2010

Metro Services Funding Workgroup

One Size May Not Fit All: Exploring the Frequency & Configuration of Services in Supportive Housing

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1/31/2011

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Workgroup Summary

Supportive housing is a key strategy for ending homelessness, especially for those who have been homeless the longest and for those with multiple barriers to maintaining stable housing. Across the country and here in Minnesota, supportive housing has proven to be a sound, long-term solution for housing and helping people who have experienced long-term homelessness. Numerous studies clearly demonstrate that supportive housing is, fundamentally:

- An effective intervention that leads to better outcomes for residents
- An efficient investment of scarce public and private money
- An effective tool for improving communities.[1]

All this being said, supportive housing models and methods could benefit from more in-depth research and evaluation. The supportive housing field is eager to improve the service configuration and programmatic methodologies that underlie supportive housing. Further research and evaluation concerning the following areas would bolster state efforts to end homelessness:

- proper targeting and assessment of homeless applicants to supportive housing (better determining which participants require short or long-term intensive services to achieve housing stability),
- the proper mix and frequency of supportive services that are required to maintain housing stability and prevent future homelessness,
- identifying the 'value added' by supportive services above the benefits achieved when participants simply access affordable housing;
- identifying how best to assess and achieve a step-down of service frequency and configuration when supportive housing participants no longer require intensive support.

The 2010 Metro Services Funding Workgroup focused on the last of these topics - discussing and planning changes in our supportive housing network that would better equip the supportive housing field to assess and achieve a step-back of service frequency and configuration when participants no longer require intensive support. This topic is timely considering the enormous state budget deficit and the potential for losses in state funding that supportive housing providers have relied upon to bring services to Minnesotans experiencing long-term homelessness. After careful deliberation, the 2010 Metro Services Funding Workgroup requests that state agencies, metro counties, and supportive housing providers consider the following recommendations:

1. Create a pilot/demonstration project for households that are ready to transition to less intensive services.
2. Establish a workgroup to draft standardized services reimbursement rates for supportive housing.

[1] Plan to End Homelessness: Saint Paul-Ramsey County PART ONE: ENDING LONG-TERM HOMELESSNESS

Background

Over the past two years, two separate workgroups have convened for the purpose of improving our state and region's approach to funding supportive services to end homelessness. These workgroups have been named the Metro Services Funding Workgroup. Both workgroups developed recommendations that were broadly accepted by metro providers, the Regional Metro Committee (the county staff who oversee the Metro Supportive Services Project), and state agencies.

Most recently, the 2009 Metro Services Funding Workgroup presented conclusions and recommendations to a broad audience of supportive housing providers in March of 2010. While the recommendations were widely embraced at this meeting, there were a few issues raised that both workgroup and community members felt warranted further investigation. Most pointedly, participants wanted future workgroup discussions to go further in investigating and describing the recommendations made on page 8 of the 2009 summary document (full document available at www.mesh-mn.org). This section states:

> *"The workgroup recommends that the public and private sector work together to create a better system to get people to the right programs. We need a system that is as seamless as possible so that if, for example, a rapid re-housing or prevention intervention does not work for someone, there are other options available, including transitional and permanent supportive housing. Seamlessness is also needed when people are ready to transition away from services. There should be flexible follow-up care, as needed. While it is anticipated that this would be a fairly small population, our workgroup recommends that there should be incentives to transition people who have benefited from supportive housing but no longer need it, in order to open the unit/services for someone who needs it. This might require rental assistance and/or short-term support, like a rapid exit program for people in supportive housing. The workgroup recommends that government consider targeting some resources to helping people exit supportive housing if they no longer want and need it. The result would be a more efficient use of the dollars being invested in supportive housing."*

Workgroup Process

Our work group met twice per month from September 2010 to January 2011 to:

- Clearly describe and define the population currently in supportive housing that would benefit from (and likely choose) less intensive or no supportive services if that option were available to them.
- Describe a services funding model that would:
  - Allow and appropriately encourage such transitions without jeopardizing the housing stability or choice of participants.
  - Create an option and incentive for supportive housing providers to transition clients to less intensive services as is appropriate.
  - Be predictable and reliable for all supportive housing models and populations served

Members of the workgroup included:

Alison Niemi	MN Dept. of Human Services
Barbara McCormick	Project for Pride in Living
David Browne	CommonBond

Gary Travis	MN Dept. of Human Services
Jane Lawrenz	MN Dept. of Human Services
Jana Curiel	YWCA of St Paul
Jessica Fresche	Project for Pride in Living
John Petroskas	Catholic Charities
Joseph O'Brien	Cabrini Partnership
Julie Shannon	Wilder Foundation
Kate Bitney	Hearth Connection
Laura Kadwell	Heading Home Minnesota
Lory Perryman	Lutheran Social Service
Mike Manhard	MESH
Pam Sabey	Resource, Inc.
Pat Crosby	Hennepin County
Rich Hooks Wayman	Hearth Connection
Simon Carvalho	Community Advocate
Vicki Farden	Minnesota Housing
Wendy Wiegmann	Simpson Housing Services

Conclusions

- **Participant choice drives this effort.** All options for transitions must be made dependent upon participant choice and available resources.

- **Not all who have entered supportive housing needed it.** Some households who are currently in supportive housing may not have needed supportive services (or the level of services they are receiving) in the first place, but were placed simply because that is where the subsidized housing was. For our purposes, we need to separate this subgroup from our consideration as the discussion is really more about those who will need supportive services to end their homelessness, but not permanently or as intensively.

- **There are no common assessment criteria and benchmarks for individual functional progress in supportive housing.** The lack of common standards and benchmarks showing participant progress in responding to supportive services impedes a common approach or methodology in determining which participants could be 'stepped-down' from intensive supportive services.

- **Supportive housing providers need to have standard service components and reimbursement rates to create a viable transition model.** Supportive housing is currently provided in such a range of styles and places that there is no common standard for what it costs to provide supportive services. In addition to the lack of Rental Assistance to make housing affordable for formerly homeless participants, the lack of standard service components and reimbursement rates is the elephant in the room that keeps us from being able to make transitions from supportive housing predictable and reliable. Our workgroup recommends developing a pilot program that could work to develop and test standard reimbursement rates.

- **It is important to maintain the breadth of supportive housing models.** In earlier Metro Services Funding Workgroups, we came to see the broad diversity of service models as an asset to our community. Any effort to standardize reimbursement rates needs to maintain flexibility for programs to retain the unique qualities of their models.

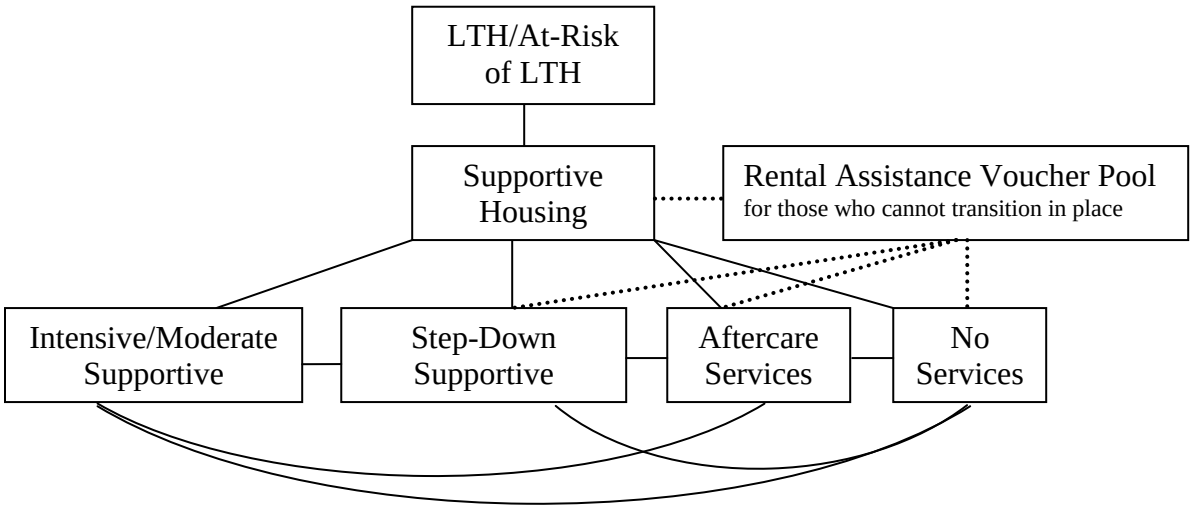
- **Most households who are now in supportive housing will require a rental assistance subsidy to exit**. In nearly all cases, a permanent housing subsidy is required to make the transition off services possible. It is not a new discovery to conclude that we need more permanent rental subsidies. The following are items to consider regarding the rental subsidy:
  - Argument for Increasing Subsidies
    - Due to a shortage of affordable housing options we are currently providing services to some households that only need a rental subsidy.
    - Opening the back door allows for supportive housing providers to target limited resources to households with higher needs.
    - Backed up system gains some fluidity.
    - Allows long shelter stayers a place to go.
  - More Flexibility is Needed
    - Households who have successfully maintained supportive housing no longer qualify for some housing subsidies since they are no longer homeless, long-term homeless, etc. This is both a state and federal issue.
    - Some federal subsidized housing is not accessible to households due to eligibility and compliance issues.
    - Flexibility of subsidy timing is needed. Providers have indicated that it is common to have a family/individual that could move to less intensive services/no services if a voucher were available, but that the timing is rarely right.
    - Not putting subsidy at risk for domestic violence, hospitalization, etc.
  - Common Practice
    - Transition planning begins at intake and continues while the person is in permanent housing. Part of this transition would be planning for long-term stable housing, appropriate level of services and averting crises and problems. Would include training on, “How to keep your rental voucher”.
    - Not everyone is able or expected to transition.

Objective. Propose and describe a model for funding the transition of households currently in supportive housing to less intensive supportive services and/or off services altogether.

Questions to answer in our model.

- Describe how this model would work (intake to exit) thinking about staffing, funding allocation, etc.
- How predictable and reliable would this model be for various SH providers? (site-based, scattered)
- How would flexibility be retained to ensure households exiting services could regain them if needed?
- What would be the incentive to client/program to transition off services?
- How is this model sustainable?
- Does this model work differently for different populations?

How It Might Look.



- A household that is long-term homeless or at-risk of long-term homelessness AND is likely to require supportive housing to exit homelessness ENTERS supportive housing.
- A permanent housing subsidy is connected to the individual upon an exit from supportive housing. We have seen the great benefits of models in which the "services" follow the household regardless of whether their housing in one particular setting is maintained. In order to create a fluid system in which households may transition to or away from services, we need subsidies that will also "follow the household".
- A rental assistance voucher pool may be needed in locations where a household will not be able to transition in place (most site-based models).
- The bottom row includes basic examples of possible service rates.
  - Supportive housing as we know it presently is mostly like "intensive/moderate" rate.
  - "Step down" is the support provided as households transition away from services.
    - For Mobile teams, step down and moderate likely look a lot alike
    - For site-based programs, step down may be more intensive than moderate
  - Aftercare is low-intensity services that are made available for households.
    - One will note: there is not a true "exit" from the supportive housing system.
    - Aftercare and No Services have been practiced, as capacity has allowed, by most supportive housing programs, but to households that have been considered "Exited" from the program
    - So long as the household continues to financially need a housing subsidy to maintain housing, households will still be enrolled in supportive housing "system" in order to quickly return household to services, as they are needed (crisis).

Recommendations

Recommendation # 1: Create a pilot/demonstration project for households that are ready to transition to less intensive services.

The Demonstration Project will allow us to:

- Document providers' service plans with households whose need for service diminishes, to identify best practices and necessary conditions for achieving the goal of reducing the need for services;
- Identify presently available options for housing and service coordination for households needing reduced services (which will vary from site-based service provision to scattered-site service provision);
- Increase housing options for households needing reduced services;
- Estimate future need for housing alternatives that would create more availability in intensive service slots.
- Identify any cost savings to public systems achieved subsequent moving participants to less intensive services.

Summary: Most current permanent supportive housing programs have not been designed with transition in mind, yet we know that residents of supportive housing often develop the capability to remain stably housed without/or with less intensive supportive services. We have stated the reasons it is beneficial to have a system that matches needs and consumer choice with the appropriate level of support. Our workgroup recommends that we (funders, supportive housing providers, consumers, and government agencies) develop a pilot to understand the elements needed for a successful transition from supportive housing by focusing on a limited number of providers, and documenting their past and current experience in adjusting services while continuing to meet housing needs. The value of such a study would be if there is a mechanism established from the outset to control, validate and disseminate the information so gathered, so the first task of this group will be to work with the Minnesota Department of Human Services to charter the process for the demonstration project.

Guiding Thoughts on the Pilot/ Demonstration Project: (*Providing people the option to move: If they no longer need services how to help them with the next step. The Pilot Project is intended to provide insights into the balance between an appropriate level of service and housing retention.)*

- **Pilot Workgroup.** This study will require careful oversight and documentation, leading to safe quality opportunities for formerly homeless households. By design, many programs could participate on a smaller scale which would offer a rich opportunity for collaboration and learning across Metro Permanent Supportive Housing Programs. This Workgroup would design the Pilot, including a determination of appropriate scale for the pilot, defining criteria for a successful transition, securing rental assistance resources, establishing duration of pilot, standards and methods for data collection, analysis and reporting and selection of participating projects/programs.

- **Affordable Housing.** We assume that some level of rental assistance will be necessary for most supportive housing residents to transition. It should also be assumed that some transitions will occur in place (retaining current housing location), while others will not (moving to new housing location). We recommend some type of voucher be made available to interested, qualified residents in the pilot group. The pilot would standardize the process for determining access to housing vouchers. Residents who receive vouchers would agree to remain in contact with their supportive housing program for purposes of learning about their future stability and the need for follow up services. It would be critical, for

purposes of this pilot, that eligibility is established by having been deemed long-term homeless upon entering the program, regardless of length of time housed while engaged in supportive housing.[2]

- **Services.** The pilot would document what services are required to support a successful transition from supportive housing. Programs participating in the pilot would need to offer additional services including assessment, transition, and some level of aftercare. The pilot would determine what aftercare services looked like and develop a way to track the experiences of the residents. Programs would ensure an option to prioritize re-enrollment of residents in supportive housing. We do not anticipate additional funding to provide these services. It is hoped that programs can deploy services to focus on skills needed for ongoing housing stability and in a way that may benefit the program and the residents in a broader way, while creating openings that allow appropriate utilization of supportive housing.

- **Pilot Participants.** Should consist of subgroups of Singles, Families and Unaccompanied Youth that include both site based and scattered site programs in both urban and suburban/rural settings – to allow consideration and understanding of differences in characteristics and needs of different populations. One method to select the subgroup could be a set point in time; for example residents who enrolled in supportive housing in January 2008 – to allow consideration of characteristics that are not only related to the amount of time in supportive housing. This model could allow for wide participation from programs, which would produce rich information sharing and broad learning.

- **Assessment Process.** It will be important to develop an understanding of what makes a successful transition. There should be consideration of resident vulnerability index and self sufficiency characteristics- what skills and abilities lead to housing stability without intensive supportive services. Determine how a program fosters these abilities and improves functionality to assist in transitioning to lower levels of services or no services. The pilot would develop an assessment process that would include participation from residents and program staff. The Self Sufficiency Matrix could be employed or another tool that examined income stability, connection to community, housing skill level (lease compliance, housekeeping, ability to follow through with rent and paperwork), ability to access resources, barrier reduction, and symptom management. The process would include assessment of resident interest and level of confidence in transitioning from supportive housing.

- **Analysis of Examples of Transitions to Less or No Services in Existing Programs.** Supportive housing programs in the metropolitan area would review past examples of 'successful' transitions from supportive housing. Real case histories where individual or family households had exited a program to independent housing or significantly reduced their interaction with intensive case managers would be captured for analysis. Committee members will search for trends in demographics, self-sufficiency domains, income, or other outcome measures (perhaps related to health care access, vocational or

[2] **Available Housing Vouchers**. One group whose experience will be particularly interesting to track are those persons moving on from project-based programs. HUD has made project-based, permanent supportive housing vouchers available, which can be portable after a resident has maintained tenancy for a year, coupled with successful completion or progress in the "supportive housing program." Currently several site based Permanent Supportive Housing projects are the conduit for portable Section 8 vouchers through the project-based supportive housing program. The vouchers are awarded primarily based on time and availability, though some programs have initiated additional criteria. These programs offer insight into this process and are interested in information about residents who leave their programs.

educational advancement) that may offer clues as to potential 'turning points' or 'catalysts' that could be implanted in a future targeting model to identify households ready for transition from intensive supportive housing.

Proposed Timeline

All these objectives could proceed simultaneously, but the time required will be six to nine months. Given the need for design input and buy-in by sponsoring agencies and providers, planning for a year's preparation time is wise.

Recommendation # 2: Establish a workgroup to draft standardized services reimbursement rates for supportive housing.

Summary: Our workgroup recommends that a new, chartered workgroup be convened to design a model of payment standards for supportive housing. This group should have strong connection/participation from MN Dept. of Human Services and staff from metro counties. Ideally this group would be chartered by DHS. *The absence of such standards thwarts our efforts to reform elements of supportive services funding, and diminishes our ability to quantify the need/solution for resources to legislators and other policy makers*.

Guiding Thoughts on Services Payment Standards: Our workgroup discussions identified that payment reimbursement standards would likely need to consider the following elements:

- Client & Programmatic Outcomes
- Service Intensity & Frequency
- Client Self-Sufficiency Level
- Costs
- Sources of Services Funding
- Client Choice
- Existing Models for Funding Services[3]

While our workgroup did not attempt to resolve the role these elements would play in establishing payment standards, we have listed questions that should be considered.

Client & Programmatic Outcomes Achieved:

- *What are the outcomes we want to buy with services funding?* Supportive housing providers are currently serving a variety of population with a variety of service models, thus seeking different outcomes. How do service standards account for this? Defining what we are trying to achieve is necessary in order to determine what we wish to purchase through a payment standard for services. Generally, there is no consensus within the supportive housing and homeless advocacy community in defining 'success.'
    - Is success ending homelessness by obtaining rapid re-housing and ongoing housing stability, or is success defined as the achievement of housing stability in addition to improvements in individual well-being.
    - Should a housing program merely focus on keeping people stably housed or should they attempt to work with individuals and families in achieving improvements in health, education, vocational, daily functioning, and interpersonal relationships?
    - How do outcomes vary by population and barriers? How can we incorporate the Self-Sufficiency Matrix into measuring outcomes?
- *How do we retain the focus on the hard to serve?* Anytime reimbursement is based primarily upon performance, we risk creating a disincentive for providers to enroll participants who are hardest to serve. How do we create a system that rewards outcomes while retaining the incentive to serve the hardest to serve?

[3] For example: SAMHSA, Refugee programs, Developmental Disabilities, nursing home care, etc.

- *What is the correlation between the services provided and the outcomes for each household?* Our workgroup expressed concern about payment being attached solely to family outcomes when supportive services are only a piece of a household accomplishing or not accomplishing goals.

Service Intensity & Frequency

- *How should the intensity and frequency of services provided influence the reimbursement rate?*
- *How is intensity & frequency measured?* Who evaluates intensity/frequency, how? How do we ensure this is not an administrative burden? How do we avoid unwanted/unintended incentives? i.e. how do we ensure that low-service requirement models are not penalized?
- *How do we arrive at target "capacity" levels?* Does this change by populations served?

*Examples of the intersection between **Outcomes** & **Service Intensity and Frequency**:*

A provider may work with FAMILY A, who is hovering at 1s and 2s on the Self-Sufficiency matrix after 4 years. They may not be working toward employment, improving parenting skills, etc. and continue living day to day crisis. Their chemical and mental health coupled with years of just surviving and living in crisis makes it nearly impossible to improve in most areas. Yet this provider spends LOTS of time offering services and resources, walking hand in hand to get them to appointments, teaching them simple concepts (to us), etc., helping them learn about basic housing concepts, etc. This is this provider's hardest to serve family with the least progress. Getting paid on outcomes wouldn't make sense here. Getting paid for intensity and frequency would make sense.

FAMILY B, on the other hand, is making steady progress up the matrix ladder. Just having stable, affordable housing, has enabled them to keep their kids in the same school so that the kids succeed. The parents have taken the initiative to get adult education, seek jobs, learn how to communicate with the landlord, etc. with VERY LITTLE time and help on this provider's part. Here it wouldn't make sense for the provider to get paid on outcomes either. Getting paid less due to less intensive services would make sense.

PERSON C has been homeless for several years. He enters a Permanent Supportive Housing program targeted to individuals with MI/CD. When he moves in his scores on the Self-Sufficiency matrix are in the ones and twos. After one year at the housing program PERSON C is on SSI, Medical Assistance, MSA and food support, his scores on the Self-Sufficiency Matrix have improved to threes and fours. While PERSON C has achieved several outcomes (stabilization of mental illness and chemical use, accessing mainstream resources) these accomplishments have required intensive services by the staff at the housing program since Person C was initially resistant to seeing a psychiatrist and missed many appointments. PERSON C can be foul mouthed requiring staff to work with the landlord to prevent eviction after he was verbally abusive to his neighbors. Payment based on outcomes would work in this case especially if the outcomes were based on an assessment of how the client was functioning at admission compared to his functioning after one year of program participation.

Client Self-Sufficiency:

- *How does a client's self-sufficiency level determine the level of services needed to achieve determined outcomes?* Does this change by populations served?
- *Consider using the Self-Sufficiency Matrix as the primary assessment tool.* Using all the domains of the Self-Sufficiency Matrix, the new workgroup would need to determine what service intensity/frequency is most appropriate for domains and levels within the assessment. As levels change, service intensity/frequency should as well.

- *How is "value added" through varying levels of services documented?* Workgroup members could explore the following using data and programmatic information collected through the Self-Sufficiency Matrix on households currently being served in the metropolitan area:
    - What are the functional improvements and other positive outcomes achieved when households (youth, families, or single adults) exit long-term homelessness and access affordable housing (without additional supportive services). Compare these results to the total programmatic cost for each household served with rental assistance only.
    - What are the functional improvements and other positive outcomes achieved when households exit long-term homelessness and access temporary supportive services (critical time intervention model) for less than 6 months? Compare these results to the total programmatic cost for each household served with temporary or transitional services.
    - What are the functional improvements and other positive outcomes achieved when households exit long-term homelessness and access permanent supportive housing? Compare these results to the total programmatic costs for each household served with intensive supportive services.

  By making a comparison between (a) frequency, duration, and intensity of services, (b) outcomes achieved, and (c) costs – the Workgroup members will be able to identify recommendations for future payment standards in order to achieve intended outcomes in supportive housing.

Costs:

- *How much does it cost?* What are the compensation amounts? What level of service are we trying to buy? Who purchases the services (federal, state or local government)?
- *How is provider flexibility retained?* Defining reimbursement and costs through payment standards suggest that a prescribed list of activities/functions/components would be established that providers may/may not be compensated for at varying compensation levels. Too much prescription could constrain providers and take away from the current diversity of Supportive Housing approaches. The variety of supportive housing models in our community is an asset that must be maintained in this effort.
- *Utilization of community resources.* Providers can enhance their programs by use of services funding which is not coordinate-able, and community resources. How do we account for or describe this?
- *Take front desk out of the equation as that is an operations expense.*
- *Predictable & Reliable.* Reimbursements must be predictable and reliable for service providers and household utilizing the services.
- What objectives do our participants believe service providers should be paid to help them achieve? Survey participants about benefit of different support services.

Sources of Services Funding

- *How do you create standards when we aren't necessarily talking about one funding source?*
- *Focus on what is coordinate-able?* We recognize that there are a variety of resources currently utilized to help fund services within supportive housing programs. The effort to create standards might take into account all funding that is potentially "coordinate-able". This might include:
    - State services funding
    - Adult Rehabilitative Mental Health Services
    - In-home therapy rate

  - Targeted Case Management
  - Innovative Treatment model funding
  - Group Residential Housing
  - Federal funding through the U.S. Department of Housing and Urban Development and the U.S. Department of Health and Human Services
  - Possibly some private funders
- *Do we need an administrative entity to coordinate the multiple funds*? To keep households enrolled who no longer need services?

Client Choice

- *How are choice and targeted services balanced?* How to better target households, move from people going where there's an opening vs. where they might best succeed. Potential need for single entity, coordination of households coming and going. How is whole system coordinated?
- *How do we ensure services are maintained for households that need but may not want services?* Households don't come to programs because they want services, they want housing. Therefore, how does one manage "choice" when choice may mean lack of stability—especially for families/children? Does this model need to address this issue?
- *What activities does a participant of supportive housing think providers should be paid to provide?* Our workgroup thought that asking such a question to a sampling of supportive housing participants might provide helpful information.

Appendix A Service Payment Standards

The following is an early draft from our workgroup regarding possible design for service payment standards. In the end, we lacked consensus on the conclusions listed in this section and determined that the scope of our workgroup's initial charter did not give us the time and attention needed to further investigate the questions that arose from this summary. At the same time, we agreed it would be of value to include this section as an Appendix to serve as a resource for the future workgroup that will focus directly on Service Payment Standards.

Please review this with the understanding noted above—that this is a Draft section, lacking full development and consensus of our workgroup.

The 2010 Metro Services Funding Workgroup proposed that a committee/workgroup to tackle service payment standards. Ideally this committee/workgroup would be chartered by DHS. The workgroup should link their efforts with the work that the Service Funding Committee did in March 2008 that described the models of housing, populations best served by different models and a menu of services for each population. The document is at - http://www.mnhousing.gov/idc/groups/public/documents/document/mhfa_006896.pdf. Basic service sets were defined for single adults, youth and families with children with additional service sets for mental health, traumatic brain injury, chemical health, physical disability and co-occurring disorders. The last section of the document describes the services and existing funding sources for some services.

We have often described the Metro Long-term Homeless services model as "services that follow the household"—regardless of whether the household is able to maintain housing in their first attempt (or second or third…) the services are permanent (no time limit) resource that will continue to work with them towards housing stability. Households that were formerly dropped if they didn't fit with their initial housing placement are now able to continue to access the services needed to obtain and maintain stable housing. This has been a major breakthrough and successful model.

At the same time, currently, as people in supportive housing obtain a permanent housing voucher (Section 8, Public Housing, etc.), they are most commonly exited from supportive housing programs. The following actions tend to occur:

- Households continue to be served by the provider with less intensive/aftercare services. These services are usually not funded activities, rather activities providers perform to follow their mission and support success.
- Households are dropped from services altogether.
- In some cases, mobile teams are able to maintain the same level of services, as needed.

We ask this new group to envision a system in which the HOUSING follows the person—in other words, permanent subsidies that are not contingent upon services are attached to an individual/family as they enter permanent supportive housing; and the SERVICES, while always available, will fluctuate based upon the individual's/family's choices/needs. Instead of "exiting" when services diminish or stop, such households would remain enrolled as long as they need a housing subsidy to remain housed. Remaining "enrolled" allows services to be fluid—ramping down or off when services are not needed, and ramping up in cases of crisis or

housing instability. Appendix A describes examples and models of funding linking frequency and intensity with outcomes and is a starting point for the next workgroup.

Once the workgroup has recommended a range of outcome measures to be achieve with participants in supportive housing there could be 5 potential Levels of Service Intensity/Frequency utilized to achieve those outcome measures:

- Intensive—In supportive housing receiving consistent and intensive services
- Moderate—In supportive housing with low to moderate services provided
- Step-Down—services provided to households transitioning out of supportive housing, moderate crisis intervention for households no longer in supportive housing
- Aftercare—occasional services provided to those no longer in supportive housing
- No Services—No longer receiving services for at least 6 months.

Service intensity/frequency could be measured with 6 month/annual reviews

- This is currently the mode of operation within the Developmental Disability field. In this case, a neutral entity is charged with monitoring service intensity and frequency.
- Oversight could possibly be a function of an administrative entity or the Regional Metro Committee. Or maybe providers monitor themselves.

Our workgroup recognized that basing payment standards *strictly* on Intensity and Frequency may have unintended negative consequences:

- Compensating programs that have "high service" requirements/components at a higher rate than harm reduction/low service requirement models. If services are required, frequency of services will likely be much higher than a program where services are not required.
- Inappropriately incentivizing providers to provide higher services to households than they may require.

For this reason, we determined that it would be important to couple Intensity & Frequency with Client Self-Sufficiency Level, AND Project Performance.

More on Project Performance:

- **Lump Sum Model.** Our workgroup considered two main options for compensating programs for providing services:
  - Adjusting funding as service intensity/frequency changes
  - Adjusting numbers served within programs as service intensity/frequency changes

  We determined that adjusting numbers served (based upon changes to intensity/frequency) would prove to be a more Predictable and Reliable method for providers. With the establishment of payment standards and a predictable level of services funding; transitions TO and FROM supportive services would be managed by **Lump Sums** to supportive housing programs based upon numbers served and intensity/frequency. To maintain lump sum compensation, providers will have the incentive to enroll new, higher intensity households as current households stabilize and decrease in services intensity and frequency.

- Mobile teams currently already doing some of this through adjustments to #s served
- Providers would be contracted a standard rate per total ***intensity score***. Example:
  - Supportive Housing Provider contracted to serve total score of 40-50—needs to be a flex amount. Might include:
    - 5 Intensive— 5 x 5 = 25
    - 4 moderate— 4 x 3 = 12
    - 3 aftercare— 3 x 1 = 3
    - Total— 40
- Need to set Floor/Ceiling for numbers served to ensure flexibility to respond if intensity levels increase. Never get enroll than this, never have a roster of less than this. Options to increase #s served based upon % of original capacity (risk piece).

Example: