. Procedure code or Healthcare Common procedure coding system
    g. DSM-5 Diagnosis
    h. First date of behavioral health service or entry into a treatment program
    i. Setting of service – i.e., jail, school, Department of Juvenile Justice (DJJ) commitment program, provider facility, state psychiatric hospital, etc.
    j. Last day of a publicly funded behavioral health service or exit from a treatment program
4. The Master Client Index would sort/match records based on a combination of the demographic fields, including partial matches, so that a significant level of confidence is achieved when two distinct individuals are identified as actually the same person.
5. Access to a patient's record in the repository would be limited to matches between the specific public funder's roster and a corresponding demographic record match from another public funder's submission. Access will be guided by adherence to federal and state privacy protections.

Rationale
Individuals whose behavioral health care needs go unmet become the high utilizers of acute care and encounters across systems. They are frequently bounced between social service systems, including the Department of Education (DOE), the Department of Juvenile Justice (DJJ), the Department of Children and Families (DCF), law enforcement agencies, the Agency for Persons with Disabilities (APD), and the Agency for Health Care Administration (AHCA), Department of Housing and Urban development (HUD). By developing a standard methodology for building a Master Client Index that cross-checks certain demographic values with an advanced algorithm to include partial matches, the potential for a truly integrated and informed behavioral health care system is attainable. The effects of successfully identifying those who would most benefit from a targeted care coordination strategy would be a reduction in duplicative or conflicting services, more effective resource allocations by informed funders of behavioral health services, and better outcomes for the complex individuals served.

Recommendation 2

Create a Florida behavioral health data repository or comparable effective data system that includes data harmonization and cleaning of identified data sources.

Following creation of a statewide data collaborative and development of information sharing guidelines, then a behavioral health repository can be formed to include various data from organizations such as (but not limited to):

- Department of Children and Families (DCF)
- Agency for Health Care Administration (AHCA)
- Department of Juvenile Justice (DJJ)
- Department of Education (DOE)
- Department of Housing and Urban Development (HUD)
- Florida Department of Law Enforcement (FDLE)
- Agency for Persons with Disabilities (APD)

In order to mobilize this recommendation, the Commission proposes the following steps:

1. Secure the administrative authority and commitment from stakeholders/agencies (DCF, AHCA, etc., to establish the state-wide Florida Behavioral Healthcare Data Repository (FBHDR)).
2. Due to the sensitivity of this data, the legalities of Health Information Portability and Accountability Act (HIPAA), Family Educational Rights and Privacy Act (FERPA), and SAMHSA must be addressed.
3. Determine structure of the repository (centralized, federated, etc.), as well as policies and protocols for data standardization, security, and access.
4. Determine a process to identify and partner with parties responsible for creation and maintenance of a data repository.
5. Implement innovative technology to address privacy concerns and make the data more accessible with fewer data sharing consequences (e.g., personally identifiable information and protected health information).
6. Incorporate technological and data science innovations to improve data collection, upload, cleaning, harmonization, and statistical analyses.

7. Budget appropriate initial funding for the initiative, including a fiscal analysis of elements/components (associated costs) of establishing and maintaining the repository and the possible addition of a qualitative component and analysis.

Rationale
The overall goal is to provide information on access, prevalence, quality, costs, and outcomes of the behavioral health system in Florida. Key questions have been developed based on national standards and guidance relating to understanding and improving statewide health systems aimed at effectiveness, efficiency, and fairness. In addition, states that have embarked on characterizing and optimizing behavioral health care and outcomes have provided guidance on initial questions that inform policy, spending, and clinical capacity. Initial research questions will evaluate major behavioral health outcomes and evaluation of current performance metrics to provide detailed information defining what they are and what outcomes they are achieving.

Recommendation 3

Provide information on behavioral health data sources in Florida for high-risk individuals. The Commission's Data Strategy for improving outcomes is included in Appendix 2.

In order to mobilize this recommendation, the Commission proposes the following steps:

1. Establish an FBHDR oversight steering committee that will identify appropriate behavioral health data sources and will guide and prioritize analytic direction and initiatives. Membership should include representatives from major stakeholders.
2. Initially, this level of research will focus on people served by public-funded services and supports. Specifically, the research will descriptively report on people served within each public service and across departments (e.g., DCF, AHCA, DOJ, etc.). Specific research questions will include, but not be limited to:
    - Demographic and diagnostic characteristics.
    - Prevalence of specific psychiatric and medical diagnoses.
    - Specific behavioral health and medical services.
    - Client outcomes, using available direct and proxy outcome measures, based on the above client and service characteristics.

    In a later exploration, comparisons of the above outputs will be made among people covered by Medicaid versus Medicare versus private insurance versus uninsured. Some recommendations for additional analyses may be proposed.
3. Additional considerations:
    a. Implement a mixed-method or qualitative component to inform/contextualize the data:
        i. Focus on the following questions: (1) what services are being provided, (2) how services are being provided, and (3) how effective services are for different populations.
        ii. Prioritize consumer voices (e.g., advocacy groups focusing on housed individuals, individuals with a criminal record, etc.).

For more information on national data frameworks, refer to Appendix 3.

Rationale
States that have embarked on integration of behavioral health information from multiple agency sources have found significant improvements in accuracy of information on**:**

1. Personal characteristics (e.g., age, sex, gender, race, ethnicity, geographic location).
2. Diagnoses, including co-morbidities (e.g., DSM-5 ICD-10 dx, multiple diagnoses, screening tool results, medical dx).
3. Service use types and intensity/frequency (e.g., visit types- assessment, intake, medication management, psychotherapy and counseling, crisis intervention, individual, group treatment, provider type).
4. Person outcomes and health care quality (e.g., clinical severity scores, such as PHQ9, functioning outcomes, outcome measures, such as follow up with care, medical screening for patients with psychotic disorders, etc.).
5. Collect data on individuals receiving services and start collecting a 'catalogue' of mental health and behavioral health resources that are available.
    a. Identify all existing statewide behavioral health service directories (e.g., Hope for Healing and 211 services).
    b. Compare county level resource differences (i.e., organizations, providers, practitioners, etc.) between DCF and AHCA systems.
6. Identify information that is not being collected through publicly funded care that should be collected for outcomes.

Recommendation 4

Develop a workgroup to establish a statewide core set of metrics that will provide a comprehensive, standardized, and transparent approach to assessing and evaluating quality of care and health outcomes. These metrics will address the following domains:

- Preventive care and screening.
- Referrals and care coordination.
- Treatment and follow up.
- Risk factors and health outcomes.

Rationale
Health surveillance is the process of continuously monitoring attitudes, behaviors, quality of care, and health outcomes over time. Statewide surveillance is important for monitoring the achievement of overall program goals. Evaluation is used to assess the implementation and outcomes of a program, increase efficiency and impact over time, and demonstrate accountability. Standardized and comprehensive data to accurately assess and monitor substance abuse and mental health related metrics are currently not available at a state level. Development of a comprehensive approach to substance abuse and mental health quality metrics will provide a source of reliable and valid information for use in developing, implementing, and evaluating efforts to improve the health and safety of all Floridians and visitors. A detailed collaboration roadmap is provided in Appendix 1.

Access to Care

Considering that Florida's population is rapidly expanding, timely access to behavioral health services when needed is critical to preventing crisis situations that result in admissions to crisis stabilization units or inpatient facilities. As one of the State's main priorities, improving access to care is not only essential to improving individual outcomes, but also to reducing the financial and human costs of behavioral health crises that involve intense levels of care or law enforcement. Because of this need, the Commission has made several recommendations that will improve access to behavioral health care so that more individuals will have their first encounter with a provider at the community level rather than the emergency department or local jail.

Recommendation 5

In partnership with AHCA, conduct an explorative study to assess the potential impact of adjusting the Medicaid income eligibility criteria for young adults ages 18-26 years, in the coverage gap whose parents are not insured. The results of this study will be used to meet the following goals:

- Assess the data to ascertain the behavioral health needs of uninsured or underinsured youth
- Identify evidence-based interventions to address their specific needs and increase access to care (e.g., pilot)
- Develop a strategic, data-driven approach to addressing behavioral health care access and costs for a targeted population at risk that will benefit from early intervention.

Rationale

An estimated **415,000 Floridians** are in the **coverage gap**. They do not have health insurance through an employer, possibly because they work at a small business, work part-time or seasonally, or they are self-employed. They earn too much to qualify for Medicaid, but not enough to qualify for subsidies to purchase health insurance in the Marketplace.

Coverage for Behavioral Health

In 2019-2020, over 1,000,000 adults in Florida reported needing, but not receiving, mental health treatment, and 51.9% cited cost as the barrier.

In Florida, behavioral health care can be covered by commercial insurance, Medicare, Medicaid, state or federal funding, or self-pay. An estimated 14.9 percent of adults in Florida who reported a mental health disorder were covered by Medicaid, while 54.9 percent were covered by private insurance. Because the Managed Medical Assistance (MMA) plans are paid on a capitated basis, determining how much is spent specifically to treat mental or substance use disorders is difficult and requires analysis of encounter data for each plan.

However, it is worth noting that behavioral health care costs are not limited to behavioral health treatment. A recent 2020 study found that people with behavioral health disorders also had higher utilization and costs for physical health care. This study included 21 million individuals covered by employer health plans. The study also found that 27 percent had a behavioral health diagnosis or treatment but accounted for **56.5 percent of the total health care costs** for the entire study population. More than 95 percent of their health care spending was for physical treatment and only 4 percent was used

for behavioral health. Better care coordination and integrated services would appear to be important tools to reduce health care costs, regardless of payer source. (Davenport et al, 2020)

Young adults ages 19 to 26 account for 8.3 percent of Florida's total population, but 14.1 percent of the uninsured population. This percentage has improved since young adults up to age 26 became eligible to remain on a parent's health insurance plan. Youth ,who age out of foster care are also permitted to remain on Medicaid until age 26, if income requirements are met. Adjusting the income eligibility criteria for Medicaid for young adults in the coverage gap whose parents are not insured would improve access to care for behavioral health and for primary and preventive care that could promote better long-term physical health outcomes. The study would include a comprehensive system of qualitative and quantitative data analysis to assess utilization and results. This approach allows for a better understanding of gaps in behavioral health services that exist for young adults whose families are not able to afford health insurance, and for youth pursuing technical education without access to college health clinics and those who are living independently and working, but in jobs that do not offer affordable health coverage.

Recommendation 6

Implement a three-year pilot in which one agency level entity manages all public, behavioral health funding in a geographic area, minimally including:

- Department of Children and Families (DCF) safety net funding.
- DCF child welfare prevention funds related to substance use and mental health.
- Criminal justice funding (Department of Corrections and DJJ).
- Medicaid managed care funding.
- Private Insurers.
- Medicaid fee-for-service funding (including Florida Assertive Community Treatment).
- Local funding (county, city, Children's Services Councils, independent tax districts, etc.).
- Department of Education and Local School Boards mental health funding.

To ensure the community has access to timely, quality, and comprehensive services, it is further recommended that the pilot must provide a minimum of nine types of services through contract with partner organizations, with an emphasis on the provision of 24-hour crisis care, evidence-based practices, care coordination with community partners, integration with physical health care, and provider payment through a prospective payment system or other payment systems, regardless of the patient's payer source.

Based on a comprehensive assessment, individuals would have access to the entire service array. The agency level entity would be responsible for billing the responsible entity, blending and braiding funding to ensure comprehensive, equitable care for all. The following topics will require development and definitions.

- Independent care coordination.
- Prospective payments based on cost.

- CCBHC certification criteria in addition to the federal minimum standards.
- Contracts with the various funders.
- Uniform performance measures to satisfy federal Medicaid and Substance Abuse and Mental Health Services (SAMHSA) reporting requirements.
- Coverage policies for individuals who have commercial or federal coverage (i.e., Medicare, Tricare, etc.), but are not able to access the services they need under these plans because the service is not covered, or co-payments/deductibles are so high that the individuals cannot afford care.

Rationale

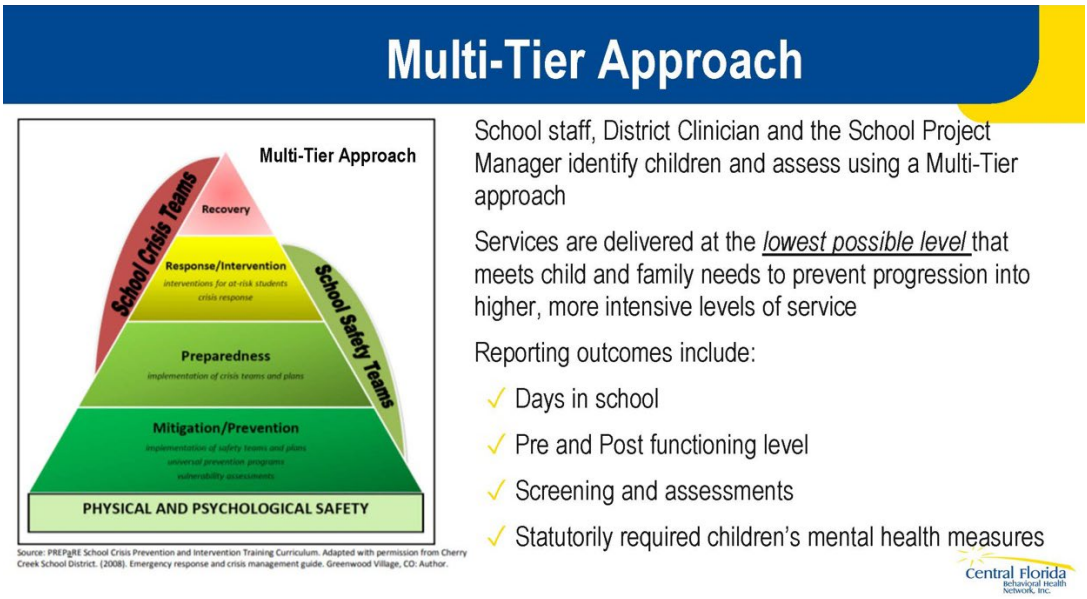
Florida's current payment structure for publicly funded behavioral healthcare has resulted in a fragmented and siloed service system. The services a person with mental health and/or substance use disorders receives is often dependent on how their services are funded, rather than their individualized needs. The system of care is a patchwork of programs, care delivery, and oversight that is complex, disjointed, and inequitable. Because each payor has differing covered services, reporting requirements, and eligibility, it is challenging to provide individualized care or maintain needed service levels when insurance/fund source changes occur. The recommended approach would allow providers of behavioral healthcare to serve individuals with the flexibility necessary to provide person and family-centered care. Provider time would be spent on what they do best – provision of prevention, recovery, and treatment services instead of complicated billing processes and reporting that differs for each funder. A predictable, stable payment structure based on actual costs will allow providers to hire and retain the workforce necessary to manage the challenging needs of the target population. The entity would function as the single point of accountability for payment, oversight, and care-system management with the ability to leverage resources and reduce duplication. Another advantage to this approach is that one entity would have all the behavioral health care history for the person served in one place, including service encounters, assessments completed, multiple provider involvement, and service intensity. This will allow the agency level entity to identify high utilizers, duplication of care, and care coordination needs through data surveillance. The agency level entity would also have the necessary data on service provision, cost, and performance outcomes across the system of care to effectively identify gaps, scale best practices, and plan system improvements.

Recommendation 7

Create a coordinated community behavioral health approach for public school students utilizing a single organization and amend section 1006.05, F.S., as indicated in Appendix 4.

The need for a uniform system to assure access to care, reduce fragmentation caused by siloed systems of care, care coordination, and uniform reporting of outcomes was identified by the Marjory Stoneman Douglas Commission.

A successful model has been replicated by three major school systems (Broward, Hillsborough, and Pasco) to assure the appropriate identification, referral, and care coordination of children and families with complex and co-occurring behavioral health needs. The model standardizes the process for referral, care coordination, feedback, and outcomes through contracts with Managing Entities, and will be evaluated for potential replication across the State.



Merging school and community behavioral health process

Similar to the model above, the single organization will contract with the school district to assess student needs and gaps in services, identify providers and additional services needed, and report needs and outcomes. The entity will also organize a system of care to ensure mental health services are delivered to all children and families, regardless of insurance type, identified by the school system.

The single organization would be responsible for ensuring there is an expansive network of providers with both the expertise and capacity to provide timely access to services for these high-risk children and their families. The model would include a Care Coordinator within each district to ensure students are receiving necessary services and to assure that appropriate funds are used to support the cost of treatment (including Medicaid and private or commercial insurance) prior to accessing school based mental health funding to purchase community-based services. In addition, school districts may choose to contract for the management of onsite community-based services designated to meet the students' needs in high needs schools within the district.

Single organization responsibilities include the following:

- Identification of gaps to expand and enhance services.
- Provide onsite services for high-risk schools (upon request).
- Track and report outcomes.
- Ensure community education about the availability of wraparound services.
- Identification of unique behavioral health needs for students.
- Assure that the provider network has the capacity to meet the need.
- Maintain and enhance relationship building and communication with school districts and community providers.
- Collaborate with public and private funders.

- Develop or utilize youth at risk staffing when necessary for children involved in multiple systems (Child Welfare, DJJ, students with three or more admissions to a crisis unit within 90 days, etc.).

Rationale

School districts' expertise is in the delivery of high-quality education and services to maximize each student's potential. The single organization would possess expertise in the delivery and coordination of behavioral health services (mental health, substance use, and recovery supports) for children and their families with complex and severe behavioral health needs. School districts utilize a variety of methods and services within the school system to offer mental health well-being, screen and identify youth with behavioral health needs. The majority of students identified with behavioral health services can be appropriately served within current school-based prevention and counseling services to support the student's well-being. However, there is no uniform system in place throughout Florida to assure timely access to the appropriate level of community based behavioral health services and care coordination for children identified at the highest level of risk that cannot be mitigated with school-based counseling and supports. Although school systems may have referral agreements and/or contracts with community providers, there is no mechanism to assure that linkage and care coordination feedback loops are in place to assure students' unique needs are addressed across the various systems providing services to high-risk youth and their families, or uniform reporting of outcomes for children referred to community services.

Gaps in Care

To better ensure access to care, the Commission recognizes the need to identify and fill the gaps in behavioral health services. Many of the gaps exist due to outdated processes that will require systematic change. Currently in the system, there are wait lists for services that are highly utilized. In Appendix 6, wait list data by Managing Entity is presented. This section puts forth recommendations that will improve the State's capacity to address behavioral health comprehensively.

Recommendation 8

Limit the use of Competency Restoration process to cases that are inappropriate for dismissal or diversion using the following:

1) Divert cases inappropriate for competency restoration (misdemeanor/low level felonies) from the criminal justice system through the expansion and funding or specialty courts and programs.
2) Restrict which cases are referred for competency evaluations.
3) Expand and fund section 916.185, F.S. – Competency Alternative Programs

Rationale

Competency to stand trial (CST), refers to the constitutional requirement that people facing criminal charges must be able to assist in their own defense. A criminal case cannot be adjudicated unless this requirement is met. The U.S. Supreme Court considers someone competent to stand trial if that person is rationally able to consult with an attorney and holds a clear understanding of the charges against him or her. Some people view competency restoration as a way to connect a person with mental health treatment. The reality, however, is that competency restoration services have a narrow focus on stabilization, symptom management, and required legal education. This is not the same as providing access to a fully developed treatment plan and treatment services with the goal of long-term recovery and rejoining the community.

In Florida, once an individual is adjudicated incompetent to stand trial on a felony charge, DCF must transfer the individual from jail to a competency restoration facility within 15 days of the finding. Individuals adjudicated incompetent to stand trial on a misdemeanor charge may be restored in the community, but more likely would be released to the community without access to treatment. If they remain incompetent to stand trial after one year, the charges are dismissed. Florida spends nearly 20 percent of all adult mental health dollars and half of all state mental health treatment facility dollars (approximately $198 million) annually on 1,600 forensic and forensic step-down beds serving roughly 3,300 individuals under forensic commitment. Admissions for competency restoration in state forensic treatment facilities last almost six months, at a cost to taxpayers of over $50,000 per admission. Roughly 70 percent of people restored will have their charges dropped, or they will accept a plea to credit time served or probation and will be released back to the community; in many cases there is no provision for follow-up services or access to basic necessities such as food, clothing, housing, or medication.

Individuals subject to forensic commitments are now the fastest growing segment of mental health consumers. Forensic commitments have increased by 72 percent since 1999, including an unprecedented 16 percent increase between 2005 and 2006, far exceeding existing forensic treatment bed capacity. At the same time, prison sentences of a year and a day have increased by 25 percent. On November 30, 2006, a judge in West Florida fined the Secretary of DCF

$80,000, and found her in criminal contempt of court for failing to comply with an order to transfer inmates with mental illnesses adjudicated incompetent to proceed to trial from the Pinellas County jail to state forensic hospitals in a timely manner, as required by law. This ruling followed months of controversy and high-profile media attention surrounding DCF's inability, due to lack of resources, to abide by statutory requirements to place defendants, who were found incompetent to proceed to trial or not guilty by reason of insanity, in forensic mental health treatment facilities within 15 days of adjudication.

Recommendation 9

Modernize the Baker and Marchman Acts statutes by including proposals that include the following changes in the existing laws: The recommendations represent a comprehensive modernization of Florida's civil commitment system for mental health and substance abuse treatment. The changes reflect case law and scientific developments and will conserve state resources while ensuring that care is more efficiently provided.

Baker Act Changes (Involuntary Mental Health Care):

- Defines the elements of the law's "self-neglect" criteria.
- Allows DCF to establish rules regarding a person's care after post-discharge and make recommendations to reduce high utilizer readmission based on facility data.
- Further protects minors from being forced into "voluntary treatment" by requiring they have a mental illness and be suitable for treatment.
- Grants the police same discretion the courts and medical professionals have to initiate Baker Act examinations, which should reduce number of unnecessary Baker Acts.
- Streamlines procedures to allow the court the opinion of ordering inpatient or outpatient treatment depending on individual's needs. Outpatient is less costly and respects individual liberty more than inpatient hospitalization, and grants court continuing jurisdiction to enforce its treatment orders.
- Modernizes Baker Act's Dangerousness Criteria and conforms Florida law to majority of other states which address harm on a "totality of the circumstances" basis and not just the threat of serious bodily harm.
- Enables witnesses to appear remotely if there is good cause.
- Grants State Attorney limited record access & continuance; allows appointment of public defender, regardless of respondent's indigency status.

Marchman Act Changes (Involuntary Substance Abuse Treatment):
(Note: given the overlap between mental illness and addiction, many of the above changes are made to the Marchman Act so that the laws mirror each other as much as possible.)

- Updates definition of substance abuse impaired so that Marchman Act can better address prescription drug abuse and substance abuse disorders and requires DCF to create annual reports on Marchman cases statewide.

- Makes the State Attorney the real party of interest except if private counsel retained.

- Streamlines Marchman procedures by eliminating the need to file two separate petitions (assessment and treatment).

- Modernizes Marchman Court's authority to incorporate drug court best practices, which are scientifically proven to be more effective at treating addiction.

Rationale

In 1971, the Florida Legislature passed into law the Florida Mental Health Act, which went into effect July 1, 1972. This Act brought about a dramatic and comprehensive revision of Florida's 97-year-old mental health laws. It substantially strengthened the due process and civil rights of persons in mental health facilities and those alleged to be in need of emergency evaluation and treatment.

The Act, usually referred to as the "Baker Act," was named after Maxine Baker, former state Representative from Miami, who sponsored the legislation after serving as chairperson of the House Committee on Mental Health. When the Baker Act was passed, it created a legal process to involuntarily hospitalize individuals primarily in state psychiatric hospitals. At the time, Florida had significantly more psychiatric hospital beds than it has today, serving a state population of approximately 6.8 million people. Today, there are a little over 2,600 state hospital beds. Two-thirds of admissions are forensic and 69 percent of bed capacity is occupied by individuals, with forensic involvement serving a state population of approximately 21.3 million people. In a study by three authors affiliated with the Department of Mental Health Law and Policy at the University of South Florida, they found that involuntary examinations under the Baker Act "are associated with increased risk of arrest." They concluded that "an involuntary examination" is a significant signal that individuals with serious mental illness are at risk of arrest. In fact, each involuntary examination was associated with a 12 percent increase in the risk of arrest. An individual who is Baker Acted four times in a year has almost a 50% chance of being arrested in the near future.

Based on data from the Florida Mental Health Institute at USF, there were over 205,000 involuntary examinations under the Baker Act in 2019. Involuntary Baker Act examinations more than doubled (115.31 percent increase) in the last 17 years. More than 50 percent (106,327) were initiated by law enforcement. More than half (55.84 percent) of all involuntary examinations were based on evidence of *harm to self only.* One in five (21.52 percent) were based on *both harm to self and harm to others. Harm to others only* was the evidence for 5.55 percent of all involuntary examinations. In a one-year period, it is typical for 21 percent of people with an involuntary (Baker Act) examination to have two or more. While the people with two or more involuntary exams in a year account for 21 percent of the people with involuntary exams in that year, their involuntary exams account for 44% of the total involuntary exams for the year. While the people with five or more involuntary exams account for two percent of people with exams in that year, their exams account for 12 percent of the total involuntary exams. Florida ranks 43rd nationally in access to mental health care and has the 4th highest rate of adults with mental illnesses who are uninsured. At $39.55 per capita, spending for community-based treatment ranks 49th among all states and the District of Columbia. However, Florida is spending inordinate resources on acute mental health services. Improving access to treatment under this proposal will help Florida avoid unnecessary acute care spending and will afford those with serious mental illnesses an opportunity for hope and recovery.

Modernizing the Baker Act will prevent individuals from entering the justice system, and will respond quickly to individuals who do become involved in the justice system to effectively link them to appropriate services and prevent recidivism. By designing an appropriate and responsive system of care for individuals with serious mental illnesses, severe emotional disturbances, and/or co-occurring substance use disorders, people who otherwise would continue to recycle through the justice system will be served more effectively and efficiently. Public safety will be improved and the rate of individuals accessing more costly services in forensic mental health and criminal justice systems will be reduced.

Recommendation 10

Establish pre and post diversion programs in every circuit throughout Florida for individuals with serious mental illnesses who are at risk of an arrest or charged with a non-violent offense.

Rationale

Pre-Arrest Diversion Program

Over the last several years, mental health units have been developed by law enforcement agencies across the nation to address MH/SUD calls for service. Crisis Intervention Teams, co-responder models, or MH response teams help redirect individuals with mental illness from the judicial system and other high-cost health care systems to lower cost health care interventions. The purpose of these programs is to address the growing issues surrounding mental health, homelessness, and substance abuse challenges each community faces. To deliver quality professional services to the community while minimizing the abuse of 911 and diverting emergency services response. The target population are people who contact 911, or by other means come in to contact with law enforcement and are presenting with a mental health or substance use concern. Teams will assist persons and families in crisis in the community and attempt to restore the person to a pre-crisis level. They will be able to provide direct follow up until the crisis is diverted or resolved. Outcomes of such interventions include:

1. Improving officer and client safety.
2. Redirecting clients with mental health or substance use crisis from the judicial system and other high-cost healthcare systems to lower cost of health care interventions.
3. Improve outcomes of police interactions with people with mental health or substance use concerns.
4. Reducing the number of repeat calls for service for persons with mental illness.
5. Reduction in arrests, reducing contact with an already over-burdened criminal justice system.
6. Reducing emergency room visits, thus reducing costs and drain to an overworked healthcare system.

These response teams are often funded through local county or municipal budgets and are often found in counties and cities that are able to afford to budget for such a team. There are mobile response teams divided among regions, but often response times are much too long, and law enforcement is left to handle the case, often resulting in arrest of a subject suffering from a MH and SUD. All counties and cities should have access to a response team that can respond quickly.

Post-Arrest Diversion

Florida Statutes 394.47891, 394.47892, and 397.334 all provide the ability for each jurisdiction to create a veteran's court, mental health court, and drug court. The issue is that it is optional, and counties must secure funding from sources other than the state to operate. This is achievable by those jurisdictions that can afford to operate them but is often unachievable for those fiscally constrained counties.

Misdemeanor Diversion

All defendants booked into jail should be screened for signs and symptoms of mental illnesses. Individuals charged with misdemeanors who meet involuntary examination criteria should be transferred from the jail to a community-based crisis stabilization unit, as soon as possible. Individuals that do not meet involuntary eligibility should be screened, assessed, and, if necessary, provided with treatment while incarcerated. Eligible defendants who voluntarily agree to participate in a diversion program, should have their legal charges dismissed or modified upon successful completion, in accordance with treatment engagement. Individuals who agree to services should be assisted with linkages to a comprehensive array of community-based treatment, support, and housing services that are essential for successful community re-entry and recovery outcomes. Program participants should be monitored for up to one year following community re-entry to ensure ongoing linkage to necessary supports and services. Eligible participants are likely to be homeless at the time of arrest and are likely to be the most severely psychiatrically impaired. Assisted Out-Patient Treatment (AOT) should be expanded to every circuit and county court criminal division in Florida.

Assisted Out-Patient Treatment (AOT)

Florida Senate Bill 12 went into effect July 1, 2016, and it provides the authority for County Court Criminal Judges to use AOT for individuals charged with misdemeanor offenses. AOT serves to identify individuals with histories of repeated admissions to mental health treatment services in the criminal justice and acute care treatment systems that may benefit from court ordered outpatient treatment services. These individuals will have histories of treatment noncompliance and/or refusal to engage in treatment and are unlikely to survive safely in the community without supervision. Individuals that complete AOT can be transitioned into misdemeanor jail diversion to resolve misdemeanor cases. In Miami-Dade (detailed in Appendix 5) the misdemeanor diversion program receives approximately 300 referrals annually. Recidivism rates among program participants have decreased from roughly 75 percent to 20 percent annually.

Felony Diversion

Participants in a felony jail diversion program should be referred for mental health treatment and should meet diagnostic and legal criteria. When a person is accepted into the felony jail diversion program, the State Attorney's Office should inform the court of the plea the defendant will be offered, contingent upon successful program completion. The State Attorney weighs all of the equities involved in a case and determines whether a charge is dismissed, pled to a lesser offense, or will utilize some other appropriate sanction. Like the misdemeanor program, upon successful completion, legal charges should be dismissed or modified based on treatment engagement. All program participants should be assisted in accessing community-based services and supports, and their progress should be monitored and reported back to the court

by program staff. In Miami-Dade, individuals participating in the felony jail diversion program demonstrate reductions in jail bookings and jail days of more than 75 percent, with those who successfully complete the program demonstrating a recidivism rate of just 6 percent. Since 2008, the felony jail program alone is estimated to have saved Miami-Dade County over 31,000 jail days, more than 84 years in jail bed days.

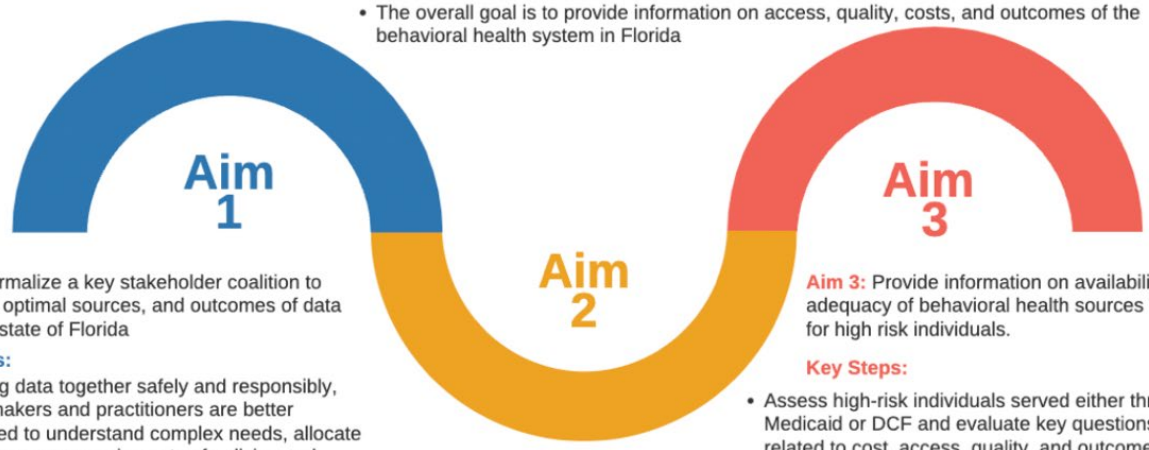
Conclusion

The Commission is honored to serve in the capacity to address the needs of the people of Florida. The ultimate goal is to ensure individuals facing behavioral health issues have access to high quality, affordable, person-centered care. To effectively and efficiently meet the most pressing needs currently facing the mental health system in Florida, it is recommended that the state invest in a redesigned and transformed system of care oriented around ensuring adequate access to appropriate prevention and treatment services in the community, minimizing unnecessary involvement of people with mental illnesses in the criminal justice system, and developing collaborative cross-systems relationships that will facilitate continuous, integrated service delivery across levels of care and treatment settings. In order to have sustainable and pervasive impact, the Commission recognizes that this work cannot happen overnight, and will require systematic changes and improvements. The Commission stands ready to partner with stakeholders across the state in order to achieve the aforementioned recommendations and utilize data to reach those most in need.

Appendix 1

Recommended Data Collaboration Roadmap

The Data Analysis Subcommittee of the Commission on Mental Health and Substance Abuse have designed the following phased approach roadmap for data sharing, collaboration, and analysis in the state of Florida.



Aim 1: Formalize a key stakeholder coalition to determine optimal sources, and outcomes of data within the state of Florida

Key Steps:

- Bringing data together safely and responsibly, policymakers and practitioners are better equipped to understand complex needs, allocate resources, measure impacts of policies and programs, engage in shared decision-making about data use, and institutionalize regulatory compliance.
- Assess county- and state-level data collaboratives to account for specified approaches related to the creation of Memorandum of Understanding (MOU) documents, linking resources across agencies, and assignment of unique identification numbers.

Aim 2: Create a Florida behavioral health data repository or comparable effective system that includes harmonization and cleaning of identified data sources for analyses.

Key Steps:

- Once a statewide data collaborative has been created and information sharing guidelines have been developed, then a behavioral health repository can be formed to include various data from organizations such as (but not limited to) DCF, AHCA, DJJ, and FDLE.
- The overall goal is to provide information on access, quality, costs, and outcomes of the behavioral health system in Florida

Aim 3: Provide information on availability and adequacy of behavioral health sources in Florida for high risk individuals.

Key Steps:

- Assess high-risk individuals served either through Medicaid or DCF and evaluate key questions related to cost, access, quality, and outcomes.
- Integration of behavioral health information from multiple sources have significant improvements in accuracy of personal demographics, diagnoses (including co-morbidities), service use types and frequency of use, and personal outcomes and health care quality
- Establishing a Florida Behavioral Health Data Repository (FBHDR) oversight steering committee can identify appropriate data sources and can guide and prioritize analytic direction and initiatives.

Appendix 2

Improving Outcomes

The Commission's Data Strategy for improving outcomes will include the following aims aligned to statute direction (§394.9086, F.S.):

Outcome 1: Describe the continuum of services available for Floridians' mental health and substance use disorders. Descriptive statistics will be used to report on the number of people and rates of utilization for the continuum of mental health and substance use services spanning from disease prevention to screening and detection, and from treatment to recovery support services that maintain sobriety and prevent relapse. Comparisons will be made among geographic areas, payers, Managing Entities, health systems, facility, or provider classifications. Claims-based methods will be used to estimate health care expenditures per service and per sub-classification. Particular emphasis will be made to quantifying the utilization of telehealth services for people with mental illnesses and/or substance use disorders. The number and trend of prescribing providers for medication-assisted therapy (MAT) will be reported, with respect to changes in certification requirements and clinical sub-specialty (e.g., primary care, obstetric, addiction medicine). The number and trend of mental health providers will be reported, including, but not limited to, psychiatrists, nurse psychiatrists, licensed certified social workers, licensed mental health counselors, and psychologists. The number and trend of certified community health workers as peer supports or targeted case managers for mental health will be presented. Trend data will be presented spanning before 2020, when available, to compensate for exacerbating effects of COVID-19 on mental health and substance use.

Outcome 2: Quantify the effectiveness of mental health care in Florida. The Commission will define a list of benchmarked performance measures that the Commission should use to evaluate the quality of mental health care delivery (process measures) and mental health outcomes (outcome measures). We recommend the development of a statewide behavioral health dashboard. For example, the percentage of children in a clinical practice who have documented evidence of mental health screening using the PSC-17 survey or similar instrument is measured and indicative of high-quality practice. The number of suicides or near-suicides would be a late-stage disease outcome measure. Employment or housing would be positive outcome measures of interest. Descriptive statistics will be used to show the trends of these performance measures. These performance measures, when possible, will be analyzed by subgrouping according to geographic distribution, payer, Managing Entity, intervention, health system, facility, or attributable provider classification.

Outcome 3: Identify barriers and deficiencies in the delivery of mental health services in Florida. Performance measures from Recommendation 8 that fall below national medians will be highlighted as opportunities for improvement, and will indicate either ineffective programs, systems of programs, or lack of programs. In addition, the Subcommittee will identify data sources to inform the Commission's examination of prevention services; hotline access and utilization; integration of mental health services within settings of physical health care delivery; telehealth access and reimbursement to providers; workforce training sites, faculty number, and trainee slots; access to MAT providers for pregnant women with substance use disorder; number and variety of school-based programs for preventing bullying, promoting mental health, and diverting from need for involuntary examination; number and rate of drug court utilization and referrals; and number, funding, and outcomes of community re-entry programs for justice-involved people with mental illness and/or substance use disorder.

Outcome 4: Modeling of proposed service changes. Modeling and sensitivity analyses will be performed for the Commission on programs or rule changes, with impacts calculated at least on expected health outcomes and expenditures.

Outcome 5: Surveillance of Mental Health. The Commission will develop and maintain a directory of currently available data sources related to the status of population mental health in Florida. This directory will include national, state, and local data sources. The primary purpose of this directory is to make data sources readily accessible to the Commissioners and other policy decisionmakers. To protect privacy and confidentiality, the specific datasets will still be housed and maintained by the respective data sources. The directory itself does not contain specific datasets but instead provides the Commissioners and other policy decisionmakers information on: (1) the appropriate data sources that can potentially address research questions and policy concerns, and (2) how to access those relevant datasets. The directory, at a minimum, will include the following information about the data sources: a brief description of the source, what specific type of data is included in the source, who owns and/or maintains the source, when the source is updated (i.e., its periodicity), how it is benchmarked, and how to access the data.

Appendix 3

National Frameworks

There are many national frameworks that may provide useful guidance in developing core categories or domains of quality care metrics. The following represent just a handful of examples that the workgroup may consider:

- Institute of Medicine (IOM) Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders. Outlines the six aims of high-quality health care: (1) Safe, (2) Effective, (3) Patient-centered, (4) Timely, (5) Efficient, and (6) Equitable, and provides recommendations on improving the quality of health care for mental and substance use conditions. https://www.ncbi.nlm.nih.gov/books/NBK19823/

- National Committee for Quality Assurance (NCQA) Behavioral Health Quality Framework: A Roadmap for Using Measurement to Promote Joint Accountability and Whole-Person Care. Provides a potential framework encouraging a shift from administrative metrics to quality focused metrics and focuses on three levels of management: (1) State & Federal (Macro level) to set priorities and direct resources through regulations and financial support, (2) Managed Care (Meso level) – manage delivery of evidence-based care, and (3) Facility/Provider (Micro level) – provide evidence-based treatment and services to support whole-person care.
  https://www.ncqa.org/wp-content/uploads/2021/07/20210701_Behavioral_Health_Quality_Framework_NCQA_White_Paper.pdf

- American Society of Addiction Medicine (ASAM) Standards of Care for the Addiction Specialist Physician. The Standards identify six practice domains: (1) Assessment and Diagnosis, (2) Withdrawal Management, (3) Treatment Planning, (4) Treatment Management, (5) Care Transitions and Care Coordination, and (6) Continuing Care Management. Reference: https://www.asam.org/docs/default-source/advocacy/performance-measures-for-the-addiction-specialist-physician.pdf

- Centers for Disease Control and Prevention (CDC) Four Domains of Chronic Disease Prevention. These key areas are: (1) Epidemiology and Surveillance, (2) Environmental Approaches, (3) Health Care System Interventions, and (4) Community Programs Linked to Clinical Services. Reference: https://www.cdc.gov/chronicdisease/center/nccdphp/how.htm

- Association of State and Territorial Health Officials (ASTHO) and National Association of State Alcohol and Drug Abuse Directors (NASADAD) Preventing Opioid Misuse and Overdose in the States and Territories: A Comprehensive Public Health Framework to Address the Opioid Crisis. This framework recognizes the need for a comprehensive, cross-sector response to the opioid crisis leveraging leadership and cross-sector partnerships across four strategies: (1) Training and Education, (2) Monitoring and Surveillance, (3) Treatment, Recovery and Harm Reduction, and (4) Primary and Overdose Prevention.
  Reference: https://my.astho.org/opioids/home

There are also existing national standards for tracking quality of care and health outcomes that should be considered for inclusion in the Florida substance abuse and mental health metrics. This section references metrics that would provide a national reference for benchmarking and monitoring improvement at the state and local levels. Sample topics and measures are listed below, but the list is not exhaustive. Please note that some measures are included in more than one national standard described below.

- NCQA Healthcare Effectiveness Data and Information Set (HEDIS): https://www.ncqa.org/hedis/

Domain	Sample Measures
Effectiveness of Care	• Follow-Up After Emergency Department Visit for Mental Illness. • Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence. • Diabetes and Cardiovascular Disease Screening and Monitoring for People with Schizophrenia or Bipolar Disorder. • Adherence to Antipsychotic Medications for Individuals with Schizophrenia. • Pharmacotherapy for Opioid Use Disorder.
Access/Availability of Care	• Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment. • Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics.
Utilization	• Identification of Alcohol and Other Drug Services. • Mental Health Utilization.
Measures Reported Using Electronic Clinical Data Systems	• Depression Screening and Follow-Up for Adolescents and Adults. • Depression Remission or Response for Adolescents and Adults. • Unhealthy Alcohol Use Screening and Follow-Up.

- Centers for Medicare and Medicaid Services: Core Quality Measures Collaborative (CQMC) Behavioral Health Dataset: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Core-Measures

Topic	Sample Measures
Depression	• Depression Response at Six Months. • Depression Response at Twelve Months.
Serious Mental Illness	• Adherence to Antipsychotic Medications for Individuals with Schizophrenia. • Metabolic Monitoring for Children and Adolescents on Antipsychotics. • Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications.

Tobacco, Alcohol, and Other Substance Use	• --Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling. • --Pharmacotherapy for Opioid Use Disorder.
Other	• --Follow-Up After Hospitalization for Mental Illness. • --Follow-Up After Emergency Department Visit for Mental Illness.

Healthy People 2030: https://health.gov/healthypeople

Domain	**Sample Indicators**
Addiction	• --Increase the proportion of people with a substance use disorder who got treatment in the past year. • --Reduce the proportion of people who had drug use disorder in the past year. • --Increase the proportion of people who get a referral for substance use treatment after an emergency department visit.

Mental Health and Mental Disorders	• --Increase the proportion of people with substance use and mental health disorders who get treatment for both.
	  ■ Increase the proportion of primary care visits where adolescents and adults are screened for depression.
	  ■ Increase the proportion of children and adolescents with symptoms of trauma who get treatment.
	  ■ Increase the proportion of adults with serious mental illness who get treatment.
	• -- Reduce emergency department visits related to nonmedical use of prescription opioids

Appendix 4

Section 1006.05, Florida Statutes, Amendment to Recommendation 6

1006.05 Section 1. Subsection (1) to be added. Pursuant to section 394.491 and to further promote the effective implementation of a coordinated system of care pursuant to 394.4573 and 394.495 each school district that provides mental health assessment, diagnosis, intervention, treatment, and recovery services to students with one or more mental health or co-occurring substance use diagnosis and students at high risk of such diagnoses shall be guided by and adhere to the principles of the child and adolescent mental health treatment and support system.
1006.05 Section 1. Subsection (2) (a) to be added. School districts shall contract with Managing Entities to provide children's care coordination for students with complex behavioral health needs who continue to experience adverse outcomes due to their unmet needs or inability to engage. Care coordination is as defined in 394.573(1)(a).

1006.05 Section 1. Section (2) (b) to be added. School districts shall address recommendations from the Managing Entity children's care coordinator whenever a student is identified as having experienced an involuntary admission to an acute care psychiatric facility upon the return of the student to the school setting.

1006.05 Section 1. Subsection (2) to be added. Pursuant to s. 394.494(1) Each school district shall meet the general performance outcomes for the child and adolescent mental health treatment and support system.
(This recommendation would connect school districts with the mental health system of care and reads:
394.494 General performance outcomes for the child and adolescent mental health treatment and support system.—
(1) It is the intent of the Legislature that the child and adolescent mental health treatment and support system achieve the following performance outcomes within the target populations who are eligible for services:
(a) Stabilization or improvement of the emotional condition or behavior of the child or adolescent, as evidenced by resolving the presented problems and symptoms of the serious emotional disturbance recorded in the initial assessment.
(b) Stabilization or improvement of the behavior or condition of the child or adolescent with respect to the family, so that the child or adolescent can function in the family with minimum appropriate supports.
(c) Stabilization or improvement of the behavior or condition of the child or adolescent with respect to school, so that the child can function in the school with minimum appropriate supports.
(d) Stabilization or improvement of the behavior or condition of the child or adolescent with respect to the way he or she interacts in the community, so that the child or adolescent can avoid behaviors that may be attributable to the emotional disturbance, such as substance abuse, unintended pregnancy, delinquency, sexually transmitted diseases, and other negative consequences.)

Revise 397.96 Case management for complex substance abuse cases.— Change case management to care coordination as defined in 394.573(1)(a).
397.96 Section (1) Replace case management with care coordination.
397.96 Section (2) Replace case manager with care coordinator.
397.96 Section (3) Replace case management with care coordination.
397.96 Section (4) Replace case manager with care coordinator.
397.96 Section (5) Replace case manager with care coordinator.

Appendix 5

MIAMI-DADE FORENSIC ALTERNATIVE CENTER (MD-FAC) PROGRAM

Since August 2009, the Miami-Dade Criminal Mental Health Project has been diverting individuals with mental illnesses committed to the Florida Department of Children and Families from placement in state forensic facilities to placement in community-based treatment and forensic services. Participants include individuals charged with 2nd and 3rd degree felonies that do not have significant histories of violent felony offenses and are not likely to face incarceration if convicted of their alleged offenses. Participants are adjudicated incompetent to proceed to trial or not guilty by reason of insanity.

Unlike individuals admitted to state forensic treatment facilities, individuals served by MD-FAC are not returned to jail upon restoration of competency, thereby decreasing burdens on the jail and eliminating the possibility that a person may decompensate while in jail and require readmission to a state facility. To date, the project has demonstrated more cost-effective delivery of forensic mental health services, reduced burdens on the county jail in terms of housing and transporting defendants with forensic mental health needs, and more effective community re-entry and monitoring of individuals who, historically, have been at high risk for recidivism to the justice system and other acute care settings. Individuals admitted to the MD-FAC program are identified as ready for discharge from forensic commitment an average of 52 days (35 percent) sooner than individuals who complete competency restoration services in forensic treatment facilities and spend an average of 31 fewer days (18 percent) under forensic commitment. The average cost to provide services in the MD-FAC program is roughly 32 percent less expensive than services provided in state forensic treatment facilities.

4) Revise restoration protocols.
5) Address operational inefficiencies.
    a. Evaluator training, availability, and speed.
    b. Evaluation templates.
    c. Limit multiple evaluations
    d. Case managers and court liaisons.
    e. Court case management – centralized calendars, frequent reviews, and teams.
        i. Centralized calendars
        ii. Frequent reviews
        iii. Teams
6) Address training, recruitment, and retention of staff.
7) Coordinate and use data.
8) Develop robust community-based treatment and supports for diversion and re-entry.

Appendix 6

FISCAL YEAR 20-21 Individuals Served Each Month – Unduplicated Monthly

Clients Served	Column Labels												
Row Labels	July	August	September	October	November	December	January	February	March	April	May	June	Grand Total
AMH	**51,207**	**50,373**	**49,769**	**49,854**	**46,511**	**47,316**	**48,441**	**48,222**	**49,600**	**50,698**	**49,929**	**49,345**	**591,265**
CSU/Inpatient	2,852	2,898	2,784	2,733	2,556	2,575	2,715	2,611	2,883	2,725	2,789	2,517	32,638
Outpatient	47,106	46,251	45,736	45,855	42,708	43,422	44,454	44,273	45,363	46,653	45,636	45,343	542,800
Residential	1,249	1,224	1,249	1,266	1,247	1,319	1,272	1,338	1,354	1,320	1,504	1,485	15,827
ASA	**22,699**	**23,014**	**23,060**	**23,563**	**22,474**	**21,490**	**22,628**	**22,512**	**23,125**	**23,140**	**24,273**	**23,500**	**275,478**
Inpatient Detoxification	1,216	1,330	1,282	1,359	1,294	1,218	1,317	1,266	1,313	1,320	1,470	1,247	15,632
Outpatient	19,715	19,899	19,903	20,260	19,310	18,449	19,507	19,517	19,900	19,885	20,597	20,040	236,982
Residential	1,343	1,340	1,430	1,486	1,456	1,427	1,471	1,426	1,552	1,559	1,837	1,774	18,101
Detox	425	445	445	458	414	396	333	303	360	376	369	439	4,763
CMH	**9,094**	**8,981**	**9,485**	**9,556**	**8,619**	**9,132**	**9,425**	**9,817**	**10,457**	**10,440**	**10,657**	**10,379**	**116,042**
CSU/Inpatient	358	418	549	531	478	494	596	697	631	589	496	362	6,199
Outpatient	8,689	8,524	8,900	8,996	8,122	8,614	8,792	9,082	9,803	9,832	10,143	9,999	109,496
Residential	47	39	36	29	19	24	37	38	23	19	18	18	347
CSA	**2,447**	**2,419**	**2,520**	**2,572**	**2,520**	**2,684**	**2,597**	**2,691**	**2,840**	**2,935**	**3,235**	**2,757**	**32,217**
Inpatient Detoxification	2						2	1		1			6
Outpatient	2,303	2,277	2,375	2,427	2,373	2,533	2,461	2,552	2,713	2,810	3,097	2,620	30,541
Residential	142	142	145	145	147	151	134	138	127	124	138	137	1,670
Grand Total	**85,447**	**84,787**	**84,834**	**85,545**	**80,124**	**80,622**	**83,091**	**83,242**	**86,022**	**87,213**	**88,094**	**85,981**	**1,015,002**

FISCAL YEAR 20-21 Individuals Added to the Waitlist

Clients added to wait list	Sum of Added To Wait List
AMH	**1,315**
CAT	27
CCT	204
CSU/Inpatient	70
FACT	222
Outpatient	382
Residential	388
Forensic MT	22
ASA	**5,117**
Care Coordination	8
Inpatient Detoxification	21
Outpatient	411
Residential	4,677
CMH	**809**
CAT	681
Outpatient	128
CSA	**9**
Residential	9
Grand Total	**7,250**