



COMMONWEALTH of VIRGINIA

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COMMISSIONER

DEPARTMENT OF
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February 17, 2020

The Honorable Janet D. Howell, Chair
Senate Finance Committee
The Honorable Luke Torian, Chair
House Appropriations Committee
900 East Main Street
Richmond, VA 23219

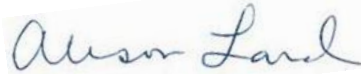
Dear Senator Howell and Delegate Torian:

Item 312.Z. of the 2019 Appropriation Act appropriated funds requires the Department of Behavioral Health and Developmental Services to report on Permanent Supportive Housing. Specifically, the language states:

The Department of Behavioral Health and Developmental Services shall report on the number of individuals who are discharged from state behavioral health hospitals who receive supportive housing services, the number of individuals who are on the hospitals' extraordinary barrier list who could receive supportive housing services, and the number of individuals in the community who receive supportive housing services and whether they are at risk of institutionalization. In addition, the department shall report on the average length of stay in permanent supportive housing for individuals receiving such services and report how the funding is reinvested when individuals discontinue receiving such services. The report shall be provided to the Chairmen of the House Appropriations and Senate Finance Committee by November 30, 2019.

In accordance with these items, please find enclosed the report pursuant to Item 312 Z. Staff at the department are available should you wish to discuss this report.

Sincerely,

A handwritten signature in cursive script that reads "Alison Land". The signature is written in dark ink on a light-colored background.

Alison Land, FACHE
Commissioner

Cc:

The Honorable Daniel Carey, MD

Vanessa Walker Harris, MD

Susan E. Massart

Mike Tweedy



Permanent Supportive Housing: Outcomes and Impact (Item 312 Z)

November 30, 2019

DBHDS Vision: A Life of Possibilities for All Virginians

Permanent Supportive Housing: Outcomes and Impact

Preface

This report responds to Item 312 Z of the 2019 Appropriations Act requiring the Department of Behavioral Health and Developmental Services (DBHDS) to submit a report on Permanent Supportive Housing funds for adults with serious mental illness.

Z. The Department of Behavioral Health and Developmental Services shall report on the number of individuals who are discharged from state behavioral health hospitals who receive supportive housing services, the number of individuals who are on the hospitals' extraordinary barrier list who could receive supportive housing services, and the number of individuals in the community who receive supportive housing services and whether they are at risk of institutionalization. In addition, the department shall report on the average length of stay in permanent supportive housing for individuals receiving such services and report how the funding is reinvested when individuals discontinue receiving such services. The report shall be provided to the Chairmen of the House Appropriations and Senate Finance Committee by November 30, 2019.

Permanent Supportive Housing: Outcomes and Impact

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Executive Summary

Permanent supportive housing (PSH) is an evidence-based practice for adults with serious mental illness (SMI) that has been implemented, refined, and studied for more than three decades. A notable subset of individuals with SMI are unstably housed or are homeless and, as a result, have poor behavioral health outcomes and are high utilizers of costly treatment and criminal justice resources. Multiple peer-reviewed research studies, including eight randomized controlled trials, have found that PSH is particularly effective in improving participant's housing stability and reducing their emergency department and inpatient hospital utilization.¹

The two core components of the PSH model are (1) affordable rental housing and (2) community-based supportive services designed to assist individuals with improving behavioral health conditions and maintaining housing. PSH is widely endorsed as a critical resource to prevent unnecessary institutional stays and facilitate discharges from institutions for persons with disabilities as required by the Americans with Disabilities Act, as interpreted by the U.S. Supreme Court's Olmstead decision.

In state fiscal year 2020, the Virginia General Assembly appropriated more than \$17 million to DBHDS to fund permanent supportive housing for very low-income individuals with SMI. DBHDS adopted evidence-based practice standards for Permanent Supportive Housing from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) to define the program model, operating standards, and evaluation framework for Virginia's PSH program. This report describes key characteristics of the program and its participants as well as statewide outcomes for the 950 individuals who were housed between February 6, 2016 and July 1, 2019.

Findings in this report support the value of investment in PSH for this population:

- One hundred forty-seven individuals were discharged from a state behavioral health hospital into DBHDS PSH, and overall, 228 individuals in PSH had a state hospital admission in the year before move-in.
- At least 95 individuals served in PSH were on the extraordinary barrier list (EBL) in the year before move-in.
- PSH providers are effectively prioritizing individuals with extensive histories of homelessness and repeated, long-term use of institutional care before move-in.
- Eighty-six percent of individuals served in PSH remained stably housed.
- Only 6 percent of those served have been discharged to an institutional setting or higher level of care.
- State hospital utilization decreased 82 percent the year after PSH move-in, resulting in avoided costs of \$9.5 million.
- A DBHDS cross-system cost impact analysis identified a 29 percent decrease in private hospital, state hospital, jail, and Community Services Board (CSB) costs after one year of PSH.
- After PSH costs were included in this analysis, a total cost reduction of \$1,375 was identified for each individual housed.

¹ Center for Budget and Policy Priorities. (2016). Supportive Housing Helps Vulnerable People Live and Thrive in the Community. Retrieved from http://www.cbpp.org/research/housing/supportive-housing-helps-vulnerable-people-live-and-thrive-in-the-community#_ftn27

Permanent Supportive Housing Program Characteristics

Housing and Supportive Services Components

DBHDS uses a scattered-site approach where individuals choose their own rental unit from those available on the private market that meet HUD-established affordability standards for the community of residence. In state fiscal year 2019, 73 percent of PSH funds were used by providers to support housing costs for enrolled individuals. Of these housing costs, almost all (91 percent) are paid by PSH providers to landlords as rental assistance to subsidize the cost of individual rental units leased or sub-leased by PSH participants. Individuals contribute approximately thirty percent of their income to rent, as well. Other eligible housing costs include security deposits, application fees, and items such as furnishings needed to establish a household. These one-time costs accounted for nine percent of housing expenditures.

Twenty-five percent of PSH funds support the costs of housing stabilization services, related operational costs, and local program administration. PSH housing specialists assist individuals with locating and moving into housing; understanding the rights and responsibilities of tenancy; establishing and following a budget; communicating effectively with landlords and neighbors; utilizing community resources and supports; and improving household management skills. Housing specialists also coordinate with participants' behavioral health service providers to ensure their emerging needs are addressed proactively in order to promote housing stability, recovery, and quality of life, thereby reducing the over-utilization of costly institutional care.

Community behavioral health services received by PSH participants are provided by CSBs and private providers and are funded through other mechanisms including federal grants; Medicaid; Medicare; and other federal, state, and local behavioral health funds. A key feature of the PSH model is that participants have access to a range of community-based behavioral health services that may change over time based on each individual's evolving needs, interests, and preferences. The type and intensity of behavioral health services provided varies, accordingly, by participant. Among the services accessed by PSH participants are Programs of Assertive Community Treatment (PACT), case management, peer support, mental health skill building, psychosocial rehabilitation, psychiatry, supported employment, and outpatient therapy.

Target Population

DBHDS PSH is deeply targeted to address two pressing issues faced by individuals with SMI in Virginia: institutionalization and homelessness.

Eligible sub-populations of individuals with SMI include:

- Individuals in state behavioral health hospitals
- Individuals leaving supervised residential settings
- Individuals who meet HUD's definition of chronic homelessness or who are literally homeless and at-risk of chronic homelessness
- Individuals who are unstably housed and frequently using hospitals, crisis services, and/or criminal justice interventions

Individuals being discharged from state behavioral health hospitals are prioritized over applicants from other sub-categories.

PSH Providers and Unit Allocations

Eighteen CSBs and one non-profit are contracted to provide PSH. Unit allocations below reflect funding obligations as of October 2019. A second fiscal year 2020 funding round is planned to align with awards for new HUD Mainstream Vouchers that will be announced in the coming months. Several communities have already successfully partnered with their public housing authority to leverage vouchers to provide PSH to individuals with SMI as indicated below.

In July 2019, 732 individuals were living in a DBHDS-funded PSH unit, and providers statewide were assisting approximately 30 new individuals each month with moving into PSH.

Table 1: Permanent Supportive Housing Units by Provider (FY20)

| PSH Provider | DBHDS PSH Units | Auxiliary Grant Supportive Housing Units | Leveraged Vouchers | Total PSH Units | Percentage of Total Units |
|---|-----------------|--|--------------------|-----------------|---------------------------|
| Region 1 | 173 | 0 | 20 | 193 | 17% |
| Northwestern | 30 | 0 | 0 | 30 | 3% |
| Rappahannock Area | 30 | 0 | 0 | 30 | 3% |
| Rappahannock - Rapidan | 28 | 0 | 20 | 48 | 4% |
| Region Ten | 55 | 0 | 0 | 55 | 5% |
| Valley | 30 | 0 | 0 | 30 | 3% |
| Region 2 | 182 | 0 | 0 | 182 | 16% |
| Arlington | 44 | 0 | 0 | 44 | 4% |
| Pathway Homes (Alexandria, Fairfax, PWC) | 138 | 0 | 0 | 138 | 12% |
| Region 3 | 168 | 90 | 4 | 262 | 23% |
| Blue Ridge | 75 | 40 | 0 | 115 | 10% |
| Danville – Pittsylvania (Region 3b project) | 42 | 0 | 0 | 42 | 4% |
| Mt. Rogers | 45 | 35 | 4 | 84 | 7% |
| Southside/Piedmont (Region 3b project) | 6 | 15 | 0 | 21 | 2% |
| Region 4 | 172 | 0 | 0 | 172 | 15% |
| District 19 | 30 | 0 | 0 | 30 | 3% |
| Henrico | 30 | 0 | 0 | 30 | 3% |
| Richmond Behavioral Health | 112 | 0 | 0 | 112 | 10% |
| Region 5 | 330 | 0 | 20 | 350 | 30% |
| Chesapeake | 15 | 0 | 10 | 25 | 2% |
| Hampton - Newport News | 114 | 0 | 0 | 114 | 10% |
| Norfolk | 131 | 0 | 10 | 141 | 12% |
| Virginia Beach | 70 | 0 | 0 | 70 | 6% |
| Grand Total | 1,025 | 90 | 44 | 1,159 | |

Permanent Supportive Housing Participant Characteristics

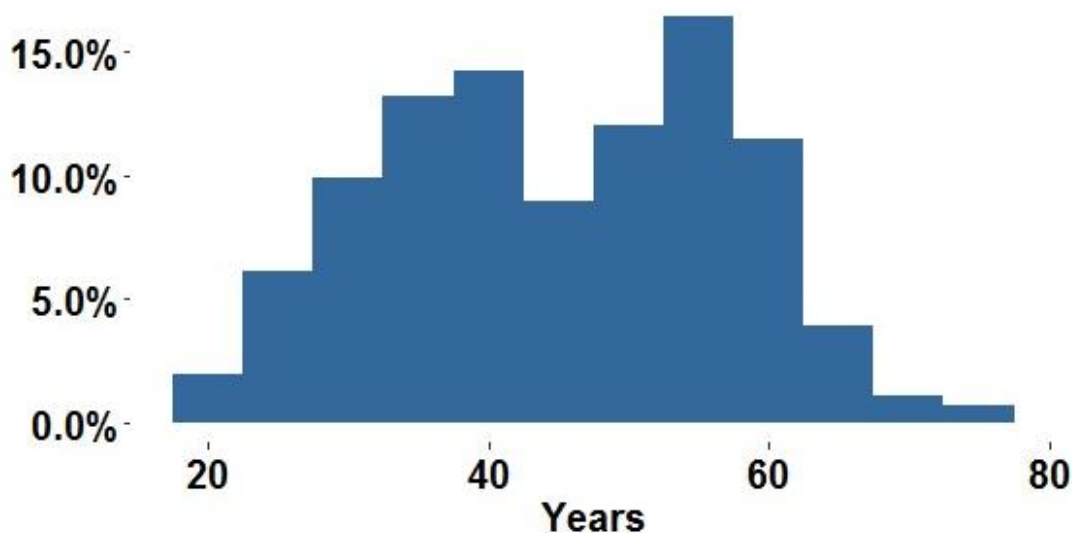
Data presented in this report is based on self-reports from individual interviews and client-level program data from each of the participating sites as well as administrative data from the Community Services Board (CSB) Community Consumer Submission 3 (CCS 3), Virginia Health Information (VHI), Local Inmate Data System (LIDS), the Department of Medical Assistance Services (DMAS), and AVATAR (state behavioral health hospitals). Interview instruments included the Timeline Follow Back (TLFB) Inventory which measured individuals' housing history in the six months before their initial PSH move-in.

This report includes outcomes for the 950 DBHDS PSH participants who were housed between February 6, 2016 and July 1, 2019.

Demographics

The median age of an individual receiving PSH was 45 years. Age followed a bimodal distribution, with an older cohort of individuals whose ages clustered around 55 years and a younger cohort whose ages clustered around 35 years.

Figure 1: Two Age Cohorts



Most individuals receiving PSH were male. Almost half of those served were Black and nearly another half were White. Two percent of clients were Hispanic. Demographics are largely reflective of the population of single individuals experiencing homelessness in Virginia.

Table 2: Demographics

| | Total | | Total |
|------------------|------------|------------------------------------|-------|
| N | 950 | Race | |
| Gender | | White | 46% |
| Male | 63% | Black | 49% |
| Female | 37% | Asian | 1% |
| Ethnicity | | Native American | 1% |
| Hispanic | 2% | Native Hawaiian / Pacific Islander | 0% |
| Non-Hispanic | 97% | Multi-race | 1% |

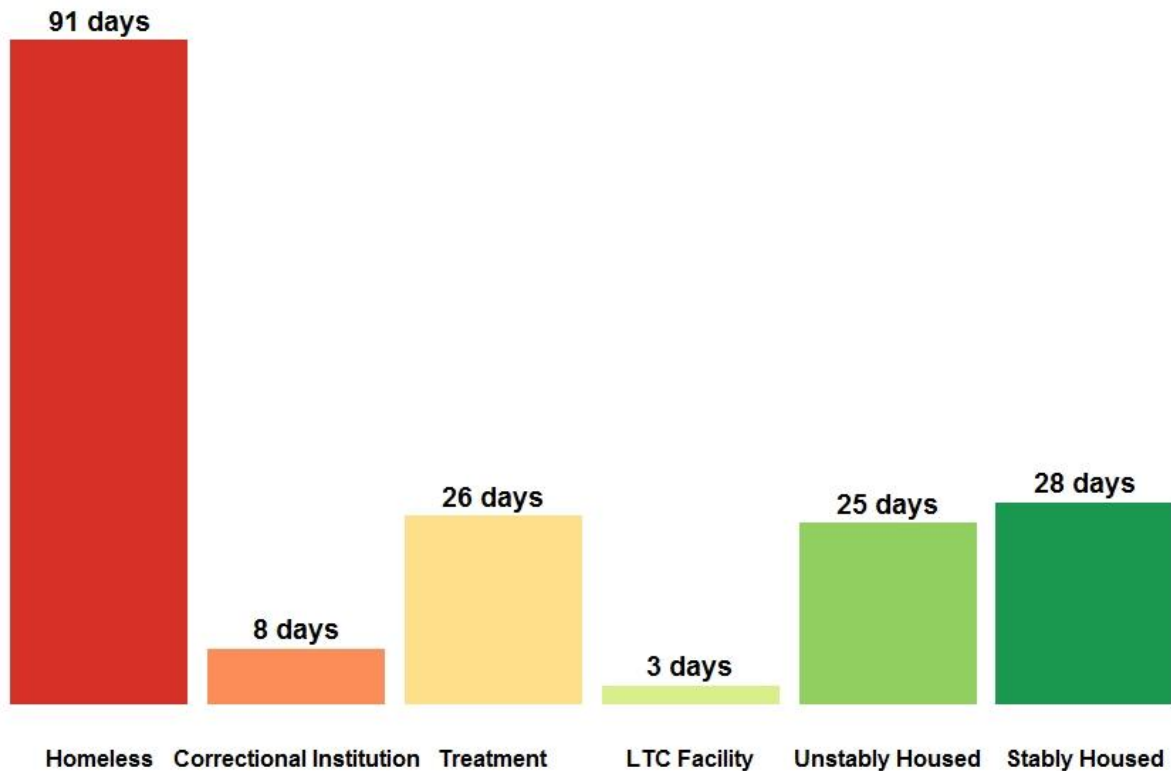
Living Situations Six Months before PSH Move-In

Individuals narrated their housing history using the TLFB inventory, including hospital stays, homeless stays, incarcerations, and stable living arrangements, for the six months before they were housed with PSH. The large majority (68 percent) of individuals had at least one episode of homelessness before entering PSH, spending half their nights sleeping in emergency shelters, outdoors, or in other places not meant for human habitation.

Thirty-four percent of individuals spent at least one night in a treatment setting, averaging nearly four weeks spent in a hospital, crisis stabilization facility, or substance use disorder treatment program.

Only 21 percent of individuals reported even a single night in stable housing in the six months before moving into PSH, and the large majority cycled through multiple setting types, reflecting multi-system involvement and failed interventions.

Figure 2: Length of Stay by Setting Type (n = 950)



State Behavioral Health Hospital and Extraordinary Barrier List (EBL)

Many individuals served through PSH had an admission to a state behavioral health hospital before move-in. Overall, 228 individuals (24 percent) had a stay in a state hospital in the year before PSH enrollment. Through July 2019, 147 individuals (16 percent) were discharged to PSH directly from a state hospital.

The Extraordinary Barriers List (EBL) includes individuals who are determined to be clinically ready to leave a state hospital, but who cannot safely return to the community due to lack of resources, capacity, or services, so remain in the hospital while these issues are addressed. Ninety-five PSH participants (10 percent) were on the EBL at some point in the year before move-in. Sixty-five PSH participants were on the EBL in the two weeks before moving into PSH, and 47 individuals from the EBL were discharged from the state hospital on the same day they moved into PSH.

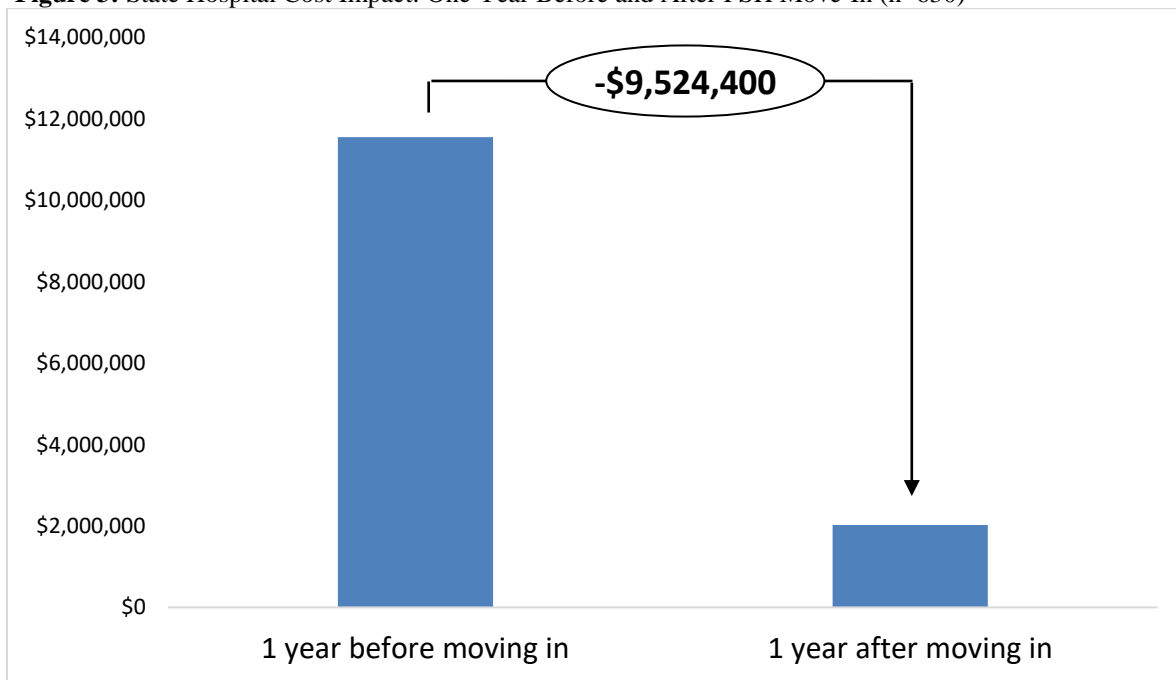
In September 2019, state hospital treatment teams estimated that sixteen percent, or 35 of the 220 individuals on the EBL, were clinically appropriate for PSH.

Outcomes

State Behavioral Health Hospital Impact

State hospital utilization was examined for a cohort of 630 individuals who entered PSH at least one year before July 2019. The cost of state hospital bed days for this group in the year preceding PSH move-in was \$11.6 million for 128 hospitalized individuals. The costs for 49 individuals hospitalized in the year after moving into PSH dropped 82 percent to \$2.0 million resulting in state hospital cost reduction of more than \$9.5 million for this cohort.

Figure 3: State Hospital Cost Impact: One Year Before and After PSH Move-In (n=630)



Reductions in Emergency Services, Hospital Stays, and Jail Utilization

DBHDS conducted a comprehensive, cross-system cost analysis using administrative data from private hospitals, state hospitals, jails, Medicaid, CSBs, and PSH providers. One hundred sixty-three individuals who received PSH for at least a year before March 31, 2018 were matched across these data sets, and their utilization one year before and after PSH move-in was analyzed.

The analysis identified cost reductions of nearly \$1.8 million across these systems, reflecting a 29 percent decrease and an average cost reduction of \$10,885 per person one year after PSH move-in. When the cost of PSH was included in the analysis, there was still an average cost reduction of \$1,375 per person.

While CSB costs rose 17 percent after PSH move-in, there was a favorable shift in the nature of services individuals accessed. After move-in, CSB service costs decreased for emergency, inpatient, and crisis stabilization services. An increase was seen across a range of the services that comprise the “supports” in supportive housing. For example, individuals used more Programs of Assertive Community Treatment (PACT), outpatient, case management, mental health skills building, supported employment, and SAMHSA-funded community behavioral health services.

Of note, individuals discharged from PSH before one year in housing were included in this analysis. Cost reductions were even more significant for those who remained in PSH, but the inclusion of discharged individuals permits application of the results to future investments. In other words, outcomes for this cohort suggest a positive return on PSH investment even considering that some individuals do not remain stably housed.

Figure 4: Total Costs One Year Before and After PSH Move-In (n = 163)

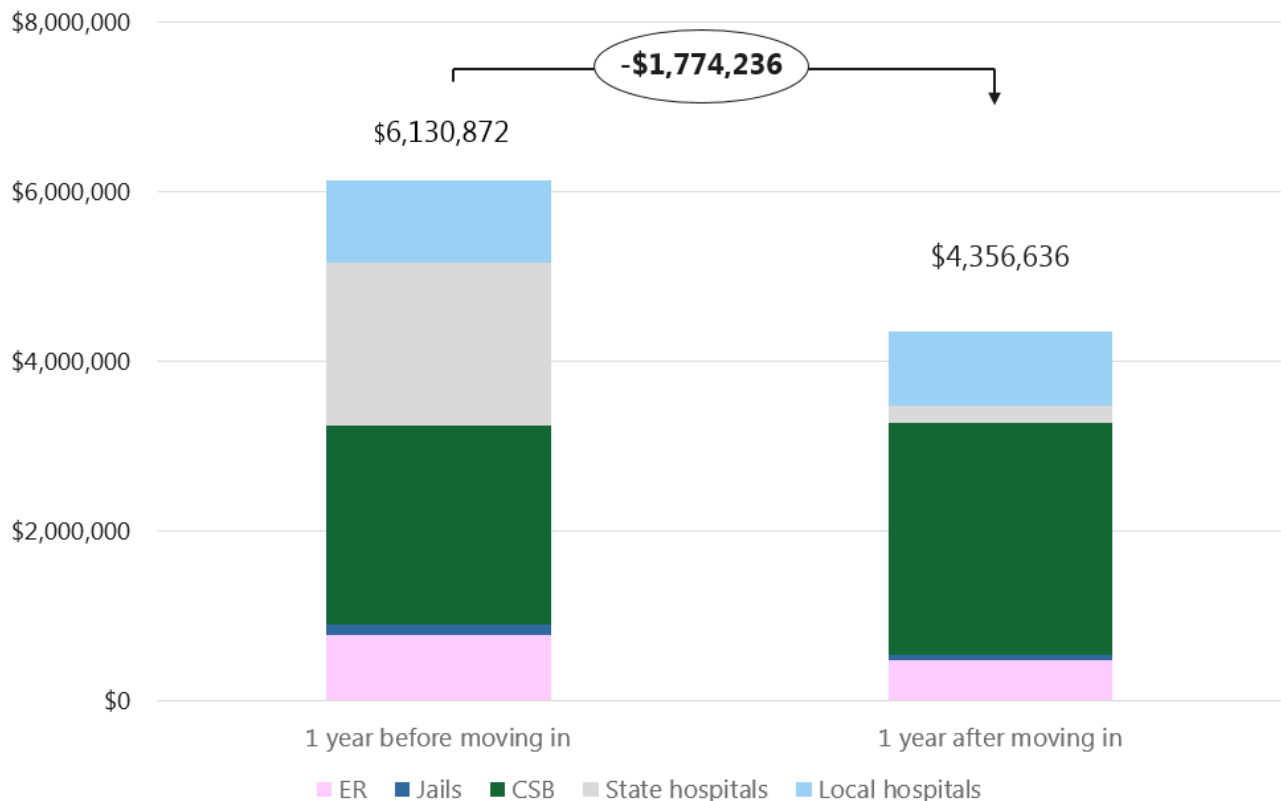
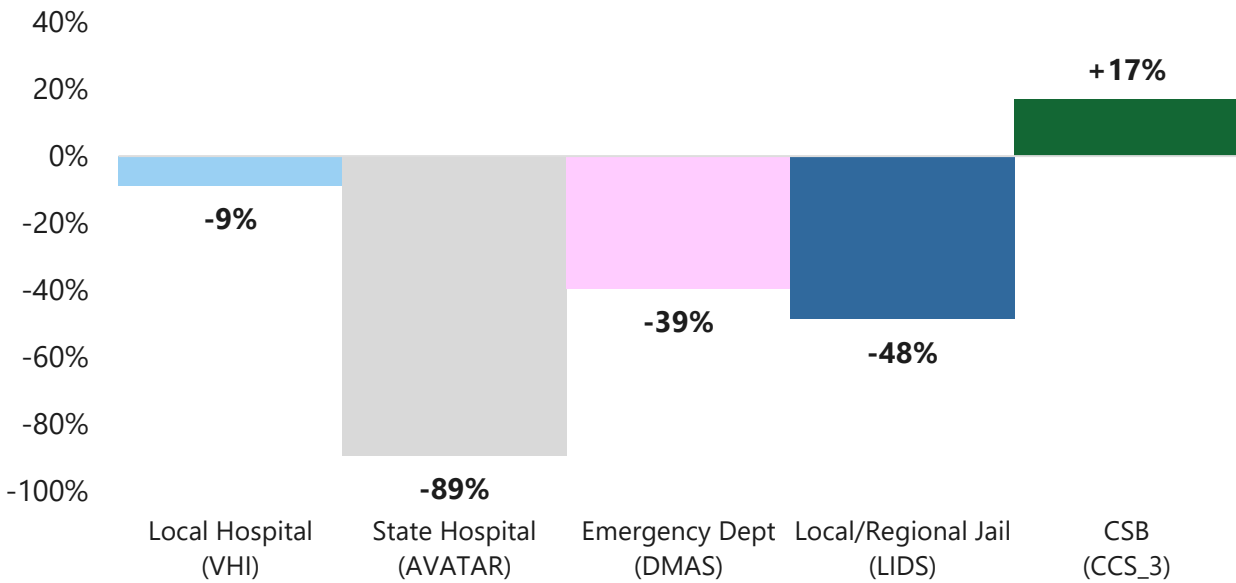


Figure 5: Change in Cost by Sector One Year After PSH Move-In (n=163)



Housing Stability, Length of Stay, and Reinvestment of Funds at Turnover

Eighty-six percent of all individuals enrolled are still in PSH or were discharged to other stable housing. The large majority (89 percent) of this group remained in PSH. Of the 77 individuals who were discharged from PSH to other stable housing, some remained in their rental unit (43) without a DBHDS subsidy; others moved in with family and friends (18), and some (16) moved to another rental unit or house without the need for supportive housing services.

Average length of stay in DBHDS PSH was fifteen months. Overall length of stay was negatively skewed by the high volume of recent move-ins attributable to the significant expansion of PSH funding in recent years. For those who moved in at least 12 months before the end of this reporting period, length of stay was 20 months. For those who moved in at least 24 months before the end of this reporting period, length of stay was 26 months.

PSH programs maintain an active system of outreach and engagement to referral sources and eligible individuals. When an individual is discharged from PSH, providers identify the next eligible individual who meets the prioritization criteria, and assists them with securing housing and supportive services. DBHDS includes unit utilization in its contracting and monitoring protocols.

Individuals at Risk of Institutionalization

To analyze the risk of institutionalization of PSH participants, DBHDS examined rates of hospitalization and incarceration before and after PSH move-in as well as the number of individuals who have been discharged from PSH to a higher level of care or a correctional institution. As described earlier in this report, individuals in PSH spend fewer days in local and state hospitals and jails than they did in equivalent periods before move-in. This lower utilization

is sustained over time. Individuals are unlikely to be discharged to a higher level of care or to a correctional institution, reflecting low risk of institutionalization for PSH participants.

Nineteen individuals, or two percent of PSH participants, were discharged from a program due to their need for a higher level of care. Six individuals were discharged to a state hospital and three were discharged while at a local hospital. In addition to hospitals, higher levels of care include nursing homes, assisted living facilities, group homes, and residential substance use disorder treatment programs. Seven individuals have been discharged to one of these non-hospital higher levels of care. Thirty-seven individuals, or four percent of PSH participants, were discharged during an incarceration. With some exceptions, DBHDS does not permit PSH providers to pay rental assistance on a unit when the tenant is not able to return for more than 90 days.

Table 3: PSH Discharges to Institutional Settings

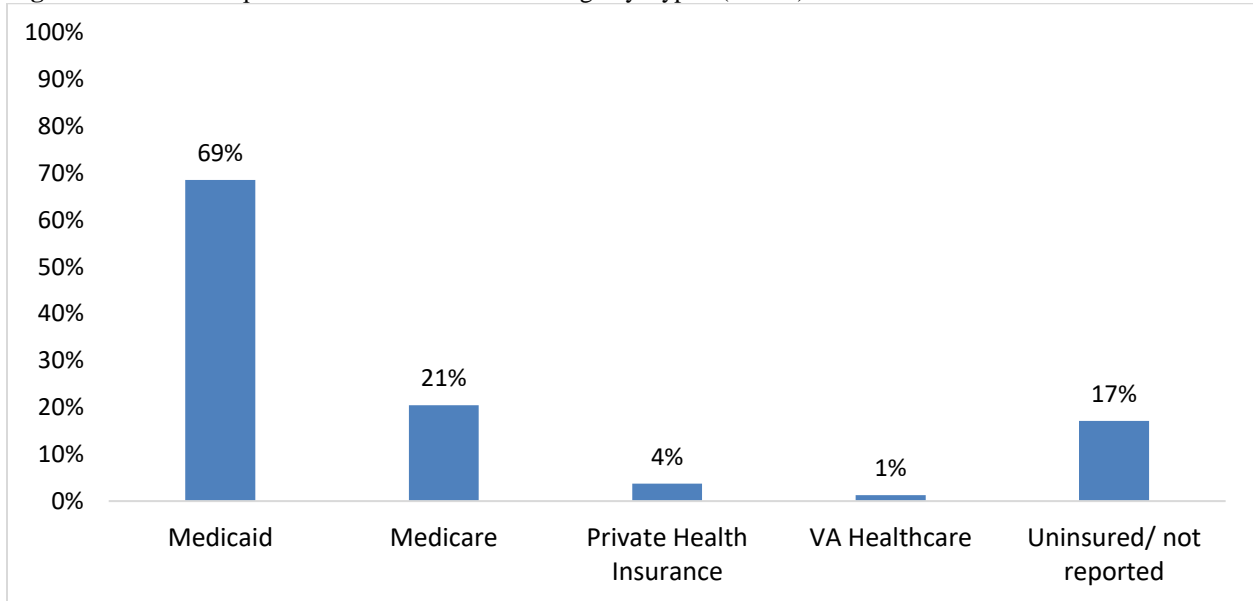
| Discharges to Institutional Settings | N | % of Total Served |
|---|-----------|--------------------------|
| Treatment Facility | 14 | 1% |
| Psychiatric Hospital | 11 | 1% |
| Crisis Stabilization Facility | 1 | 0.1% |
| Substance Use Disorder Program | 2 | 0.2% |
| Long Term Care Facility | 5 | 1% |
| Group Home | 2 | 0.2% |
| Nursing Home | 1 | 0.1% |
| Assisted Living Facility | 2 | 0.2% |
| Correctional Institution | 37 | 4% |

Benefits and Health Insurance Coverage

Nearly half (46 percent) of individuals had no income at PSH intake. Median total monthly income for the 54 percent who did have income at intake was \$735. Income at intake varied considerably by region, ranging from a median monthly individual income of \$750 in Northern Virginia to \$194 in the Southwest region.

More individuals have income and benefits now than they did at intake. The percent of clients with any source of income rose from 54 at intake to 71 at the end of the reporting period. The median monthly income also increased to \$771. The percent of those with health insurance rose from 69 percent to 82 percent.

Figure 3: PSH Participants' Health Insurance Coverage by Type* (n=762)



*Multiple simultaneous types of coverage are possible.

Conclusion

Overall, individuals who are enrolled in PSH experience dramatic improvements in housing stability and rely less on emergency, crisis, and inpatient care while increasing their use of community-based behavioral health services. PSH participants also increase their incomes and access to health insurance. Together, these changes reflect improved recovery outcomes and self-sufficiency, reduced public costs, and the value of PSH as a foundational community behavioral health intervention.

One PSH participant in Roanoke shared his personal perspective on the value of PSH,

“One day, I’d like to take care of my own finances and move out of the program. But for now, it’s really helped me and supported me to stay stable, to stay consistent. I have a job now. I see my family regularly. I have friends, I go dancing. I go to trivia nights. I go to poetry nights. I’m much more social than I used to be. I feel that permanent supportive housing has really given me the ability to come into my own instead of being, like, a victim on the streets. I really have some place to call my own and be proud of.”

² Anonymous PSH participant (personal communication, July 26, 2019)