Opportunities to Expand Permanent Supportive Housing for Virginians with Serious Mental Illness: A Report to the General Assembly

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I. EXECUTIVE SUMMARY

Permanent Supportive Housing (PSH) is an evidence-based practice that meets the housing preferences of many individuals with serious mental illness (SMI) and demonstrates positive outcomes such as reduced hospitalizations and homelessness, increased housing stability, and improved behavioral and physical health. These outcomes avoid costs associated with use of expensive systems such as psychiatric in-patient facilities, emergency departments and corrections facilities and helps the state comply with the Americans with Disabilities Act and *Olmstead*.

Recognizing the benefits of PSH, the General Assembly has requested the Department of Housing and Community Development (DHCD) work with state agencies and other stakeholders to develop and implement strategies to expand PSH for individuals with SMI. In order to fulfill the Assembly's request, DHCD (1) established the Strategy Group, a cross disciplinary group including critical state agencies, stakeholders and other partners, (2) hired subject matter expert technical assistance to assist in developing strategies to expand PSH (Phase I) and an action plan to implement the strategies (Phase II), and (3) conducted Strategy Group meetings, individual agency interviews and collected data to inform decision making.

Based on this data collection and feedback from the Strategy Group, DHCD and its partners Department of Behavioral Health and Developmental Services (DBHDS), Department Medical Assistance Services (DMAS) and Virginia Housing Development Authority (VHDA) identified the following opportunities to expand PSH for individuals with SMI. Appendix C includes a Glossary of Terms.

Opportunities to Expand PSH through DMAS

Existing Medicaid Services

- Review existing Virginia State Plan and Medicaid Home and Community Based Waivers to:
    - Identify what housing transition and tenancy support services, as described per Center for Medicare and Medicaid Services (CMS) guidance, are currently allowable under Virginia Medicaid and identify any gaps or opportunities for Virginia to cover new housing related services under Medicaid.
    - Identify and address operational barriers to existing housing transition and tenancy support services for those individuals with SMI who are eligible for Medicaid (MA).

New Medicaid Services

- If new services are needed to cover the full array of transition and tenancy support services for Medicaid and Governor's Assistance Program (GAP) enrollees with SMI, Virginia would need to obtain authority and funding from the Virginia General Assembly to include transition and tenancy support services as Medicaid-covered services, and:
    - Amend the State Plan to include a full array of transition and tenancy support services for those individuals with SMI who are eligible for Medicaid (MA); and/or

- Amend the Managed Care Waivers with CMS and the Medicaid Managed Care contracts to include the new services; and
- Amend the GAP Program Waiver with CMS to allow individuals who have SMI but don't otherwise qualify for Medicaid to access these services.

Managed Care Organizations (MCOs)

- MCOs can be engaged in risk sharing approaches to support PSH such as:
  - Implement performance/outcomes measures clearly related to housing stability.
  - Add PSH as a performance measure for Medicaid managed care contracts.
  - Develop alternative payment arrangements that support a package of transition/tenancy sustaining services and supports.
- DMAS to add housing status to assessments and require for MCO reporting, to better identify housing instability and evaluate the impact of services.

Opportunities to Expand PSH through DBHDS

DBHDS will seek to:

- Continue to emphasize the role of PSH (housing and community-based supportive services) in the STEP-VA model for strategic transformation of the publicly-funded behavioral health system by:
  - Including PSH in the STEP-VA rollout, including planning, funding, and system alignment activities.
  - Ensuring that PSH implementation adheres to STEP-VA's goals to increase access, strengthen quality, build consistency, and bolster accountability across the Commonwealth.
- Examine current Discharge Assistance Program (DAP) utilization and explore strategies to align this funding with other housing initiatives for individuals with SMI, such as bridge funding to housing.
- Expand current, and explore additional, options to fund housing transition and tenancy support services for uninsured individuals, for example using state general funds and Mental Health Block Grant funds.
- Promote the impact of PSH on reducing criminal justice involvement for individuals with SMI.
- Fund additional DBHDS staffing to conduct evaluation, monitoring, and provide operational support to assure fidelity to PSH.

Opportunities to Expand PSH through Capital and Rental Assistance

Capital

DHCD and their partners recognize the need for capital funds to incentivize the development of PSH for individuals with SMI. Opportunities to expand capital include:

- Increasing funding for State Housing Trust Fund.
- Continuing to serve special populations, including individuals with SMI, within existing DHCD and VHDA housing efforts.

- Providing education and training to strengthen housing developers' ability to successfully apply for funding to develop PSH for individuals with SMI.
- Exploring opportunities to use housing resources to create additional PSH for individuals with SMI.
- Through participation in the Innovation Accelerator Program (IAP), identifying need for new resources to create additional PSH for individuals with SMI, e.g. health care investments.

Rental Assistance

DHCD and their partners recognize the need for operating or rental assistance to make housing affordable to extremely low-income individuals with SMI. Opportunities to accomplish this include:

- Continuing to expand DBHDS PSH Program.
- Exploring project-based PSH including:
    - Opportunities to project-base a limited number of DBHDS PSH vouchers.
    - Opportunities for local Housing Authority Project-Based Vouchers targeted for SMI.

Opportunities to Expand PSH through Systems Supports

State Level Systems

- Expand the existing interagency, collaborative infrastructure to include the Strategy Group to address the housing needs of the SMI population:
    - Through a network mapping process, analyze where there are overlapping efforts working on housing for special needs populations
    - Through state and federal initiatives aligning housing and services for individuals with disabilities, e.g., IAP and continued work with the Strategy Group, assess the capacity of state partners to implement recommended strategies; enhance systems capacity as needed.
    - Through IAP and continued work with the Strategy Group, work to align PSH funding, policies and systems across partner agencies e.g. screening, assessment and referral processes; data matching systems, etc.
    - Through IAP and continued work with the Strategy Group, explore how to "braid funding" to maximize use of state resources.
- Explore incorporation of PSH – SMI needs in planning processes, e.g. Consolidated Planning, Public Housing Authority Plans, and the Olmstead Plan.

Local/Regional Level Systems

- Continue to expand local PSH Program Housing Specialists to ensure all consumers in DBHDS PSH-funded programs have this service.
- Ensure CSBs and providers in all regions of the state have the opportunity to participate in a PSH Learning Collaborative.

Opportunities to Expand PSH through Public/Private Partnerships

- Engage health care systems to improve health by investing in housing:

    - Educate health care systems on benefits of investment in housing.
    - Identify opportunities to provide incentives for health care system investments in housing.
- Engage the philanthropic community.

DHCD plans to continue to work with the Strategy Group to develop and implement an Action Plan based on this Report and these identified opportunities. Working collaboratively at the state and local levels, the Commonwealth was able to decrease overall homelessness by 33 percent from 2010 to 2017, and in 2015, Virginia became the first state to effectively end veterans' homelessness. Similarly, since 2015, the Commonwealth has housed approximately 700 individuals with developmental disabilities through the Housing & Supportive Services Initiative. The Commonwealth will build on these successes to inform the expansion of PSH for individuals with SMI and decrease homelessness and institutionalization for this population.

II. INTRODUCTION

Through budget language, the 2017 General Assembly charged the Department of Housing and Community Development (DHCD) with developing and implementing strategies to increase permanent supportive housing (PSH) for individuals with serious mental illness (SMI). The Assembly indicated that strategies could potentially include Medicaid financing. The Assembly directed DHCD to include other agencies in the development of strategies, naming the Virginia Housing Development Authority (VHDA), Department of Behavioral Health and Developmental Services (DBHDS), Department of Aging and Rehabilitative Services (DARS), Department of Medical Assistance Services (DMAS), and Department of Social Services (DSS). Further, the Assembly required DHCD to include stakeholders whose constituents have an interest in expanding supportive housing for individuals with serious mental illness, naming the National Alliance on Mental Illness of Virginia, the Virginia Housing Alliance and the Virginia Sheriff's Association. Finally, the General Assembly required DHCD to provide an annual report on such strategies and the progress on implementation to the Chairmen of the House Appropriations and Senate Finance Committees. This Report is the first DHCD report to the General Assembly in response to its charge to develop PSH strategies.

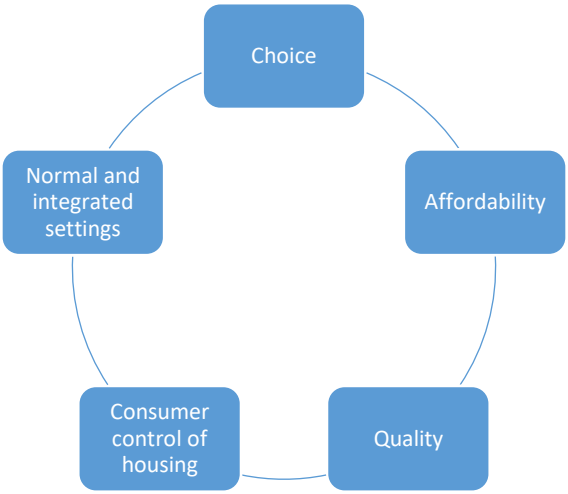
As described in detail in Section IV, DHCD began this important planning process in June 2017. Since June, DHCD has secured the technical assistance of PSH subject matter experts, assembled and held three meetings with the "Strategy Group", comprised of the named state agencies, stakeholders as well as other interested parties. This report codifies the initial planning phase for the expansion of PSH for Virginians with SMI. DHCD will continue to include the Strategy Group as the agency works with partners to implement the activities proposed in this report. DHCD expects to continue to provide implementation reports annually.

III. BACKGROUND

What is Permanent Supportive Housing (PSH)?

The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) describes PSH as "decent, safe, and affordable community-based housing that provides tenants with the rights of tenancy under state and local landlord tenant laws and is linked to voluntary and flexible supports and services designed to meet tenants' needs and preferences."[1] PSH is affordable rental housing that may be scattered site or single site. Support services are available to tenants but not required; PSH is not a treatment setting. Figure 1. illustrates the key characteristics of PSH.

Figure 1



PSH is a cross-systems' approach that requires tactical use of resources. Figure 2 depicts the three critical components necessary for PSH to be successful: housing, support services and systems supports.

[1] SAMHSA (2010). Permanent Supportive Housing Evidence-Based Practices (EBP) Kit. PowerPoint Presentation: http://store.samhsa.gov/product/SMA10-4510.

Figure 2

Housing is essential and needs to be safe, decent and affordable. Housing affordability is a critical issue for states working to comply with ADA requirements because most individuals with significant disabilities rely primarily on federal Supplemental Security Income (SSI) payments that average only 20 percent of median income nationally. Nowhere in the U.S. can a person with a disability on SSI afford housing at the Fair Market Rate[2]. Affordability is created with capital to write down the cost of acquisition, development or rehabilitation of housing and rental or operating assistance to ensure tenants pay only what they can afford for rent. The tenant's limited income also means it is difficult to save for payment of a security deposit, utility hook-ups or furnishings; tenant's need assistance with these one-time costs as well.

Services are essential, to assist individuals with SMI in gaining access to and transitioning to housing, and for successfully sustaining PSH. PSH programs generally provide tenancy supports to help individuals maintain successful tenancies and connect tenants with community-based organizations for health care, mental health, substance abuse and other services. States have options for how to deliver and fund PSH services. It is critical to ensure services are readily available when needed and available for a long as the individual wants and needs them.

System Supports are essential, to serve as the "glue" that makes PSH work. The delivery of housing and services requires the collaboration of systems that use different language, rely on different funding sources and have different measures of accountability. Collaboration and strategic planning at multiple levels including the state, regions, and community-level are critical to the development and management of system supports. Each system's roles and responsibilities need to be clear and accountable at the planning stage to ensure the needed collaboration and communication is functional when programs are ready for implementation.

SAMHSA has identified PSH as an evidence-based practice (EBP) for individuals with SMI. This means that research has demonstrated that PSH has consistently demonstrated its effectiveness

[2] Priced Out 2017, Technical Assistance Collaborative.

in helping individuals with mental illnesses achieve their desired goals. Research has shown the cost-effectiveness of the PSH model, particularly for people with extensive or complex needs such as those with co-occurring conditions, who often experience homelessness and who are frequent users of costly institutional and emergency care.[3] Research has also demonstrated positive impacts of PSH on housing stability, health, and behavioral health.[4] In one review of existing research studies, a consistent finding emerged that the "provision of housing had a strong, positive effect in promoting housing stability and reducing homelessness."[5]

Other federal agencies, including the Department of Housing and Urban Development (HUD), CMS, the Department of Justice (DOJ), and the US Interagency Council on Homelessness (USICH) recognize PSH as a best practice. HUD and CMS for example, have programs or projects in place to promote PSH. HUD has provided funds annually to Continuums of Care serving chronically homeless individuals – the vast majority of whom have SMI - to expand PSH. As costs for institutional settings have grown, and alternative service approaches emerged, CMS recognized and promoted options for states to shift, when appropriate, the care of individuals in nursing facilities and ICF-IDs to more inclusive and less costly community-based alternatives. Initiatives such as Money Follows the Person and the Balancing Incentive Program, as well as home and community-based service waivers became popular tools to assist states in reducing reliance on institutional settings, thereby reducing their contribution (approximately 50 percent) to Medicaid costs. In January 2014, CMS put in place the Home and Community Based Waiver "settings rule", providing strong incentives for state Medicaid agencies and their Mental Health and Intellectual/Developmental Disabilities counterparts to develop and promote integrated community based housing for individuals with disabilities. In June 2015, CMS issued an Informational Bulletin clarifying that while Medicaid cannot pay for "room and board", the program can assist states with coverage of certain housing-related activities and services. The bulletin was intended to assist states in designing Medicaid benefits, and to clarify the circumstances under which Medicaid reimburses for certain housing-related activities, with the goal of promoting community integration for individuals with

[3] Culhane, D. P. et al. (2002). Public service reductions associated with placement of homeless persons with severe mental illness in supportive housing. *Housing Policy Debate*, *13*(1):107–163

Larimer, M. E. (2009). Health care and public service use and costs before and after provision of housing for chronically homeless persons with severe alcohol problems. *The Journal of the American Medical Association 301*(13):1349

Chalmers McLaughlin, T. (2010). Using common themes: Cost-effectiveness of permanent supported housing for people with mental illness. *Research on Social Work Practice*, *21*(4):404–411.

[4] Rog, D. et al. (2014). Permanent supportive housing: Assessing the evidence. *Psychiatric Services 65*(3):287-294

Padgett, et al. (2011). Substance use outcomes among homeless clients with serious mental illness: Comparing Housing First with Treatment First programs. *Community Mental Health Journal 47*(2):227–232.

Wolitski et al. (2009). Randomized trial of the effects of housing assistance on the health and risk behaviors of homeless and unstably housed people living with HIV. *AIDS and Behavior 14*(3):493–503.

[5] Rog, D. et al. (2013). Permanent supportive housing: Assessing the evidence. *Psychiatric Services 65*(3):290.

disabilities, older adults needing long term services and supports (LTSS), and those experiencing chronic homelessness.

Prioritizing the housing needs of individuals with disabilities who are institutionalized or homeless is not only the most cost-effective strategy for states and the federal government, it is also a requirement of the ADA. States are increasingly moving toward expansion of this option within their housing and services continuums because of its alignment with the ADA's integration mandate, as well as with individual housing preference and choice for many individuals with mental illness in particular.[6] This is especially true where lack of availability or lack of access to such options, due in part to reliance on congregate or institutional settings, seriously limits the housing choices of individuals with disabilities.

Estimates of Existing PSH for Virginians with SMI

An accurate, comprehensive count of the number of existing PSH units targeted to individuals with SMI is difficult to make. As described in detail below, DBHDS has the capacity to serve 700 people through its PSH SMI rental assistance program and 60 people through the Auxiliary Grant in Supportive Housing (AGSH) program. In addition, DBHDS estimates that the community services boards (CSBs) have developed about 500 units of PSH, although the state does not have a high level of confidence that this number is complete and accurate. Data only recently released by HUD provides the number of PSH and other housing units available through the 16 Continuums of Care (CoCs) for individuals experiencing homelessness across Virginia as of summer 2017.

[6]Carling, P. (1992). Housing, community support, and homelessness: Emerging policy in mental health systems. *New England Journal of Public Policy 8*: Issue 1, Article 24.

Tanzman, B. (1993). An overview of surveys of mental health consumers' preferences for housing and support services. *Hospital and Community Psychiatry 44*(5):450-455.

Yeich, S. et al. (1994). The case for a 'Supported Housing' approach: A study of consumer housing and support preferences. *Psychosocial Rehabilitation Journal 18*(2):75-86.

Table 1. PSH and Other Housing for Homeless Individuals in Virginia 2017 [7, 8]

Permanent Housing Model	Number units targeted for homeless individuals not with children	Number units targeted for homeless veterans not with children	Number units targeted fort chronically homeless individuals not with children
Permanent Supportive Housing	2,866	1,766	1,682
Rapid Rehousing	730	320	
Other Permanent Housing	574	54	

At any point in time, the vast majority of these resources are occupied.

The DBHDS and CoC data does not include targeted units developed locally by public, nonprofit and private housing developers; there is currently no count of these units.

Estimates of Need for Additional PSH for Individuals with SMI

Estimates of need for additional PSH for individuals with SMI are made using DBHDS and HUD Annual Homeless Assessment Report (AHAR) data. Table 2 provides DBHDS' August 2017 estimates of the need for PSH for individuals with SMI who are residing in inappropriate locations including on the streets, in shelters and in jail.

Table 2. DBHDS Estimates of PSH Need

Subpopulation of People with SMI	Need	Source
People who are homeless	516	The State of Permanent Supportive Housing in Virginia, 2015, Virginia Housing Alliance
Unstably housed CSB Clients who are high utilizers of crisis, hospital, and emergency services	2,684	CSB CCS_3 data submissions DBHDS, 2016
Assisted Living Facilities	829	Auxiliary Grant payments to localities ,Virginia DARS, 2016
Jail	1,056	Mental Illness in Jails Report, Virginia Compensation Board, 2015

While the Commonwealth has had great success in ending and preventing homelessness for all subpopulations, especially veterans, individuals with SMI have not fared as well as some other

[7] HUD AHAR.
[8] Data is not totaled as one unit might fit into several categories.

subpopulations. Point in Time counts from 2011-2017[9] for subpopulations including individuals with substance use disorders, veterans, families and chronically homeless single individuals saw homelessness decrease from 45 to 50 percent while homelessness among individuals with SMI decreased only by 28 percent.

[9] AHAR data provided to TAC by DBHDS

IV. PROCESS FOR ASSESSING VIRGINIA'S CAPACITY TO INCREASE PSH

As described above, DHCD secured the services of a subject matter expert, the Technical Assistance Collaborative (TAC) to employ a multi-pronged approach to gathering the information necessary to thoroughly understand the systems that currently serve and support individuals with SMI in Virginia, as well as to identify opportunities for improvement.

Research and Environmental Scan

TAC conducted an environmental scan and literature review of the current mental health and housing systems in Virginia, comparing this information with current national trends and best practices in PSH. TAC worked with DHCD, VHDA, DBHDS and DMAS to secure relevant reports that were not readily accessible. TAC reviewed published reports such as DBHDS's *Permanent Supportive Housing: Virginia Investment and Estimated State Cost Avoidance,* reports related to Virginia's affordable housing policies, housing development and rental assistance programs, housing gaps analysis, and market conditions; the service delivery system for individuals with SMI and the ability of the system to provide services in PSH; and the funding of services, including the use of Medicaid and other state and local resources.

TAC analyzed Virginia's mental health service delivery system and financing to determine strategies to increase PSH for individuals with SMI who can benefit from the approach. TAC reviewed documents including the Mental Health Block Grant Plan and Report, Medicaid state plan and relevant waivers, other policy and program documents, and recent legislative committee reports to gain an understanding of PSH and other residential programs in Virginia, facility- and community-based services, the array of available services, how services are funded (e.g. state funds, Medicaid), eligibility criteria, and geographic access to services and community supports.

Finally, TAC consultants conducted a review of existing affordable housing resources and programs paid for by federal, state, and other funding mechanisms.

Stakeholder Engagement and Key Informant Interviews

Strategy Group Meetings

TAC facilitated three meetings with stakeholders. The first session was held to gather information about the mental health system; the second, to obtain feedback on observations about housing and services for individuals with SMI in Virginia; and the third session, to review TAC's preliminary recommendations. DHCD made the recommendations available for public comment. TAC also provided a webinar to review the recommendations and respond to questions. The webinar was recorded and made available upon request. The list of Strategy Group members can be found in Appendix A.

Key Informant Interviews

TAC conducted interviews with key stakeholders in order to obtain a broad base of perspectives on housing, services and supports for individuals with SMI in Virginia. VHDA and its partners identified individuals within TAC-identified stakeholder groups to be interviewed.
In addition, TAC conducted individual interviews with state staff members from VHDA, DBHDS, DMAS, DHCD and the Office of the Secretary of Health and Human Resources. All interviews included a structured discussion/interview guide that was shared with VHDA and its partners in advance. Please see Appendix B for a list of key informants interviewed.

Strategy Group Steering Committee

TAC participated in regular meetings of the Strategy Group Steering Committee, consisting of staff from VHDA, DHCD, DBHDS, and DMAS.

TAC also attended meetings of the steering committee to ensure that unique housing and service issues were discussed together and to elicit strategies that could realistically be implemented in Virginia and incorporated into the framework or strategic supportive housing plan. TAC organized information and recommendations gathered in the external stakeholder meetings to inform the Steering Committee's work.

V. SNAPSHOT OF VIRGINIA'S CURRENT SYSTEM

This section summarizes TAC's observations about the housing and services available to individuals with SMI in Virginia based on direct feedback from each agency partner and interviews with stakeholders.

The Cost of Inadequate Housing for Individuals with SMI

There was little disagreement among stakeholders and state agencies that the lack of stable and affordable housing with supportive services for individuals with SMI is costing Virginia in many ways.

Pressure on State Hospitals

According to DBHDS' 2017 data, state hospitals experienced a 224 percent increase in temporary detention order admissions and a 58 percent increase in total admissions over the past three years[10]. As a result, state hospitals were operating at 95 percent occupancy or higher, and direct care staff turnover rates were their highest in 10 years.

There are individuals in state hospitals across the Commonwealth who are clinically ready for discharge but who cannot be safely returned to the community due to the lack of community capacity to support them. The number one need identified for individuals awaiting state hospital discharge is housing.

To address the pressure on state hospitals, DBHDS provided regions one-time bridge funds (see discussion of DAP on pg. 21) to address individual service plans identifying the need for housing and services. Additional DAP funds have been appropriated periodically by the General Assembly to cover these costs ongoing. An additional appropriation for FY 2018 was necessary to release immediate pressure on the state hospital census, but it was viewed as temporary relief until a more permanent solution can be implemented.[11]

DBHDS has begun to examine the impact of its new PSH programs on state hospital utilization. Twenty (20) DBHDS PSH participants have both a history of state hospitalization and at least a year in PSH. Total state hospital bed days for this group decreased form 2,333 in the year before housing to 139 in the year after housing – a 94 percent decrease.

Inappropriate Use of Hospitals and Healthcare

Individuals with SMI have high rates of comorbid medical conditions and substance use disorders. Absent a stable and supportive living environment, they are less likely to follow-through with routine or preventive healthcare, behavioral health treatment or adhere to their treatment regimen, often resulting in over-reliance on high cost, episodic care such as emergency department visits, emergency services and inpatient admissions.

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[10] *Financial Realignment of Virginia's Public Behavioral Health System,* Jack Barber, M.D., Interim Commissioner, Virginia Department of Behavioral Health and Developmental Services, 2017.

[11] Same Day access and System Reform Updates presentation, Jack Barber, M.D., Interim Commissioner, DBHDS, July 2017.

In a report on the impact of stable housing on inpatient utilization among individuals who were previously homeless, client-level data was obtained from three Virginia area hospitals (HCA, Bon Secours and Virginia Commonwealth University Health System) on individuals served in PSH. Clients in the analysis had been housed for at least one year, and hospital data was available for a full year prior to the individuals being housed. PSH provided to the core group of 71 clients who had previously been homeless resulted in:

- 42 percent reduction in inpatient hospitalizations
- 34 percent reduction in overall hospital days
- 52 percent decrease in Emergency Department (ED) visits
- 34 percent decrease in ED costs

In 2017, DBHDS reported that 62 of its PSH participants with previous admission to a local hospital used 66 percent fewer local inpatient hospital bed days in the six months after being housed as compared to the six months before PSH. Moreover, emergency admissions to local hospitals for this group decreased by 80 percent in the same time frame.

Interface with Jails, Law Enforcement and Related Costs

In 2016**,** 59 of 60 local and regional jails in Virginia reported a 5.36 percent increase in the percent of inmates with a mental illness, as well as a 3 percent increase in the percent of inmates with a serious mental illness, since 2012. The total cost of mental health treatment was estimated at approximately $14 million in FY16, with 70.28 percent of these costs funded by the locality and 10.43 percent funded by the state.[12]

DBHDS is engaged in a number of initiatives targeted to better serve individuals with SMI who are justice involved. DBHDS has designated a tool and is developing training for jail officers to perform required SMI screening of inmates upon incarceration. Inmates who screen positive are to have a comprehensive assessment within 72 hours, however, resources have yet to be identified to support jails in meeting this requirement. The State Compensation Board and DBHDS are collaborating on a study to determine the cost and needed resources. DBHDS is also tasked with improving access to housing for inmates to facilitate their successful return to the community. Absent additional resources, the agency is utilizing a portion of its existing PSH funding to house forensic populations.

Finally, individuals with SMI are creating financial pressure for law enforcement. If an inmate in a local jail needs mental health inpatient treatment and is at a local hospital awaiting medical clearance, the jurisdiction must send a sheriff's deputy to stay with the individual at the hospital, impacting both costs and, potentially, public safety.

[12] Compensation Board Mental Illness in Jails Report, Nov. 1, 2016

Homelessness

DBHDS has captured data on 318 individuals the agency is supporting with PSH. Their utilization of other costly systems of care further demonstrates the interaction between housing instability and crisis and institutional care. In the year before PSH, 77 percent (245) of participants had slept on the streets or in a homeless shelter. In fact, before being housed by a DBHDS PSH program, the typical PSH participant spent 63 percent of their nights homeless, and only 14 percent (44) spent even one night stably housed. This group also averaged more than a week incarcerated and two weeks in a treatment setting in the six months before being housed. In spite of long histories of homelessness and institutional care, 93 percent (296) of DBHDS participants remain stably housed, demonstrating the effectiveness of the intervention with a highly vulnerable population.

PSH Services in Virginia

In order for PSH to be effective, individuals with SMI need readily available housing access and transition services as well as community support services. Table 3 provides examples of these services.

Table 3. Services Necessary to Support Individuals with SMI in PSH

Housing Access and Transition Services	Community Support Services
• Locating housing • Housing Application • Meeting Tenant Selection Criteria • Dealing w/ Reasonable Accommodation • Obtain Furnishings/Household Supplies • Move In • Maintenance of Relationship with the Landlord • Assurance that Rent is Paid, and On Time	• Assistance in Accessing Benefits • Referral to Behavioral Health and Social Services • Behavioral Health and Primary Care Treatment • Assertive Community Treatment • Skill Building Instruction in Natural Settings where the Skill will be Used • Peer/Recovery Supports • Employment/Supported Employment

General Observations about Virginia's System

Medicaid and DBHDS provide the bulk of funding for services for individuals with SMI in Virginia.

- The strict eligibility criteria for Virginia Medicaid contributes to a high rate of un-insured adults; 10.7 percent of Virginians under age 65 are without medical insurance.[13] DBHDS serves as the safety net for individuals with SMI who are not eligible for Medicaid or who lack insurance. In addition, DBHDS funds key community support services that DMAS does not cover.

[13] 2017 Profile of Virginia's Uninsured, Virginia Healthcare foundation.

- While the General Assembly approved the demonstration grant to provide GAP coverage for adults with a significant behavioral health condition, GAP coverage provides for limited MH services. GAP is a limited benefit program and does not cover the same services as full Medicaid coverage. While the benefit does provide for care management/care coordination (CM/CC), emergency services, and outpatient treatment, MH community support services are not covered. Substance use disorder (SUD) treatment was only recently added in October 2017.

- There is considerable variation among the 40 CSBs, the agencies with primary responsibility for administering services at the local level. There are some benefits to local onus of control: services can be delivered in response to local priorities and better mirror population demographics. There are also disadvantages with locally driven systems. The availability of local resources is far less in poorer, less populated areas of the state. This puts some CSBs at a huge disadvantage in their ability to meet increasing demands for services, as well as to compete for additional resources when available from DBHDS. Regardless of the availability of resources, philosophical differences also contribute to some CSBs' reluctance to take on responsibility for services and supports unless mandated to do so. Housing is not a mandated service.

Strengths of Virginia's System in Supporting Individuals with SMI in Community-Integrated Settings

Virginia's Medicaid program covers a number of services that are essential for supporting individuals with SMI in community integrated housing.

- Medicaid covers many community support services, including targeted case management, mental health skill building, psychosocial rehabilitation and Certified Peer Specialist Support.
- There are 25 sites providing Program of Assertive Community Treatment (PACT) and five smaller Intensive Community Treatment (ICT) teams across the state which serve 2,100 adults with SMI. Medicaid covers PACT/ICT in Virginia; DBHDS also provides more than $17.3 million. See Table 4 for Outcomes associated with PACT/ICT in Virginia.[14]

Table 4. Community and State Hospital Outcomes for 2,100 PACT/ICT Recipients

Stable Housing = zero to one move, no homelessness, no jail as residence	84%
Lived in Stable Private Households	69%
Only zero to one Hospital Admission	90%
Had no arrests	95%
Had some employment experience	10%

- Addictions Recovery Treatment Services have been added to the Medicaid managed care benefit, which will provide more comprehensive treatment for the individuals who have co-

[14] 2017 DBHDS Data

occurring SMI and substance use disorders. Individuals with mental health disorders are more likely than individuals without mental health disorders to experience an alcohol or substance use disorder. The consequences of undiagnosed, untreated, or undertreated co-occurring disorders can lead to a higher likelihood of experiencing homelessness, incarceration, medical illnesses, suicide, or even early death.[15]

In addition to Medicaid, the community-based MH system also provides services needed for individuals to be successful in PSH. Though not required, some CSBs that are committed to serving individuals in PSH have targeted resources within their existing budgets to fund housing support specialists. Housing Specialists provide access to and stabilization in housing. These CSBs have experienced the benefits of and value PSH and can serve as leaders among their peers.

Challenges for Virginia's System in Supporting Individuals with SMI in Community-Integrated Settings

TAC identified a number of challenges within the community service system that will need to be overcome in order to expand support for individuals with SMI in PSH.

Insufficient Services Capacity/Quality

Virginia's Mental Health system lacks sufficient services and supports to assist individuals in accessing, transitioning to and sustaining supportive housing. There is a strong focus on CC within the Medicaid managed care program, and CC is arguably a benefit of the program. However, CC is more effective if there are services and resources to connect individuals to.

- As a result of legislative efforts and commensurate funding, the Community MH system in Virginia is better able to *respond* to mental health crises and emergencies, but has limited focus on and resources to *prevent* crises and emergencies. In 2016[16], CSBs reported serving 82,967 adults with mental illness; 55,567 or 67 percent had an SMI. Of the almost 83,000 adults served –
    - 62,264 received emergency services
    - 4,677 received rehabilitation services
    - 4,111 received supported residential services
    - 2,023 received PACT or ICT services and
    - 1,644 received Supported Employment Services

  Responding to emergencies with limited capacity to follow-up with ongoing recovery sustaining services and supports may alleviate the immediate crisis situation, but will not promote individuals' ongoing stabilization and progress, thereby preventing further crisis situations.

[15] Retrieved on December 11, 2017, from: https://www.samhsa.gov/disorders/co-occurring

[16] 2017 data has been collected but not yet reported publicly. Initial observations depict a similar pattern of service delivery in 2017.

- In spite of the positive PACT outcomes identified above, PACT capacity in Virginia is limited. See Table 5 for a comparison of PACT Team capacity in Virginia to other states with similar-sized populations. Only three communities have more than one PACT/ICT team; densely populated urban centers are especially likely to need additional capacity for this service. Some staff expressed concerns about the ability to develop and sustain PACT in the more rural areas of the state; however, there are a number of states that have successfully implemented PACT in rural communities including Oklahoma, Indiana, New York and North Carolina.[17]

Table 5. Selected States Development of Programs of Assertive Community Treatment (2015)

State	# of PACT Teams[18]	State Population[19]
Maryland	20	5.8 M
Michigan	90	9.9 M
North Carolina	77	10.1M
Pennsylvania	41	12.8M
Wisconsin	41	5.7M
Virginia (2016)	30	8M

- In 2016, CSBs reported employing 79 FTE Peer Support Specialists (PSS) statewide. Many states rely on peer specialists to help individuals with SMI to transition from state hospitals and jails/prisons to more independent community-based settings, and to maintain ongoing relationships with individuals in these settings in order to prevent isolation that can lead to decompensation. While PSS became a Medicaid covered service effective July 2017, some CSBs have indicated that the Medicaid rate for peer support is insufficient to promote and sustain the service. TAC's research on state Medicaid rates for Certified Peer Support Specialist services found that Virginia's Medicaid rate is lower than Georgia, Kentucky, Maryland, Minnesota and Pennsylvania.[20] While DMAS' rate is lower than other states, Medicaid reimbursement is so new for the service that there is little history to determine if the rate is impeding further development of the service.

- Mental Health Skill Building (MHSB) as described in the VA code is intended to build independent and daily living skills for adults with SMI to live successfully in community-based settings. Evidence of incorrect billing for MHSB prompted DMAS to institute more

[17] Meyer, Piper & Morrissey, Joseph. (2007). A Comparison of Assertive Community Treatment and Intensive Case Management for Patients in Rural Areas. Psychiatric services (Washington, D.C.). 58. 121-7. 10.1176/appi.ps.58.1.121-a.

[18] *PACT Data Source - National Association of State Mental Health Program Directors*

[19] *2010 U S Census Data retrieved at https://www.census.gov/2010census/*

[20] *Data Source - Various state Medicaid Fee Schedules*

stringent service requirements. As DMAS continues to evaluate appropriate use of MHSB, it can advance quality improvement of the service by further evaluating MHSB outcome data.

- There is no requirement for CSBs to provide, or consistent mechanism to fund, housing support specialists (HSS). For example, Norfolk CSB has access to over 200 units of housing for vulnerable populations, but has had to "cobble together resources" for housing stabilization services not covered by Medicaid. CSBs that have been awarded PSH grant funding from DBHDS are permitted to use a limited amount of that funding for HSS. These positions typically provide assistance with PSH operations, through outreach to landlords and presentations to community groups; assistance to consumers in securing and maintaining housing; and providing housing advocacy and supportive services. If DMAS was able to fund housing transition and tenancy support services, most if not all of these activities would be covered by Medicaid. Fewer DBHDS housing dollars would be needed to support HSS and could be used to support actual housing.

- The lack of adequate services is limiting access to affordable housing for adults with SMI in some CSBs, even when the individual has a housing voucher. Landlords that have had a poor experience when they have rented to an individual(s) with SMI in the past, are often reluctant to rent to other individuals with SMI, especially in a highly competitive housing market. Efforts are needed to re-engage landlords and property owners, to build trust that someone will monitor PSH residents and respond if and when needed.

- Finally, there is a lack of sufficient resources to address services, rental assistance and the affordable housing needs of multiple special populations, including individuals with SMI, intellectual/developmental disabilities, and the chronically homeless.

Additional Policies and Practices that Inhibit the Expansion of PSH

In addition to the lack of service capacity, there are policies and practices that inhibit the use of existing resources, impeding the ability to support individuals with SMI in community-integrated settings.

- In spite of data to the contrary, some CSBs and state hospital staff believe that individuals can only be discharged safely to settings that provide on-site staff supervision. This results in individuals being discharged to assisted living facilities (ALFs) where they do not want to live, especially young adults who want more recovery focused opportunities, and individuals staying in state hospital beds that may be more clinically appropriate for others, while they wait for a supervised setting to become available. In both scenarios, the individuals could be discharged to PSH units with wrap-around services and supports.

- In 2016, 1,212 individuals left state hospitals with Discharge Assistance Program (DAP) support. DAP was created by DBHDS to provide a temporary assistance to individuals ready for state hospital discharge in addressing barriers that prevent transition to the community. DAP has proven to be a highly cost-effective strategy to facilitate state hospital discharge:

On average, DAP can support nine individuals in the community at the cost of serving one individual who is discharge ready in a state psychiatric hospital.[21] However, some CSBs report that due to the lack of affordable housing, DAP is used to provide rental assistance for an extended period of time, in order for some individuals to afford community-based housing. DAP was funded at $11.89 million in 2001, and had grown to $29.9 million in 2017.

- Absent a readily accessible alternative, individuals who are clinically ready to leave the state hospital will agree to discharge to a setting that is not of their choice nor reflective of their needs. Young adults with SMI report not wanting to live in an ALF, yet it may be the only option available to them at the time of discharge. Others may opt to return home to live with family or friends, which may or may not be conducive to their recovery. The lack of timely discharges and the re-admissions resulting from discharges to settings that are not optimal for recovery contribute to unnecessary and inappropriate state hospital utilization.

- Virginia residents who reside in assisted living or adult foster care homes can receive direct financial assistance under the Auxiliary Grant (AG) program to help offset the cost of their monthly board and care. Initially designed only for individuals receiving Supplemental Security Income (SSI), in recent years the eligibility criteria have become less restrictive and today individuals with income over $735 per month can receive assistance. In 2016, Virginia approved supportive housing as a new setting for the state's AG program, allowing up to 60 individuals to use their AG to offset the cost of rent in a unit of their choice. DBHDS has estimated that an additional 824 individuals with SMI residing in ALFs who would choose to move to PSH if a unit and alternative use of their AG were available to them. Currently, the Virginia Code limits access to supportive housing to individuals who have already resided in an ALF for one year or more.

Current Affordable Housing Resources Targeted to Individuals with SMI in Virginia

PSH – and affordable housing programs generally – rely on two types of funding to make housing affordable to individuals with SMI. Capital funds are grants, forgivable loans and other sources of funds that increase the equity and decrease the debt in a property. Lower debt can translate into lower rents. For people with extremely low incomes, however, writing down debt is often not sufficient to make housing affordable. Because individuals with significant disabilities including individuals with SMI have extremely low incomes, they generally cannot afford to pay this rent, especially if it is market based. TAC's recently release Priced Out in 2017 found that in Virginia, a person with SMI whose sole source of income is SSI – or $735 per month - would have to pay 132 percent of their income for rent. The second type of funding, rental assistance, pays the difference between what the tenant can afford to pay for rent and utilities (generally 30 percent of their income) and the actual rent for the unit[22]. A PSH project,

[21] Office of the Inspector General Report to Governor McAuliffe and the General Assembly, The Virginia DBHDS DAP Performance Review, February 2014.

[22] This rent level might be a "market rent", i.e. whatever the owner believes the market will bear, or a "cost-based rent" , i.e. the amount needed to cover operating costs (including reserve). When the rent is cost-based, the rental assistance is general called operating assistance.

whether it includes all of the units in a property or only a portion will generally require both capital and rental (or operating assistance) in order to be affordable to a person with SMI.

Rental assistance can be provided in several forms including project-, tenant- and sponsor-based. When the PSH program is tenant-based, the tenant takes the rental assistance or voucher and selects a unit in the community. Tenant-based programs use rental assistance and no capital funds to create affordability, although tenants sometimes select units in properties that were awarded capital funds (and thus lower rents) such as tax credits.

In Virginia, a number of state as well as local agencies administer PSH capital and/or rental assistance programs for individuals with SMI as well as programs funding housing for individuals with disabilities generally and/or individuals who are homeless. While not targeted to individuals with SMI, individuals with SMI can be among the beneficiaries of these latter programs.

PSH Programs Targeted to Individuals with SMI

DBHDS administers two PSH programs specifically targeted to serving individuals with SMI. The DBDHS PSH SMI Program provides funds to local organizations to administer PSH programs for individuals with SMI. Of the funds awarded to an organization about 85 percent is used for tenant-based rental assistance. The remaining 15 percent is used to administer the program including a required Housing Specialist position as well as an array of one-time costs often needed by individuals with SMI who are moving into an apartment from the streets, shelters, institutions, and other facilities. These might include security deposits, utility deposits, application fees, vacancy payments, payments owed to landlords and other one-time costs that can be barriers to move-in for this population.

The program was first funded by the General Assembly in 2015. The program currently has an annual budget of $9.27 million and will serve an estimated 700 households. Table 6 below lists the organizations administering the program by region and number of vouchers. These local agencies are responsible for all aspects of the program, either directly or through subcontracts, including outreach to potential applicants, housing search assistance, on-going tenancy supports (using existing community based services and supports), landlord development and rental assistance payments.

Table 6. DBHDS PSH SMI Program Units by Region

Region CSB	Existing DBHDS PSH Units (FY 16 & 17)	AGSH Units	New PSH Units (FY18)	Total Units	% of Unit Allocation
Region 1	**0**	**0**	**64**	**64**	**8%**
Region Ten	0	0	38	38	5%
Rappahannock - Rapidan	0	0	26	26	3%
Region 2	**98**	**0**	**50**	**148**	**19%**
Arlington	30	0	10	40	5%
Fairfax SUSTAIN	33	0	30	63	8%
Pathway Homes (Alexandria, PWC, FFx)	35	0	10	45	6%
Region 3	**0**	**40**	**101**	**141**	**19%**
Blue Ridge Behavioral Healthcare	0	20	50	70	9%
Danville - Pittsylvania	0	0	30	30	4%
Mt. Rogers	0	20	21	41	5%
Region 4	**52**	**20**	**82**	**154**	**20%**
District 19	0	0	30	30	4%
Henrico	0	0	30	30	4%
Richmond Behavioral Health	52	20	22	94	12%
Region 5	**134**	**0**	**120**	**254**	**33%**
Hampton-Newport News	42	0	50	92	12%
Norfolk	42	0	50	92	12%
Virginia Beach	50	0	20	70	9%
Grand Total	**284**	**60**	**417**	**761**	**100%**

The target populations for the program are adults with SMI, as defined by DBHDS, who are currently:

- Patients in state psychiatric facilities who are interested and eligible for PSH, or
- Residents of supervised residential settings (e.g., ALFs, group homes) who can live more independently, or
- Chronically homeless or literally homeless and at-risk of becoming chronically homeless, or
- Unstably housed and frequent users of hospital or criminal justice system interventions

A review of the program operations manual, training materials and discussions with program administrators suggests the program is operated in fidelity with evidence-based practices. Early data suggests the program outcomes are similar to other successful PSH programs. Of 133 tenants, 93 percent remained stably housed after one year with significant decreases in number of days in state psychiatric beds and local hospital beds. Despite the strong housing market, low vacancy rates and challenging rental histories, DBHDS reports that PSH participants have not had difficulty leasing units.

At the state level, the program is administered by the Homeless Projects Coordinator. A full-time evaluator is also assigned to work with the program. Funding for the evaluator position is currently paid through the state's SAMHSA CABHI grant; this grant will end at the end of December 2018.

Through the AG Program (see above), DBHDS's second PSH program, Virginia provides an income supplement for individuals who receive Supplemental Security Income (SSI) and certain other elders or individuals with disabilities who reside in a licensed assisted living facility. The state FY17 budget provided funds for 60 individuals with disabilities living in ALFs who wanted to move into PSH. The AG program faces administrative barriers including the requirement that participants live in an ALF for at least a year before becoming eligible for the AG in supportive housing. Currently only four individuals are participating. DBHDS expects that 60 individuals with SMI will be enrolled by spring 2018.

Some CSBs also administer supported housing (SH) programs for individuals with SMI funded through mainstream affordable housing funding streams over the last three decades[23]. DBHDS's best estimate is that CSBs or their partner agencies operate about 500 units. Not all CSBs have developed SH or administer SH programs. This is true for a variety of reasons including CSB's lack of expertise or experience, lack of capacity to develop or administer PSH programs, lack of local resources and developing/owning housing is inconsistent with the mission or philosophy of the agency. Some CSBs have developed partnerships with affordable housing organizations and/or created affiliated local nonprofit organizations to develop and manage programs for CSB target populations. There is great disparity in capacity across the state, and as a result, not all CSB clients have access to these critical housing resources.

PSH Programs Targeted to Individuals with Disabilities[24]

State and local agencies have PSH programs that are targeted to serve individuals with disabilities including but not limited to individuals with SMI. DHCD's Affordable and Special Needs Housing (ASNH) program provides capital funds for affordable housing projects including but not limited to PSH. The program issues requests for proposals twice annually. The program combines funds from the HOME Program, National Housing Trust Fund, Virginia Housing Trust Fund and DHCD's Permanent Supportive Housing Program. While some of these

[23] We are using the term supportive housing instead of permanent supportive housing to describe these units as TAC does not have sufficient information to determine whether these programs are operated to PSH fidelity.
[24] The state also administers the HOPWA program that can fund PSH for people living with HIV/AIDS.

programs can be used as rental or operating assistance, the AHSN program makes capital funds available for projects. The most recent funding round included $1.7 million of HOME funds, $2.9 million of National Housing Trust Fund, $500,000 of DHCD's PSH Program and $1.5 million of the Virginia Housing Trust Fund.

The DHCD RFP described Special Needs Projects as "projects that are specifically targeting at least 20 percent of the total units to households with disabilities". In recent rounds, special preference was given to projects that will target units to Department of Justice Settlement (DOJ) population (individuals with intellectual or other developmental disabilities (I/DD)). The RFP noted that "DHCD wishes to promote the development of units targeted to meeting the needs of special needs households by both giving scoring preferences to projects that exceed minimum accessibility requirements and those that target units specifically to special needs household. Although DHCD gives scoring preference for targeted special needs housing, applications identifying mixed or integrated affordable housing projects are encouraged."

The most recent round funded 15 projects. Four of these projects included special needs housing. Two of these include units for DOJ Settlement Agreement population and one includes units for individuals with SMI. DHCD staff indicated the program is very competitive with 27 and 34 proposals submitted in the last two cycles.

While Virginia's Low Income Housing Tax Credit (LIHTC) program – administered by VHDA - does not currently provide a preference specific to the SMI population, the program incentivizes the production of affordable housing for special needs populations. Credits awarded through the Accessible Supportive Housing pool are given a preference if the project includes units for individuals facing homelessness. LIHTC defines Permanent Supportive Housing as housing consisting of units designated for individuals or families that are homeless, at-risk of homelessness or who have multiple barriers to independent living. Specifically, the tax credit manual states that, "Preference will be given to developments providing permanent supportive housing for homeless occupants." VHDA has awarded LIHTC to projects meeting the PSH criteria, and, as described below, it is likely that at least some of the formerly homeless PSH tenants are individuals with SMI. In addition, one CSB has developed housing using LIHTC, and units for individuals with SMI are included in at least one of these properties.

In addition, the 2015 through 2018 QAPs provided preferences for developers who would provide a capped preference for individuals with I/DD who are the target populations for the DOJ Settlement. This preference resulted in a significant number of targeted units for the I/DD population.

PSH Targeted to Homeless Individuals and Families

One of the few federal funding sources that has seen annual increases since FY12 are the federal Homeless Assistance Grants. Available to Continuums of Care through a competitive application, these grants can be used for PSH. HUD has provided incentives through the Notice of Funding Availability (NOFA) process for Continuums of Care (CoCs) to shift funds and focus to PSH including PSH for chronically homeless individuals. New project funds awarded to CoCs

have generally been for Permanent Housing (including PSH and Rapid Rehousing) or Homeless Management Information Systems (HMIS).

In addition to homeless funding provided by the federal government, the state has allocated funds toward ending and preventing homelessness. DHCD's Virginia Homeless Solutions Program (VHSP) allocates nearly $7 million or approximately half of the program funds to Rapid Rehousing programs.

There are 16 CoCs in Virginia. We reviewed PSH funding for the state overall, for the Balance of State CoC administered by DHCD – and five of the CoCs with the largest homeless populations:

- Richmond/Henrico, Chesterfield, Hanover Counties CoC
- Norfolk/Chesapeake/Suffolk/Isle of Wright, Southampton Counties CoC
- Newport News/Hampton/Virginia Peninsula CoC
- Virginia Balance of State (BoS) CoC
- Arlington County CoC
- Fairfax County CoC

In the HUD FY16 competition, the state as a whole was awarded 10 new PSH projects/programs and five new Rapid Rehousing programs. Six of the 10 new PSH and two of the five new RRH programs are in these six CoCs.

The 2017 Housing Inventory Charts for the state indicate that in 2017, the state had identified 4,188 PSH "beds" including 1,682 PSH "beds" for chronically homeless individuals. It is likely that many of the PSH programs for people who are chronically homeless are serving individuals with serious mental illnesses. A person is considered to be experiencing chronic homelessness when he or she has a disability and has been continuously homeless for 1 year or more or has experienced at least four episodes of homelessness in the last 3 years where the combined length of time homeless in those occasions is at least 12 months. SAMHSA reports approximately 30 percent of individuals experiencing chronic homelessness have a serious mental illness, and around two-thirds have a primary substance use disorder or other chronic health condition[25].

Important to note that eligibility for these resources is limited to individuals who are homeless as defined by the HEARTH statute. In accordance with the statute, individuals eligible for PSH targeted for those experiencing chronic homelessness must come directly from streets or shelters. Eligibility for other PSH units do not include individuals coming from psychiatric institutions, jails of assisted living facilities unless the individual resided in in the institution for 90 days or less and resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

[25] https://www.samhsa.gov/homelessness-housing

Efforts across the state to end and prevent homelessness have had a significant impact. From 2010 to 2017, overall homelessness decreased by nearly 38 percent and in 2015, Virginia became the first state to effectively end veteran's homelessness.

Affordable Housing

There are many other deeply subsidized affordable housing opportunities in Virginia including:

- Over 4,500 units in HUD-assisted multifamily rental developments across the state specifically targeted to individuals with disabilities.
- Nearly 18,000 public housing units[26] in public housing authorities across the state.
- Over 50,000 HCVs administered by public housing agencies across the state. These include nearly over 1,600 HCV specifically targeted to non-elders with disabilities.

With supports such as PACT or case management, individuals with SMI could access these affordable units. These are not targeted to individuals with SMI, although these programs can provide preferences for individuals who are homeless, have a disability and/or are coming from institutions. There is no mechanism to determine how many of these resources are currently accessed by individuals with SMI.

Many of these housing programs have lengthy waiting lists; this makes PSH expansion using these resources challenging. Nonetheless, the local agencies that administer these programs as well as the CoCs described above and other mission-driven nonprofit affordable housing developers are a key source of affordable housing resources in the state. The state needs to leverage state-controlled resources such as affordable housing capital dollars and support services to secure access by individuals with SMI to these affordable housing resources. For example, by committing to provide supports for tenants – including some existing tenants whose tenancies might at risk – many other states and localities have been able to secure units with preferences for individuals with SMI and other at-risk populations. Educating property managers and public housing agencies as to the need and gaining their trust will require an investment of time and patience on the part of state partners with their regional and local partners including CSBs and/or local mental health service providers.

Acting as a public housing agency, VHDA administers over 9,600 federal Housing Choice Vouchers. They administer these vouchers through a network of 31 community-based organizations including community action programs, nonprofit service providers and CSBs. To assist the state in meetings its DOJ Settlement Agreement goals, VHDA provided a preference for 127 individuals with I/DD. The 9,600 HCVs include 100 Mainstream Program and 75 Nonelderly Disabled (NED) Program vouchers; these 175 vouchers must be allocated to individuals with disabilities, including upon turnover. Data from 2015 indicates that 26 percent of the HCV participants were headed by a nonelderly person with disabilities, higher than the national average of 20 percent.

[26] Some of these have been or will be converted to the RAD program.

VI. OPPORTUNITIES AND RECOMMENDATIONS TO INCREASE PSH IN VIRGINIA

Based on the information analyzed from various sources and the trends and themes identified, the TAC consultants drew upon their experience working with states across the country, related research and applicable federal statutes and regulations to develop recommended strategies for expanding and financing PSH for individuals with SMI in Virginia. The Strategy Group Steering Committee reached consensus on the following recommendations.

Opportunities to Expand PSH through DMAS

Existing Medicaid Services

As described later in this report, Virginia has been involved in the federally sponsored IAP. The IAP process has afforded DMAS the opportunity to identify what housing transition and tenancy support services, as described per CMS guidance, are currently allowable under Virginia Medicaid and then to identify gaps or opportunities for Virginia to cover new housing related services under Medicaid. DMAS has reported that the agency conducted an extensive review process and has determined, at least preliminarily, that most housing transition and tenancy support services are already covered under Virginia Medicaid. Since the crosswalk was not finalized prior to the submission of the report, TAC was unable to comment on coverage for individuals with SMI. However, if services are already covered, DMAS should work with DBHDS, MCOs, the Strategy Group, and other state/local agencies and stakeholders to identify policy, funding, guidance, and provider engagement strategies to promote the use of these services to ensure housing stability.

DMAS should work with DBHDS to develop educational and training opportunities for CSBs, providers and other stakeholders to promote their understanding of how Medicaid can be used to cover these services.

New Medicaid Services

If DMAS determines that new services are needed to cover the full array of transition and tenancy support services for Medicaid enrollees with SMI or GAP members, Virginia would need to take the following actions:

- Obtain authority and funding from the Virginia General Assembly to include transition and tenancy support services as Medicaid-covered services.
- Amend the Medicaid State Plan to include any missing housing transition and tenancy support services determined to be necessary to support Medicaid eligible individuals with SMI in PSH. Since the Medicaid State Plan is an agreement between a state and the Federal government describing how that state administers its Medicaid program, CMS must approve all State Plan amendments.
- Amend the Managed Care Waivers with CMS, and the Medicaid Managed Care contracts to include the new services.
- Amend the GAP Program Waiver with CMS to allow individuals who have SMI but don't otherwise qualify for Medicaid to access these services through Medicaid.

In addition to ensuring services are Medicaid reimbursable, DMAS will work with the Strategy Group to identify and address potential operational barriers to existing housing transition, tenancy support and community support services for individuals with SMI who are eligible for Medicaid. In addition to housing transition and tenancy supports, community support services such as Peer Support and MHSB will also be critical for individuals with SMI to achieve and maintain successful community tenure. DMAS should work with DBHDS to be sure that identified operational barriers perceived by stakeholders to these key services are addressed. Finally, because GAP is a limited benefit plan, a waiver amendment would be required to provide GAP members access to community support services.

Engage MCOs in Risk Sharing Approaches to Support PSH

For years, Virginia has partnered with managed care organizations (MCOs) for the delivery of Medicaid services to enrollees. Beginning in 2017, MCOs are also responsible for administering Medicaid covered behavioral health services and supports. Including MH services in managed care contracts provides opportunities to engage MCOs in supporting PSH that were not available under the previous fee-for-service or Administrative Services Organization approaches. However, DMAS' contract language must clearly articulate the expectations for PSH support and resultant outcomes for the MCOs.

Managed care contracts are typically risk-bearing, meaning that the plans are paid a set amount for administration of a set of services to enrollees with a range of service needs. CMS regulates the proportion of revenues spent on clinical services and quality improvement, also known as the Medical Loss Ratio (MLR) and requires managed care plans to spend a certain percentage of revenue on medical care. If the plans administer benefits effectively and efficiently, and cover the costs for less than the state reimbursement, the plans are allowed to keep a portion of the reimbursement and make up to a certain amount of profit. States vary in how they calculate this profit and in how much they allow the MCOs to retain. Likewise, some state contracts allow an MCO to provide additional services and benefits to members which may not be calculated in the contract amount. Depending on how widely these benefits are needed and authorized, the plan could incur a loss. MCOs are more likely to invest in services and approaches that:

- Increase the potential for profit
- Diminish their financial risk

In addition to requiring MCOs to meet administrative requirements, states are increasingly moving to performance-based contracting, which ties at least a portion of an MCO's payment to service delivery, quality and/or outcomes based on the achievement of specific measurable performance standards and requirements.

Historically, these measures have not included housing stability or lack thereof. However, given the emerging research on the impact of "social determinants of health which includes housing," TAC recommends that DMAS include performance measures related to housing stability or the

lack thereof in its managed care performance evaluation. This should specifically reference PSH for individuals with SMI. The following actions will support continued PSH expansion:

- Consider risk sharing/gain sharing with MCOs, tied to housing-related performance measures and/or outcomes.
- Add the number of members supported in PSH as a performance measure for Medicaid managed care contracts.
- Include the development of alternative payment arrangements that support a package of transition/tenancy sustaining services and supports as a performance measure.
- Implement outcomes measures clearly related to housing stability, such as retention in PSH for twelve consecutive months.
- Include Members' satisfaction with their housing as an outcome measure.

In order to determine the impact of PSH on Medicaid enrollees, plans must better identify their members who want and/or could benefit from the approach. DMAS should require MCOs to add Housing status to their member assessments, and require MCOs to regularly report on their members' housing status in order to better identify housing instability and evaluate the impact of services on housing acquisition and retention.

Opportunities to Expand PSH through DBHDS

Using Medicaid funds to appropriately support PSH is a good financial strategy for Virginia – the federal government contributes toward about half of the cost for eligible services for eligible members. DBHDS support is typically 100 percent state funded. While there are opportunities for DMAS to increase support for PSH, the need for DBHDS support will continue - both to fund housing transition, tenancy and community support services for individuals with SMI who do not qualify for Medicaid, and to fund services that may not be or may not become Medicaid reimbursable. The following actions will help to continue PSH expansion:

- Continue to emphasize the role of PSH in the System Transformation, Excellence and Performance in Virginia (STEP-VA) model for strategic transformation of the publicly-funded behavioral health system. STEP-VA has been initiated by DBHDS with the goals to increase access to services, to strengthen the quality of services, to build consistency in service availability and delivery, and to bolster accountability for service delivery across the Commonwealth. Including PSH in STEP-VA will help to address the variation in availability reported by most stakeholders.
    - Virginia should clearly recognize PSH in the STEP-VA rollout, including planning, funding, and system alignment activities.
    - Ensure that PSH implementation adheres to STEP-VA's goals as identified above.

- Examine current DAP utilization to be sure that the resources are utilized as a temporary form of assistance to address barriers to discharge. If used for longer term assistance, either fewer individuals will have access to the assistance, or DBHDS will need to continue requesting an increase in funding from the GA. DBHDS should explore strategies to align

DAP funding with other housing initiatives for individuals with SMI, such as serving as a bridge to long- term, federally funded rental assistance.

- Expand current, and explore additional, options to fund housing transition and tenancy support services for uninsured individuals, for example using state general funds and MH Block Grant funds. Admittedly, these funding sources are limited and likely already unable to keep pace with service demand. However, like DMAS, DBHDS should include PSH related performance and outcome measures, and tie funding to those measures, in future allocations/grants.

- Promote the impact of PSH on reducing criminal justice involvement for individuals with SMI. As explained earlier in this report, individuals with SMI who are unstably housed are more likely to interact with law enforcement, and for the most part, as a result of their illness. These interactions can lead to subsequent arrests and incarceration, taxing both law enforcement and jails and prisons. While there will always be a need for law enforcement and jails, these resources should be used as they are intended, to promote and provide safety, rather than to provide detention and "housing" for individuals with SMI.

- The Systems Support section later in this report identifies why state agency leadership and points of accountability are critical to the success of PSH. This support is critical not only across agencies, but within agencies as well. PSH is an evidence-based practice, but only when delivered according to the articulated criteria for the approach to be successful. TAC recommends that DBHDS request funding for additional, permanent staffing upon exhausting the current federally funded grant position, to conduct evaluation, monitoring and provider operation support to assure ongoing fidelity to PSH.

Opportunities to Expand PSH through Capital and Rental Assistance

As described above, capital as well as rental (or operating) assistance is necessary to create PSH developments or programs affordable to individuals with SMI.

Capital Opportunities

DHCD and VHDA have committed to continuing to service special populations including SMI within their existing housing efforts. As described above, while Virginia's LIHTC program – administered by VHDA - does not currently provide a preference specific to the SMI population, the program incentivizes the production of affordable housing for special needs populations. The Accessible Supportive Housing credits give a preference if the project includes units for individuals facing homelessness. VHDA's LIHTC program defines Permanent Supportive Housing as housing consisting of units designated for individuals or families that are homeless, at-risk of homelessness or who have multiple barriers to independent living. Specifically, the tax credit manual states that, "Preference will be given to developments providing permanent supportive housing for homeless occupants."

As described above, the VA Housing Trust Fund is being used to create affordable and special needs housing. There is competition for this resource to meet a broad range of critical affordable housing needs including preservation of expiring use properties, Rental Assistance Demonstration properties, the DOJ Settlement and homelessness. Expansion of this resource to meet all of these needs is more likely to result in new PSH units for this target population. DHCD and VHDA will explore opportunities to use other housing resources to create additional PSH for individuals with SMI. The agencies will identify different types of resources such as health care and philanthropic investments to create additional PSH for individuals with SMI.

Increased resources alone may not be sufficient, however. DHCD staff indicated that competition for affordable housing resources is fierce and that some of the mission-driven developers who might consider PSH development do not have the capacity to produce projects that are always competitive. Education and training can strengthen housing developers' ability to successfully apply for funding to develop PSH for individuals with SMI.

Rental Assistance

Rental assistance is absolutely critical to making PSH and other housing opportunities financially accessible to the majority of individuals with SMI. The DBHDS PSH program has demonstrated success helping individuals with SMI move into and live successfully in the community. The program is cost effective, relying on existing community-based services and limited administrative funds for implementation. Expansion of this effective program will ensure PSH is available in all areas of the state where there is need and where individuals with SMI prefer to live.

DBHDS's PSH SMI program is currently administered only as a tenant-based program. While tenant-based programs offer individuals with SMI choice in selecting where they live, tenant-based programs are also significantly impacted by volatile housing markets. For example, in Northern Virginia, market rate properties regularly increase rents to take advantage of increased housing demand. Rental assistance programs are often not able to pay these increasing rents, and over time, tenants using these vouchers get pushed to the outskirts or completely out of the market. In order to assist consumers to stay in these markets, DBHDS may have to pay increasing amounts of rent each year.

Project-basing vouchers can help low-income people stay in markets with changing rents – markets where there might be especially good access to public transportation, services and employment opportunities. Furthermore, with increasing land costs, affordable housing development in these strong markets can be expensive; affordable housing developers needing increasing amounts of capital and rental assistance to make deals viable, may be interested in project-based vouchers. In addition, the QAP has often included preference points for projects that include project-based vouchers, making these vouchers very attractive to developers competing for LIHTC.

DBHDS will explore project-basing a portion of the PSH SMI program. Project-based vouchers can provide DBHDS leverage to gain preferences for individuals with SMI in properties requesting the project-based vouchers. In addition, as project-basing units generally involves a time commitment, DBHDS can lock rents into a budget with reasonable, predictable annual increases.

DBHDS will also explore opportunities to encourage local housing agencies to project-base vouchers for PSH. While the HCV program cannot target tenant-based vouchers to a specific disability group (outside of an action such as a settlement agreement), a new statute allows housing agencies to project-base units for individuals with specific disabilities such as SMI. It is important to note, that collaboration with developers and public housing agencies, however, is time-consuming and does require the dedicated staff resources discussed in the next section.

Opportunities to Expand PSH through Systems Supports

While affordable housing, tenancy supports and community-based services are critical to expanding PSH for individuals with SMI, even these resources are not sufficient to ensure an expanded PSH system will be successful. State and local/regional structural systems supports are key to ensuring an effective PSH system, one that provides a fidelity-based service, targets the state's priority populations, fills units in a timely manner and maintains owner confidence by addressing tenant issues that arise.

DBHDS's PSH program has demonstrated the importance of local/regional housing specialists in developing and maintaining landlord relationships and ensuring their region has as an effective system in place to identify interested, eligible applicants and assist these individuals to locate and apply for housing including making requests as needed for reasonable accommodations. With the expansion of the PSH program from FY15 through FY17, all regions have some housing specialist capacity – however limited. Continuing to expand this capacity at the local level will better ensure all individuals with SMI have an opportunity to choose to live in the community regardless of where in the state they are situated.

Over the last year, the Virginia Housing Alliance has been facilitating two regional Learning Collaboratives aimed at decreasing chronic homelessness in certain regions. The Collaboratives combine on-site and remote technical assistance by subject matter experts with peer-to-peer learning opportunities. The state hopes to provide all CSBs and providers with the opportunity to participate in a Learning Collaborative in order to expand capacity and expertise across the system.

Enhancing systems supports at the state level is also critical and requires collaboration and strategic planning at multiple levels. Typically, a clearly identified partnership is demonstrated through a formal agreement ensuring all the key players and stakeholders collaborate to set goals, identify gaps, develop strategies to address any gaps as well as meet goals, and assess progress. The partnership would enhance communication among and between state agencies in order to align policies and program implementation and to better ensure collaboration rather than duplication of efforts. One of the ways to achieve this is to expand the existing

interagency, collaborative infrastructure to include the Strategy Group. This will help to ensure all agencies understand and work to address the housing needs of the SMI population. A network mapping process held in November 2017 also helped to identify overlap in the work to house special needs populations.

It is also vital to assess the capacity of state partners to implement recommended strategies, and to enhance systems capacity as needed. For example, DBHDS staff implementing the PSH SMI program is paid through a federal grant that will end at the end of 2018; it is critical that the state identify other sources of funds to ensure effective program implementation continues. In addition, as described above, even when housing and services resources are available, implementing PSH is challenging. A commitment to expand PSH for individuals with SMI will be more successful if accompanied by DBHDS staffing that is responsible for activities that will expand PSH beyond the PSH SMI program. Examples of important activities include developing relationships with local government officials in order to identify ways to leverage local resources for PSH, participating in interagency committees to ensure the needs of individuals with SMI are not overlooked and other activities to ensure no opportunity to identify resources is missed. For example, allocation of certain federal funds including HOME, CDBG and ESG funds is impacted by state and local Consolidated Plans. If the PSH needs of individuals with SMI are not included in the Consolidated Plan, it is harder to secure these resources to meet that need. The opposite is true as well; if the needs are addressed in the Plan, there is justification for a request for funding. The same is true of other planning processes including the state's Olmstead Plan and state and local Public Housing Agency plans. Ensuring the PSH needs of individuals with SMI are addressed in each of these planning processes is very time consuming and needs to be facilitated by dedicated DBHDS staff. Continuing to collect data and manage data sharing in order to evaluate the program and make midcourse adjustments are also important activities of state PSH staff.

It is also important to align housing and services across agencies to decrease competition for resources and share systems as appropriate. The state is currently participating in the CMS Innovation Accelerator Program (IAP), receiving technical assistance to achieve community integration through long-term services and supports. Through the IAP and Phase II of this work with the Strategy Group, the state is working to align PSH funding, policies and systems across partner agencies including for example, screening, assessment and referral processes, data matching and other systems. Through the IAP, the state hopes to explore how to "braid funding" to maximize use of state resources.

IAP goals include:

- Increasing state adoption of individual tenancy sustaining services to assist Medicaid beneficiaries,
- Expanding housing development opportunities for Medicaid community-based LTSS beneficiaries through facilitation of partnerships with housing agencies, and
- Increasing state adoption of strategies that tie together quality, cost, and outcomes in support of community-based services LTSS programs.

Several states involved with the IAP have identified the need for cross-systems data-matching and sharing in order to accurately identify the need for, and impact of, stable housing. Virginia has been identified as a front-runner in data matching as a result of participation in a HUD funded multi-state study. While the initiative afforded Virginia the opportunity to begin the data matching process, the information gathered was viewed as "the tip of the iceberg." Data on individuals with SMI who are homeless is likely captured in HMIS, MMIS, the DBHDS data system, the DARS data system, potentially Department of Corrections' data system, and others. Matching data across these systems is essential to determine the true cost of homelessness for individuals with SMI, and to reflect the subsequent impact of PSH across these systems. DMAS and DBHDS are entering into a data sharing agreement that will help to move this work forward, but using existing staff and resources. Additional support would help to expedite the process and the availability of comprehensive data for benchmarking and analyzing outcomes.

Opportunities to Expand PSH through Public/Private Partnerships

The Affordable Care Act added Section 501(r) to the Internal Revenue Code, which contains four new requirements related to community benefits that nonprofit hospitals must meet to qualify for 501(c)(3) tax-exempt status. One of the requirements is to…"Conduct a community health needs assessment (CHNA) with an accompanying implementation strategy." Tax-exempt status is worth a lot to nonprofit hospitals. In 2011, the value of federal, state, and local tax exemptions, tax-deductibility of charitable contributions, and tax-exempt bond financing, was valued at $24.6 billion.[27]

Compliance with requirements of the community-benefits provisions was assigned to the IRS; Final IRS regulations were issued December 31, 2014. The regulations require that the community health needs assessment address social, behavioral, and environmental factors that influence the community's health, and that hospitals also must develop implementation strategies to meet the community health needs documented through the assessment. Hospitals that fail to comply are subject to a $50,000 excise tax penalty.[28] It is also possible that under certain circumstances, noncompliance could result in a revocation of tax-exempt status for the institution. Since CHNAs must involve broad-based community input and be provided for public comment, it is not surprising that many assessments identify housing as a community need.

Engaging Healthcare Systems in Housing

Given the healthcare (including behavioral health) costs related to housing instability associated with individuals with SMI, and the IRS' enforcement of community-benefits provisions, there are ample opportunities to engage healthcare systems in investing in housing, such as:

- Educating stakeholders about CHNAs and the value of their input and feedback on identifying housing as a key factor impacting health in their communities.
- Educating health care systems on the benefits of investment in housing. Examples of healthcare systems' investments in housing for individuals with disabilities include:

[27] "Health Policy Brief: Nonprofit Hospitals' Community Benefit Requirements," *Health Affairs*, February 25, 2016.
[28] "Health Policy Brief: Nonprofit Hospitals' Community Benefit Requirements," *Health Affairs*, February 25, 2016.

- Dignity Health System in Sacramento, California invested resources in housing to qualify for tax breaks. "Housing with Dignity" was created to help insure that individuals admitted to Dignity Health who are homeless receive a place to live and follow-up care after discharge.
- In Portland, Oregon, five major hospitals are donating $21.5million towards construction of nearly 400 housing units for the homeless, many who have behavioral health conditions. The City Housing Bureau is also donating $9 million, and Central City Concern (a 501(c)(3)) nonprofit agency serving single adults and families in the Portland metro area who are impacted by homelessness, poverty and addictions) is contributing $29.5 million in tax credits, loans and fund-raising to help support the project. Construction was to begin in 2017 and be completed in 2018.
- Sutter Health in Northern California helped to launch "Getting to Zero," a $30 million public private partnership aimed at eliminating homelessness in Sacramento, Placer and Yolo Counties. Sutter Health contributed $10 million of its own resources to satisfy its community-benefit requirement as a non-profit healthcare system.
- Florida Hospital is donating up to $6million, with additional contributions from the city of Orlando and Orange County, to reduce homelessness by developing PSH. The investment was a result of an independent Consultant's report that individuals who are homeless were costing the community $31,000 per person, while PSH would cost one-third of that amount.

Identify opportunities to align incentives with healthcare system investments in housing

While healthcare systems are investing their resources in creating and supporting housing, their dollars will have a greater impact on individuals with SMI if aligned with other housing resources and services targeted to the population. This is an emerging area of interest among states wanting to explore how healthcare system resources can be leveraged to expand PSH. Virginia will want to stay informed on national opportunities, as well as explore opportunities using state and local resources.

Engaging the Philanthropic Community

In 2015, giving in the U.S. was estimated at $373 billion.[29] Philanthropic entities play a critical role in addressing highly visible social needs in an environment of continued economic uncertainty, government budget reductions and an increase in the demand for services and supports including affordable housing. Members of the philanthropic community are recognizing that:

- There is a healthy balance between providing risk capital for new approaches and investing capital in approaches proven to work; and
- In today's complex environment, it's the ability to collaborate—not just with other foundations but also with government, industry, and nonprofits—that will lead to greater effectiveness in philanthropy.[30]

[29] Giving USA Foundation™ | Giving USA 2016. The Annual Report on Philanthropy for the Year 2015.
[30] Chronicles of Philanthropy, James E. Canales, President, Barr Foundation, Boston, MA.

Virginia should continue its efforts to engage the philanthropic community including healthcare foundations that are helping to combat homelessness and to get more residents out of the emergency room and into stable housing. For example, United Health Foundation (UHF) is teaming up with the Massachusetts Housing & Shelter Alliance (MHSA) in support of their *Hospital to Housing Initiative*, a $1.7 million Foundation grant that will help MHSA provide permanent housing for local homeless individuals through expanded permanent supportive-housing providers.

VII. APPENDIX A: STRATEGY GROUP MEMBERSHIP

Name	Organization	Email
Bill Shelton	Virginia Department of Housing and Community Development (DHCD)	Bill.Shelton@dhcd.virginia.gov
Pam Kestner	DHCD	Pamela.Kestner@dhcd.virginia.gov
Kathy Robertson	DHCD	Kathy.Robertson@dhcd.virginia.gov
Erik Johnston	DHCD	erik.johnston@dhcd.virginia.gov
Daniel Herr	Virginia Department of Behavioral Health and Disability Services (DBHDS)	Daniel.Herr@dbhds.virginia.gov
Kristin Yavorsky	DBHDS	Kristin.Yavorsky@dbhds.virginia.gov
Eric Leabough	DBHDS	Eric.Leabough@dbhds.virginia.gov
Jana Braswell	DBHDS: Center for Behavioral Health & Justice	Jana.Braswell@dbhds.virginia.gov
Seon Rockwell	Virginia Department of Medical Assistance Services and Medicaid for Virginia (DMAS)	Seon.Rockwell@dmas.virginia.gov
Ann Bevan	DMAS	Ann.Bevan@dmas.virginia.gov
Sarah Broughton	DMAS	Sarah.broughton@dmas.virginia.gov
Beth Seward	Virginia Housing Development Authority (VHDA)	elizabeth.seward@vhda.com
Suzanne Armstrong	VHDA	Suzanne.Armstrong@VHDA.com
Tara Ragland	Virginia Department of Social Services (DSS)	Tara.Ragland@dss.virginia.gov
Annette Kelley	DSS	Annette.kelley@dss.virginia.gov
Missy Currier	DSS	Missy.currier@dss.virginia.gov
Kendra Coleman	Virginia Department of Corrections (DOC)	Kendra.Coleman@vadoc.virginia.gov
Stephanie Beardslee	DOC	Stephanie.Beardslee@vadoc.virginia.gov
Rhonda Thissen	NAMI- Virginia	rthissen@namivirginia.org

Stephany Melton	NAMI- Virginia	smelton@namivirginia.org
Sim Wimbush	Virginia Housing Alliance (VHA)	swimbush@vahousingalliance.org
Sheriff Steve Draper	Virginia Sherriff's Association (VSA)	smdraper@ci.martinsville.va.us
Major Laura Hopkins	VSA	LHOPKINS@ci.martinsville.va.us
Mike Edwards	Virginia Association of Regional Jails (VARJ)	medwards@kemperconsult.com
William "Chris" Smith	VARJ	smithw@wtrj.org
Superintendent Tim Doss	VARJ	tdoss@mprsc.org
Sarah Paige Fuller	Virginia Association of Community Service Boards (VACSB)	sarah.fuller@norfolk.gov
Joy Cipriano	VACSB	JoyC@hnncsb.org
Jim Tobin	VACSB	jtobin@piedmontcsb.org
Jennifer Kelly	Virginia Hospital and Healthcare Association (VHHA)	Jennifer.kelly@uhsinc.com
Amy Clarke	VHHA	Amy.Clarke@HCAHealthcare.com
Allison Bogdanovic	Virginia Supportive Housing (VSH)	ABogdanovic@virginiasupportivehousing.org
Deidre Johnson	VOCAL – Virginia	deidre@vocalvirginia.org
Malaina Poore	VOCAL – Virginia	malaina@vocalvirginia.org
Mira Signer	Magellan	msigner@magellanhealth.com
Cornel Hubbard	Magellan	cphubbard@magellanhealth.com
Joe Flores	Office of the Secretary of Health and Human Resources (HHR)	joe.flores@governor.virginia.gov
Lauren Schmitt	Commonwealth Strategy Group	Lauren@commonwealthstrategy.net

VIII. APPENDIX B: KEY INFORMANT INTERVIEWS

KEY INFORMANT INTERVIEWS	
The Hampton/Newport News	Joy Cipriano, Norfolk Sara Page-Fuller, Piedmont Jim Tobin and Richmond John Lindstrom Community Service Boards
Pathway Homes	Sylisa Lambert-Woodard
NAMI of Virginia	Stephany Melton Mira Singer
VOCAL	Diedra Johnson Malania Poore
Mental Health America of Virginia	Bruce Cruser
Center for Behavioral Health and Justice	Jana Braswell
Virginia Hospital and Healthcare Association	Jennifer Wicker
Virginia Sherriff's Association	Sheriff Steve Draper Major Laura Hopkins
Virginia Housing Alliance	Sim Wimbush
State Agencies Interviewed	
DBHDS	Kristin Yavorsky Daniel Herr Mindy Conley Connie Cochran Eric Leabough
DMAS	Seon Rockwell Ann Bevan Sarah Broughton
VHDA	Elizabeth Seward JD Bondurant Neal Rogers Suzanne Armstrong
DHCD	Pam Kestner Kathy Robertson Willie Hobbs

IX. APPENDIX C. GLOSSARY OF TERMS

Alternative Payment Arrangement: Reimbursement for a service(s) that is not based on payment for delivery of a unit of service. Examples of alternative payment arrangements include a daily or monthly payment rate, or a bundled payment for an identified package of services.

Community Development Block Grant (CDBG): Created under the Housing and Community Development Act of 1974, this program provides grant funds to local and state governments to develop viable urban communities by providing decent housing with a suitable living environment and expanding economic opportunities to assist low- and moderate-income

Community Mental Health Services Block Grant: Federal funding allocated to states to support comprehensive community mental health services targeted to adults with serious mental illness and children with serious emotional disturbance. States have flexibility in the use of funds for both new and unique programs or to supplement their current activities.

Consolidated Plan (ConPlan): A document written by a state or local government describing the housing needs of the low- and moderate-income residents, outlining strategies to meet these needs, and listing all resources available to implement the strategies. This document is required in order to receive some formula funded HUD Community Planning and Development funds.

Continuum of Care (CoC): A collaborative funding and planning approach that helps communities plan for and provide, as necessary, a full range of emergency, rapid rehousing and permanent supportive housing and other service resources to address the various needs of people experiencing homelessness. HUD also refers to the group of agencies involved in the decision-making processes as the "Continuum of Care."

Discharge Assistance Program: Provides supplemental funding for services and supports outside the basic array of community-based services, to assist individuals who have been discharged from state behavioral health facilities with reintegrating into their communities.

HOME: The HOME Investment Partnerships Program (HOME) provides formula grants to states and localities that communities use—often in partnership with local nonprofit groups—to fund a wide range of affordable housing activities including building, buying, and/or rehabilitating affordable housing for rent or homeownership or providing direct rental assistance to low-income people.

Homeless Management Information System (HMIS): An HMIS is a computerized data collection application designed to capture client-level information over time on the characteristics and service needs of men, women, and children experiencing homelessness, while also protecting client confidentiality. It is designed to aggregate client-level data to generate an unduplicated count of clients served within a community's system of homeless services. An HMIS may also cover a statewide or regional area and include several Continuums of Care. The HMIS can provide data on client characteristics and service utilization.

Housing Choice Voucher Program: This program provides rental assistance to assist very low-income families, the elderly, and people with disabilities to afford decent, safe, and quality housing in the private market. It was previously known as "Section 8."

Housing First: An approach to ending homelessness that centers on providing homeless people with housing quickly and then providing services as needed. What differentiates a Housing First approach from other strategies is that there is an immediate and primary focus on helping individuals and families quickly access and sustain permanent housing.

HUD: The U.S. Department of Housing and Urban Development (HUD) was established in 1965. HUD's mission is to increase homeownership, support community development, and increase access to affordable housing free from discrimination.

Individual Housing Transition Services: Services that support an individual's ability to prepare for and transition to housing. Transition costs may include security deposits for an apartment or utilities, first month's rent and utilities, basic kitchen supplies, and other necessities required for transition from an institution.

Individual Housing & Tenancy Sustaining Services: Services that support the individual in being a successful tenant in his/her housing arrangement and thus able to sustain tenancy. Examples may include services, such as, education/training on the role, rights, and responsibilities of the tenant and landlord, coaching on developing/maintaining relationships with landlords/property managers or, continuing training on being a good tenant and lease compliance.

Low-Income Tax Credit (LIHTC): A tax incentive intended to increase the availability of affordable housing. Through state allocating agencies, (often the state's Housing Finance Agency), the program provides an income tax credit to developers for new construction or rehabilitation of low-income rental housing projects.

Managed Care Organization: A health plan with a group of doctors and other providers working together to give health services to its members. MCOs cover all state approved Medicaid services, including medical services, behavioral health services, nursing facility services and "waiver" services for community-based long term care.

Medicaid State Plan: The agreement between Virginia and the Federal government describing the policies and procedures that the state will follow in administering the Medicaid program, including those related to the methods of program administration, eligibility criteria, covered services, and reimbursement methodologies.

Medicaid Waiver: An agreement between a state and the Federal government which outlines how Medicaid services and/or payment will be delivered apart from the approved Medicaid State Plan. A waiver may establish an alternative setting for services (such as in the community versus an institution), limit eligible providers, limit implementation to a part or parts of a state target a population(s) to be served and/or identify alternative payment approaches to fee-for-service reimbursement such as managed care.

Olmstead Plan: In 1999, the Supreme Court ruled that the Americans with Disabilities Act (ADA) required states to provide services in the most integrated settings appropriate to the needs of individuals with disabilities. An Olmstead Plan is a State's document describing what strategies that state will employ within targeted timeframes to achieve this goal.

Outcome Measure: Assesses the *impact* or *result* of a service or intervention on an individual, group or population.

Performance Measure: Assesses the *delivery of* a service or intervention intended to impact an individual, group or population.

Project-Based Rental Assistance: This term refers to a series of HUD programs that provide loans, grants, and/or renal assistance to private developers for the development and management of subsidized housing. In these programs, tenants pay 30% of their income for rent and utilities. The term is also used to differentiate between any type of rental assistance that is tied to a specific property, versus tenant-based rental assistance (see below).

Public Housing Agency (PHA): Any state, county, municipality, or other governmental entity or public body, or agency or instrumentality of these entities that is authorized to engage or assist in the development or operation of low-income housing under the U.S. Housing Act of 1937.

Qualified Allocation Plan (QAP): A Qualified Allocation Plan is the mechanism by which a state housing finance agency promulgates the criteria by which it will select to whom it will award tax credits. Each state must develop a QAP. The QAP also lists all deadlines, application fees, restrictions, standards and requirements.

Risk-sharing/Gain-sharing Arrangement: Identifies the amount of financial loss that a payer and provider may each incur as a result of poor performance or increased costs, or the amount of financial reward that a payer and provider may each retain as a result of high performance or cost-savings.

Supportive Housing: Supportive housing is decent, safe, affordable, community-based housing that provides tenants with the rights of tenancy and links to voluntary and flexible supports and services. There are three main types of supportive housing models:

- Single-site: Apartment buildings exclusively or primarily housing individuals and/or families who need supportive housing.
- Scattered-site: Rent subsidized apartments leased in the open market.
- Integrated/clustered: Apartment buildings with units set aside for people who need supportive housing.

System Transformation, Excellence and Performance in Virginia (Step-VA): The framework established by DBHDS to transform the Commonwealth's behavioral health system through implementation of

incremental strategies intended to increase access, strengthen quality, build consistency, and bolster accountability across the Commonwealth.

Tenant-Based Rental Assistance: Housing assistance that pays to the property owner the difference between 30% of the tenant household's income and what the owner charges for rent. The Housing Choice Voucher Program (see above) is one example of a tenant-based program. In contrast to project-based rental assistance, which is tied to a specific property, a program participant can move their tenant-based rental assistance to a different property.