2019 National Conference on Ending Homelessness & Capitol Hill Day
July 2019
National Alliance to End Homelessness

Pre-Conference: Youth Homelessness Demonstration Program: Everything We Know, So Far!

- Round 4 will be released in the next few months
- What makes it a demo:
    - Dedicated TA – very regular contact
    - Access to YHDP SNAPS team
    - Requirement for Coordinated Community Plan
    - Request Waivers
    - Evaluation
- Key Takeaways
    - Youth Collaboration
    - Age is a key consideration in system planning for youth
    - Cross system coordination and opportunities to address risk upstream
    - You have to manage the work at all levels
    - Be innovative
- Moving from individual programs to a system
- YHDP – Coordinated Community Plan
    - Figure out plan for ALL youth: solutions may not be YHDP funds
    - Eliminates time spent arguing about definitions
- System modeling: how many young people : known & projected, what intervention do we need: know and project how much
- Pay attention to how the process can be led by the knowledge and expertise of young people throughout the process
- Key steps
    - Come to a common understanding of what program models exist and what we want
    - Create pathways out of homelessness
    - Decide on proportion of youth that will use each pathway
    - Decide on average length of time youth will use each pathway
    - Come to annualized number of young people who touch system
    - Estimate the amounts of interventions needed in each of the pathways, what does it lead to? Plan to end youth homelessness!
- Create ideal pathways out of homelessness and into housing
- Use Stella P as a resources for where things are now
- May modify some program elements
- Do separate modeling for minor and those 18-24
- How are biases playing out in who gets services?
- Managing System Work
    - Data driven: be sure to look at utilization rates of current programs
    - Relationships
    - Non-YHDP funding & initiatives
    - Beyond planning
    - Leadership
- Identify champions who will move it forward: not necessarily the directors
- Authentic Youth Collaboration
    - Build YAB: be sure to pay them, address barriers to attend

    - Strategic plan about how to best engage young people: best to have one point of contact for YAB as far as adult partners
- Cross system collaboration
    - Unaccompanied minors
    - Diversion workers on child welfare teams, homeless, juvenile justice
- Housing stability and family conflict as indicators of homelessness: 5 questions about this and then link to family based intervention services
- Ramping Up and Scaling Up new housing
    - YHDP communities doing RRH
    - How to find units?
- Exploring different program models
    - Diversion as RRH
    - Waivers: requirement for 12 month lease
- Deep Dive: Managing System Work
    - Day 1: Awarded
        - Team: who is responsible for planning
        - Individual capacity, who has data, special populations
        - Decision making ability and champion of change
        - YAB: experience needs change, youth who are using current system, what is their role going forward? PIT? Advocacy?; hired CoC staff to run and support YAB: both full and part-time
    - Update governance processes
    - Partner with workforce development to fund YAB positions, conferences
        - Use WIOA funds
    - Team started large, but has shrunk
    - Planning and implementation has different needs
    - Can start looking at current initiatives
    - Plan how points are awarded for local competition
    - Signatures: plan time to get this, let them know it will be coming
    - YAB
        - Quality over quantity
        - Ensure there is an agreement on support provided to YAB
    - Plan submitted
        - Funding Competition
            - Young people on rating and ranking team
            - Criteria for scoring based on plan
            - Agencies struggle with transparency around YHDP
        - Figuring out ways to fund non-CoC eligible projects long term outside of YHDP
        - What are we trying to test out?
        - What do we want HUD to know about how to end youth Homelessness?
    - Think about implementation now
        - Governance structure
        - Integrate YAB into CoC
        - Capacity- who else to drive plan beyond funded agencies
        - Calls, conferences, other TA opportunities, TA brings people together at conferences

1.03 Leading Systems Change

- Simple system: right ingredients, right instructions, doe it enough that you no longer need to look at the instructions
- Complicated system: a bunch of experts together with an agreed upon director

- Complex system: serves complex people
- What is the opportunity for innovation in practice or interconnectivity that would provide a new way of examining homelessness
- Moving people to your why
- Law of diffusion of innovation: innovators, early adopters, early majority, late majority, laggards
- Connection to permanent solutions instead of emergency services
- Treat homelessness as a mass catastrophe – must triage
- Morality, Values and System Leadership
    - Harm/care
    - Fairness/reciprocity
    - In group loyalty
    - Authority/respect
    - Purity/sanctity
- Resistance to change and the Tension of Change
    - Conservation
    - Creative destructions: stop doing what isn't working
    - Renewal and reorganization
    - Rebirth
- Charity doesn't solve complex social issues
- Bureaucratic response doesn't solve complex social issues
- How do we understand the needs of the populations we are serving
    - Needs assessment, community development
    - Get into the spaces to envision the change
- 1. How you make decisions
- 2. Communicate
- 3. Relate to followers
- 4. Change
- 5. Respond to pressure
- Where are you looking to anticipate change?
- How do you understand trends and their impact?
- In which ways are you managing diversion of people and opinion?
- Are you developing relationship with people who are different from yourself?
- Are you courageous to give up the past: are you willing to reinvent your work?

2.04 What happens after shelter opens: lessons about creating housing exits?

Stacy Borke, Portland
Transition Projects

Legacy Shelters
Not designed to serve most people
Vulnerability, opportunity, accessibility weren't a major focus
Highly programmed: case managers and employment services onsite

2015: Declared a Housing Emergency
Shelter Expansion
Who wasn't coming into shelter?
Who were we unable to serve?
Where was the greatest need?

Mindset Shift

- Asking critical questions about equitable access and inclusion
- Linking resources: shelter doesn't have to be everything to everyone
- Challenging your own assumptions; staffing levels, staffing focus
- Reckoning with reality: staff training needs, level of support for guests
- Expansion and culture shift are different lifts

Win: Increase capacity and get people inside
Win: greater understanding of need and vulnerability
Shelter is not a destination and does not end homelessness
Next: Capacity is the place to start, not the end goal: People need to exit to have space for the next person who needs the resource
Next: rent assistance and housing options and supportive housing
Goal: Housing ends homelessness and shelters are a crisis response

Maximizing Flow Through:

- Housing focused shelters
- Set targets for increased exits (stable/permanent)
  - Eyes on data accuracy and consistency across providers
- Resource and coordination that matches guest needs
- Focusing on equitable outcomes

Strategies

- Role of shelter staff: talking about moving towards housing, not staying in shelter
- Intake process: what's your plan to move out of here?
- Weekly staffing sessions:
  - Review needs/barrier/opportunities for every shelter guest: Go through EVERY name
  - Case managers, shelter staff, mangers, wellness, everyone who is part of your shelter team should be represented
- Population focus
  - Long-stayers: top 25 people who have been in shelter the longest
  - People with income
  - Older adults
- Being services onsite: coordinated access, case management and housing advocacy, tenant education, housing workshops, wellness

Alisha: Northern Minnesota

- Wall of Forgotten Natives
- Navigation Center

Created Temporary Transitional Shelter
Navigation Center

- 24/7 low barrier shelter with supportive services on-site
- Built to meet people where they were at utilizing harm reduction practices
- To get people connected to services, provide basic needs

Built utilizing a variety of partnerships with community organizations and a variety of governments

Goal: Reduce Crisis

- Increase trust in system
- Create safe environment
- Increase engagement in support services
- Increase peer support

- Increase connection to cultural and traditional values
- Crease a sense of family for the clients
- Avert crisis

Community Activities:

- Greater tribal engagement/awareness
- Increase collaboration with law enforcements
- Increase community support/collaboration
- Increase government engagement

Lessons learned

- Invest more time in the planning process, there was a lot we worked through as the center was already operational
- Never underestimate the power of partnership
- Listen to the community you serve and meet them where they are at: treat co-occurring disorders
- Current systems are broken and need to change

Open for 6 months: housed 156 people, increase in trust in various service providers, partnership between Avivo and Red Lake Band of Chippewa, barriers to housing have been reduced in some properties, building rehabilitation to increase the number of housing units

Catholic Charities, Washington D.C.
Amanda Chesney

- About 1000 beds of shelter
- Less movement in women's beds compared to men's

Staffing Structure

- On site Staff
  - Program director/Senior manager
  - Social work managers
  - Program supervisors
  - Case managers
  - Program assistants
  - Administrative coordinators
  - Data entry clerk
  - Receptionist

Vendor Partners

- Cleaning/janitorial
- Maintenance and repairs
- Security guards
- Food services and delivery…..

11 staff funded by private donations and then asked for continued funding

Used to have 1 case manager to 190 individuals
Now has 1 to 30 ratio

Necessary for Change

- System:
  - Invested leadership guided by best practice
  - Funding in community for permanent housing and supports/willing landlords
  - A functional coordinated entry system
  - Contracts that reflect values and desired outcomes
- Program/Agency:

Case a new vision for how YOU fit in to the bigger Ending Homelessness Picture in your community
Capitalize on willingness to help and add new tasks to get there
Program Assistants-formalized referrals and VI-SPDATS

Culture Shifts - It takes time
What are we doing now? Build on those strengths
What is your job really? Build on that felt purpose
How can we catch this wave? Because its coming! No guaranteed invite
Cast a new vision and provide education for all
Shorter hallways
Trainings to define what Housing First looks like in shelter
Define a new purpose for each staff position to meet the goal
Prior to this shift Housing was a case management only kind of goal
Everybody's job to work on ending homelessness

Lessons Learned
Define target population early
CoC priorities, mission of agency, willingness of team
Choosing the hardest to serve is hard; balance the momentum
Worked with long stayers, but also some of the "easier" people: show that people are moving out
Engage and educate: staff and clients
Track and monitor progress
Talk/debrief honestly with staff, partners and people experiencing
Stay in the loop with the rest of the system

HUD Listening Session: Prevention

- Case coordination with child welfare
- Train child welfare on asking housing risk questions: diversion: only refer those with highest need to homeless service system
- Don't let other sectors off the hook for work they are supposed to do
- FUP is underutilized: there will be an announcement from HUD re: young people aging out of foster care
- Crisis intervention team for households who are losing their housing

Executive Session: Navigating Common Challenges Faced by Homelessness System Leaders

- 5 dominant leadership styles for navigating change
  - 1. Autocratic: policy and procedure
  - 2. Transformational: big picture, creative destruction, have great group of followers
  - 3. Charismatic: cheerleader, help when morale is low
  - 4. Servant: team out front, lead from behind, relationships based on trust & collaboration, followers stay for a long time
  - 5. Participative: bring people together for conversations, all about process, inclusive
  - People who work on the system, but are not in the system. They ask difficult questions: going in same direction, but are often outcasts
  - What happens when someone is working against us?
    - People that are working with me will leave. Those against us get $, air time, etc.
    - Need a collaborative conversation around motivation: why are you doing this?
  - Ending homelessness is part science and part art
    - Science is easy, art is hard
    - Art: in which ways do you connect emotionally with others that share your pursuit of ending homelessness?

- Turn motivation in to action
  - What are you doing to focus on? Now give it a meaning that produces an emotion
  - What are you after? Talk about the change you want to see.
  - What is your map to get there?
  - What is going to fuel you?

4.01 The best way to reduce inflow? Target your Prevention resources!

Greg Barchuk
Nichele Carver
Sue Mcmahon

40 million people are poor, but they don't all become homeless

Nichele: Virginia Department of Housing and Community Development
We have an eviction problem, but we have homeless prevention funds
PIT numbers have decreased every year since 2010
Started to wonder who was being served with prevention money as programs were running out of funding after 6 months
Only 19% of people coming into shelter had a prior living situation as a rental, while 72% of people receiving prevention were in a rental situation……this was eviction prevention, not homeless prevention

Training focused on using data from households in emergency shelter to target prevention assistance
Without using shelter data in targeting prevention assistance recipients, communities may run a much higher risk of inadvertently serving households who would never have become homeless in the first place, limiting the resources available to households that truly need them.
Need staff who are able to figure out a situation with folks that may not involve providing financial assitance
Funding
Dedicated State General Fund source for prevention - $3.9 million
There is an expectation that funds are targeted
The data should support that the funds are being used properly
Arlington County
Eviction Program: have some funds for eviction prevention
Targeted Prevention Focus
Systematic and Coordinated Approach
Key takeaways and outcomes

Sue: Syracuse, New York
Received a onetime ESG supplemental funding in 2017
Used HMIS data nad Input from community to determine the best way to target these one-time funds
Used this opportunity to test out piolot projects to limit inflow into emergency shelter

Volunteer Lawyers Projects and Housing Authority
PHA had a history of brining a lot of evictions to court
Early intervention case management model
Two case managers: one ESH funded one PHA funded
-connect on day 5 of being late on rent, talk to the tenant and figure out what is going on
PHA re-designed outreach process for evictions
Provided six months of follow-up case management to ensure stability
Outcomes: evictions going to court decreased by 75%
Prevented 30 families from being evicted, 89 families protected from threat of eviction, saved $116,019 in eviction filings and lost rent,
Volunteer Lawyers Project would provide any necessary legal services

Clinton Plaza (330 units of subsidized housing) and Catholic Charities
- Early intervention case management
- Referrals directly from property manager
- Self referrals through on site case management 'office hours'
- Funded through ESG and CDBG
- Reach out when 5 days late on rent
- Homelessness decreased in homelessness by 16%, 19% decrease in first time homeless

Greg: Your Way Home, Montgomery County, PA
- People of color vastly over-represented in homeless services system
- 23% of people served in homeless services are African-American children

Eviction is a primary driver of homelessness in very specific locations
- 2016: 5,545 landlord-tenant cases filed and 2.120 orders of possession issued
- 60% of evictions were in only two zip codes of 66 total zip codes (where most people of color live)
- County schools had 683 doubled-up children 970% in doubled up situations)

Strategies to reduce inflow #1: eviction prevention
- Program design:
  - Cross system partnership between legal/court system, private philanthropy, and homeless cirisi response system
  - Targets area with highest evictions, which disproportionately impact women, households with children and African-Americans
  - Intervention provided day-of, onsite, with financial and free legal assistance with staff trained in local landlord-tenant law
  - Participants offered services as need to avoid eviction,
  - Served 81 households and prevented evictions for 85% of them

School-Based Prevention
- Partnered with school district, private funder and local RRH provider
- Started with idea to provide RRH-esque model to all households
- Rehousing efforts limited to same school district to prevent students changing schools
- Found that not all households needed re-housing
- Often doubled-up for other reasons (save on childcare, etc)
- Shifted to a mixed-intervention strategy based on unique needs of each household
- 16% reduction in first time homelessness
- Households accessing CE fell by over 50% in the last 9 months

Lessons learned
- Building partnership with multiple non-homeless sectors is absolutely critical to success
- Listen to what participants actually need. Prevention programs must be very oriented to local communities and require individualized outside the box thinking around solutions
- If targeted intentionally, prevention work is racial equity work

5.01 Go with the Flow

What is an effective homeless response system?
- House people as quickly as possible and divert people whenever possible
- Use a systemic approach to align intreventions and resources

Endgame
- People in a housing crisis have access to immediate help, including a safe place to go and diversion services
- People are not unsheltered
- People do not spend long periods of time homeless
- People exiting homelessness do not quickly cycle back into homelessness

System flow: an efficient coordinated process that moves people from homelessness to housing as quickly as possible

Poor system flow:

- Unchanging or increaseing number of unsheltered people
- Waitlists for shelter
- Long lengths of stay in shelter
- High percentage of exits from shelters to homelessness
- Average length of homelessness is not decreasing
- Inflow is increasing
- Significant amount of people aren't getting any kind of assistance

Rightsizing Family Resources: NAEH Resource

An effective homeless response means

- Right-sizing your system
- Having RRH to scale that is aligned with best practices is the BEST way to get flow in your system
- Balancing temporary help with permanent housing solutions
- Treating everyone's housing crisis as an urgent situation

Michele Fuller-Hallauer: Clark County: Nevada

Identified bottlenecks:

Long-stayers in shelter: need shelter providers to start talking housing, went through learning collaborative that resulted in changing contracts to mandate housing focus

A. Community Queue: 1800 people on the list, that are actively checking in, 200 families, 90 youth
   - Add Housing Units: Use marijuana licensing fees to support the addition of RRH for families, 180 families to be served
     - Addition of units for youth is underway
B. Moving into Housing Program: gap between referral and housing in PSH unit, 1400 PSH units (not including HUD VASH) but not much movement
   a. LINK Unit: Linkages, Interventions, Navigation, Knowledge: outreach goes out and find the person, puts them in a bridge unit and assign them to a client navigator to get chronic documentation, basic needs, tenancy supports and wait for PSH unit availability, are able to move into open unit within one week
C. Exit to Self-Sufficiency: people have been in PSH 20 years and no longer need the case management, how to move on
   a. Need assistance to pay their rent due to fixed income
   b. Moving On Working Group: looking to see what is needed in our community, PHA not a strong partner, has been challenging to get them to the table

Lessons Learned

- Right size all components at the same time
- Right size the right types of interventions
- Partner engagement is an essential piece of the puzzle: must own their piece of the puzzle

Eva Thibaudeau-Graczyk: Houston

2011: everyone tried to do everything, duplication, inefficiency, funding all went to the "usual suspects", ,200+days to get into PH, zero transparency, staff with the most contacts/experience were successful, people were remaining homeless and getting lost in the system, unsheltered homelessness kept growing, most vulnerable never received housing

System Re-design

Created system infrastructure: CoC Governance Committee: Can't be a majority of service providers
Committed to transparency (creation of workgroups)
Adopted CE and Housing First
Re-allocated money
Asked partners to get great at their core competencies
Created PSH pipeline

Committed wo working across systems (VA, HUD, Child Welfare, Workforce Development Board, County Jail, Mental Health Authority, Law Enforcement)

Reduced overall homelessness by more than 50%
Reduced street homelessness
Housed more than 17.000 people
Created more than 2500 additional PSH units
LoT from referral to housed is between 78 and 93 days

Still working to right size system
*Partner relationships can get precarious, a lot of board retreats and meetings, talk through what it means to move towards evidence based practices, how to keep them at the table: tried to be helpful
*Political pressures: added positions to mayor's office and other key folks to manage the political pressure, allows the CoC to stay focused on housing
*Landmines:
*Change management: hard when people feel emotionally connected to what they are doing
*Communication: average adult learner needs to hear something 7 different times
*anger
*Getting to yes
*Getting to know new bureaucracies

Have to continue to right-size the system

Educated public and private funders on housing first, CE, etc.
Refer to data in every meeting, have an HMIS administrator at every working group, use data to back up what you are saying
Being clear about how much it would cost to house all of the unsheltered people today

6.01 Creating a culture of diversion across your community

Sarah Fox: Connecticut
a moment to pause and problem solve, sitting with someone in crisis and helping them to calm down,
211 is the front door, 211 does the initial diversion screen, about 70,000 families are calling in a housing crisis, many are being diverted, then bring people in for a CAN (Coordinated Access Network) appointment,
Have seen point in time numbers decrease, annual numbers have declined, housing focused conversations are having an impact
40% diversion goal for singles, 75% diversion goal for families
Collaborations Key to Successful Implementation: schools, child welfare, criminal justice, early childhood, hospitals
What if they were having the problem solving conversations? Started training other sectors on having these conversations: do monthly diversion trainings
Statewide diversion trainings: all service providers, train the trainer, identifying training opportunities in other sectors
Scaling up: standardizing diversion, identifying and engaging other systems and training opportunities, shelter diversion supervision collaborative

Funding Diversion: private donations, state agencies, reallocation of existing budgets, fundraisers, crowd-rise/online fundraising, in-kind donations, leveraging other organizations, corporations, federal funding
The be homeful Project: Paddington bear

Kayleigh: Montgomery County
Your Way Home: Coordinated Entry, street outreach, 6 emergency shelters, RRH/PSH, connection to supportive services
Sheltered and unsheltered homelessness has declined

Incorporate diversion as a problem-solving strategy at multiple points across the homeless crisis response system
    Every household accessing Your Way Home recieves multiple diversion conversations
    Not a formal "program"
    No dedicated funding source
    Basic problem-solving for all households
    Housing focused case management in other systems can lead to even more upstream diversion & prevention
Diversion Point 1: Coordinated Entry:
    211 triage: physical location, safety, veteran status, category 1, 2, or 4
    Dedicated diversion conversations: referral directly to street outreach if unsuccessful
    Strong referral database: connecting with resources in other systems
Diversion Point 2: Street Outreach
    Face-to-face safety planning
    Clear communication about prioritization
    Creative & flexible problem-solving: bus tickets, car repairs, transportation passes, equipped with flexible private funding
Diversion Point 3: Emergency shelter
    Coordinated shelter bed prioritization: street outreach refers their most vulnerable households to ES when a bed is available
    Dedicated shelter front-door diversion: all beds are 100% utilized, emergency walk-ins can stay a night, but receive diversion next business day
    Phased assessment: VI-SPDAT & referral to community queue after approximately 2 weeks in shelter
Diversion to Rapid Resolution
    RRH Lite: might just need move-in costs to exit homelessness
    By-name meetings: monthly meetings, come up with additional problem solving strategies
Diversion Recommendations:
    Diversion is NOT a dedicated program
    Train all direct-line staff in motivational interviewing & fair housing law
    Be a resources to your community's front door of the homeless crisis response system
    Don't divert in a silo
    Flexible funding for creative problem-solving

HUD SNAPS Q&A

ESG final rule, continuing to work on it, prioritizing this, hope to be released this winter
CoC interim rule for further comment, this will come out soon??? Will have plenty of time to comment even during NOFA
HMIS proposed rule will be reopened for comment
NOFA: due 9/30 on 8PM

Veteran and Family numbers going down, individuals are going up, we can do this when we focus in on a population, we must do more for individuals

PHA's will struggle to get mainstream vouchers without coordinating with the CoC, they are a fantastic resource for CH and move on programs

Ending CH is still a priority for HUD
DV debrief will be sent out tomorrow

What is HUD and TA doing to prepare for next LSA? Many of the problems were one time bugs, anticipate it going much smoother next year

How is HUD defining "Well-being" in the NOFA? We are not.

Streamlining for CoC and ESG RRH regs: there will be some differences due to statutory differences, but will work to make statutory differences the same

YHDP: at program entry must be 24 years or younger, will provide guidance on how to serve someone who turns 25, let them serve out their lease and move them over to CoC program

You can rent a unit above FMR if it is reasonable in your market. If you have leasing dollars, you can only pay up to FMR…..you can use other funds to pay above, but they can't be funds that are used as match. For rental assistance, can pay up to rent reasonable.

Housing First: We still love housing first, evidence is still the same as it was last year and it shows housing first works really well, Must still have low-barrier and focused on moving people into PH quickly, allows you to add service participation requirements once someone has stabilized in housing, can only require substance use treatment services if you are a substance use treatment provider, keep in mind fair housing requirements, if you are a PSH program you have to make every effort possible not to evict people, if this will result in people losing their housing: don't do it, if you don't think this is a good idea, don't do it, you can stay on the 100% Housing First road,

Any chance to make the NOFA bi-annual? There would need to be legislative change to do this. 2013-2014 had a lot of problems,

There will not be new HMIS data standards annually, hope to move to bi-annual, but hoping to have it not be that often

CE SSO DV grant, complement CoC's CE, can use to set up a comparable data base, put under the case management

When will YHDP results will be released? They are reviewing projects soon. A cluster of things happening all at once, it will be soon…..3-4 weeks…..had 100 apps and 25 communities

Round 4 YHDP will be coming soon!

Will you require tiers forever? Probably, making this competitive is really important, because it's performance focused it gets money every year from Congress,

LSA and SPM will have the same opening date….10/1. closing in February

Will there be a day when we are judged on year round data rather than PIT? Will shift to emphasizing SPM more and more, really complicated to figure out how much RRH people are doing-we use the HIC- but is not great, looking at different options there

CE data elements: we knew this would be painful,

Will you start giving credit to CoC's that have people with lived experience on their boards? Making sure they have input in the work of the CoC. Will be changing the CoC rule…….may want to comment on this, can incentivize things during the CoC NOFA process……thinks this will happen in the future…..Baltimore is doing good work with this.

Will HUD require lower scoring CoC's to merge? You get 25 points in the NOFA for merging. We would rather not force. There is a lot of technical assistance if you want to explore this. We will have a real conversation about this.

Transition grant counts towards 20% reallocation

RRH for CH?

> If you are doing it and it's working, great. If you haven't tried it then it's worth trying. Work with PHA to get some vouchers for folks who RRH doesn't work out well for.

Can have someone go into RRH and then get the documentation for them to move into PSH…Brett.

HUD Listening Session: Employment

- Employment focus and serving people with high needs: how do they fit together – HUD says best strategy is to continue to serve high need people
- Employment as part of recovery process
- TA around training for people with lived experience for working our agencies
- First Step Staffing - Philadelphia

7.11 A challenge that is getting old: how to best serve older adults

Emily Rosenoff: US Department of Health and Human Services
Help people age successfully in their community
What is Long term Care?
    Assistance with activities of daily living (ADLs) such as dressing, eating, bathing, toileting
    Assistance with Instrumental Activities of Daily Living such as managing finances, transportation, shopping, meal prep
    ….
Medicare Basics
    Benefits
        Part A: hospital, home health (post hospitalization), skilled nursing facility care, hospice care
        Part B: doctors visits,
        Part C: managed care covering benefits of Part A &B
        Part D: prescription
        Medicare does NOT cover long-term care
    Eligibility
        Over 65 with work history, individuals under 65 who are on SSDI after two year waiting period

Medicaid - Program Eligibility
    Eligibility and benefits will vary by state within certain broad requirements

Medicaid Benefits
    Includes set of mandatory servcies such as hospitalizations, doctors visits, pharmacy, nursing home care, mental health
    States can cover optional services including home and community based services
    Many states cover HCBS through waivers that ma have a limit on the number of participants
    The Medicaid expansion benefit package may be less generous than traditional Medicaid
    Notably: Long-term Care may not be part of the Medicaid expansion package
    …..

Medicaid Long-term Care
    Must have a medical necessity for the specific service
    In most programs an individual must have needs that require an "institutional level of care" in order to qualify for either nursing home care or Medicaid HCBS
    Eligibility usually determined by the number of ADLs someone needs assistance with

Home and Community Based Service (HCBS)
Depending on state and specific program, HCBS and include:
    Personal care at home
    Adult day care
    Case management

Homemaker/home health aide
Habilitation
Respite services
Some states cover services in residential care, including assisted living, but Medicaid does not cover the room and board portion of the cost

Medicaid Waivers
1115: Research and Demonstration Waivers
Test new program admin/benefits/eligiblity
1915c Waivers: Provide HCBS instead of nursing home care

Older americans Act Funding
Enacted in 1965 to provide services to individuals over 60
Meals on Wheels, info and referral, caregiver support, prevention
Usually administered through local "area agencies on aging"
Not an entitlement, but also not means-tested so available to a broader populations

Types of partnership
ADRC
Visiting nurse agencies
Home health or home care agencies
Adult day health programs
PACE programs

Pascale Leone, CSH
A strengths based approach to healthy aging
Living longer and fuller lives should be celebrated and not looked upon as a crisis/drain on society
Honor and recognize strength and resiliency of aging tenants
2033 65 and older will outnumber 18 and younger for the first time in our nation's history

40% of supportive housing tenants are 50+ years of age

Key considerations for enhanced services
Physical & Behavioral health
In home services/ADLs/IADLs
Cognitive Conditions
Cultural Humility
Social Connectedness
Accessibility & safety
Nutrition
Transportation
End of live planning and care transitions

People incarcerated age faster than people experiencing homelessness
Isolation kills
Think about universal designs on the front head for aging populations, rather than making modifications later on

Innovative partnerships
HOT Team: King County
PACE: San Diego, LA
Money follows the person demonstration: New Jersey-I Choose Home Program

Beth Stokes
Episcopal Community Services
San Francisco
Adult CE
Interim Housing
Shelters
Supportive Housing, 1100 units
Healthy Aging
Behavioral Health
Workforce Development

PIT 17% increase
Largest increase was age 51-60

Hospital: Medical Respite Bed: HOT (Homeless Outreach Team) Bed: 90-day Bed….keep cycling

Interim Housing Pilot: a partnership with public agencies
- Health Coordination & Medication Management
- Nutritious Meals
- Personal Care
- Specialized Staffing

New Development: 1604 Mission Street: housing for highly vulnerable older adults, partnership with ECS, Mercy Housing, MOHCD
- -thinking through design that helps prevent falls: walk-in showers, non-slippery floors
- -congregate area