

Development of the Standard Supportive Housing (SSH) Program in King County

Our Vision:

To downsize the number of boarding home beds and redeploy the residential dollars into the community in order to create a Supportive Housing (SH) program. As a residential bed is closed a supportive housing unit or slot is created to provide an ongoing and alternative resource for persons exiting WSH and local hospitals.

National and Local Influences

- RSN commitment to a Recovery Oriented Model - boarding homes not conducive to recovery.
- Increasing number of consumers leaving hospitals did not want to live in a boarding home.
- Providers did not want to take some consumers due to behaviors
- Completed an assessment of medical necessity criteria of residents in boarding homes (2001). Approximately one third did not meet medical necessity for boarding home level of care.
- Residential study of consumers and staff in residential and supportive housing programs (2002). Interviewed 175 consumers and 119 staff in 9 residential facilities and 10 SH projects in KC.
- National trend to smaller facilities (16 or less), IMD/ Medicaid funding issues.
- Aging Facilities - no funds to upgrade
- Proven efficacy of the Supportive Housing approach nationally and successful local SH program.

Challenges - Angst

- Providers had a financial stake in their facilities, downsizing meant closing whole facilities
- Impact on WSH discharges
At the RSN everyone agreed on the long term benefit, but had concerns about the short term impact on WSH discharges.
- Lack of available subsidized housing for this new project.
- Boarding homes were seen as permanent housing for residents, residents felt safe at facilities and liked the sense of community, parental concerns about residents moving out and losing stability.

Strengths of the Plan

- We had time (time for providers to gradually downsize)
- Program was revenue neutral, no need for new funding
- Eventually something had to be done with the older facilities - motivator

- Consumer data supported our goal to provide an alternative to boarding homes
- Consistent with Recovery Model
- SH was a proven approach

Program Design

1. Transitional benefit - up to two years
2. Service package would need to serve both boarding home discharges and WSH discharges
3. Created a new benefit rate that was revenue neutral- Residential rate + OP benefit rate = SSH benefit rate
4. Started with two Providers
5. Used a scattered site, cluster house, set-aside model
6. Housing is permanent and subsidized
7. Low caseloads 15:1
8. CM scheduled to work 7 days a week
9. Use a SH approach - services provided at the housing site
10. Focus on building natural supports and community integration activities ("Someone to see and something to do")
11. We use the LOCUS (Level of Care Utilization System for Psychiatric and Addiction Services - Adult Version 2000) assessment tool developed by American Association of Community Psychiatrists
12. Providers report on the High Intensity Modality

Where We Are Today

Year	\$\$\$	Beds
2005	1,993,047	340
2009	1,222,797	159

- Reduced the # of beds by 53% and
- Reduced the SL budget by 39%
(The difference is a result of a rate increase of the SL rate in 2008 - also raised the SSH benefit rate).
- 5 boarding homes have closed
- Created 195 new SSH slots
- Current SSH Placements - 115
- In 2008 we added two additional SSH Providers, now have 4 providers and 4 teams.
- In 2009 we added Rental Assistance for 35 persons in 2009 with MIDD funds
- In 2009 new housing units will come on-line for SSH

- SSH is funded primarily by Medicaid
- The majority (approx. 85-90%) of consumers graduate from SSH to an Outpatient benefit within 2 years

Timeline

- 2001 - Internal planning discussions begin
- 2001 - Medical assessment of boarding home consumers completed
- 2002 - Residential Study of consumers and staff
- 2003 - Statement of Policy Intent to Downsize Boarding Home Beds issued to Providers
- 2004 - Planning meetings with residential providers
- 2005 - RFQ/ Letter of Intent
- 2005 - SSH Start-up with 72 slots
 - One facility closed - 53 beds
 - At another facility 19 beds were closed
- 2008 - 3 facilities closed end of 2007 and 2008 for total of 109 beds
- 2008 - Two additional providers added
- 2009 - 35 Rental subsidies added
- 2009 - New housing coming on-line for SSH

From "Transforming Housing for People with Psychiatric Disabilities Report" SAMHSA, Center for Mental Health Services 2006

"Board and care homes, which are also known as adult homes, emerged as a tentative solution to the problem of housing low-income people with psychiatric disabilities in an environment that offered few alternatives."

"Reliance on board and care homes needs to be reconsidered. States are relying on them too heavily when more integrated arrangements are possible. Too many of these homes are being managed in ways that barely distinguish them from large institutions."

"Even many smaller board and care homes operate like institutions. In these smaller homes, residents are required to line up for their medications and to receive their disability checks; they have little privacy and little choice concerning roommates, meals, or activities; little effort is expended helping them get jobs or job training; and there is no effort to help residents find more integrated housing or to plan their departures. Most problematic is the fact that most residents in board and care homes live with more than 51 residents."

The "Transformation Proclamation":

A Consensus Statement on Board and Care Homes

The participants in the national strategy meeting adopted the following consensus statement:

The Americans with Disabilities Act [ADA] and the Supreme Court's Olmstead decision require that state and local mental health agencies provide access to housing and other services in the "most integrated setting" appropriate to the needs of people with psychiatric disabilities. That means a setting that enables them to interact "to the fullest extent possible" with people who do not have disabilities.

We firmly believe that board and care homes serving people with psychiatric disabilities—as currently configured—are generally not consistent with the ADA and the Olmstead mandate, and that the overreliance on such homes undermines recovery, community integration and the transformation of the public mental health system called for by the President's New Freedom Commission on Mental Health. The current system of monitoring, oversight, and licensure does not ensure a quality, recovery-based environment.

Every person with a psychiatric disability deserves a range of housing choices and to live in a home of his or her own. That includes the full rights of tenancy, including a lease, a key, privacy, and the choice of roommate, where relevant.

We believe that state and federal government should take urgent action to ensure that public funds are no longer expended to support segregating living arrangements such as board and care homes. Rather, these funds (including SSI and SSDI disability benefits, state supplements, rent subsidy benefits and funds available from any other federal, state or local source) should be converted into an individual benefit or voucher that will, with any infusion of new money necessary to augment these resources, permit people with psychiatric disabilities to purchase housing of their choice.

This is a matter of highest priority for transformation of the public mental health system. Failing to attend to this matter will diminish the promise of integration for people with psychiatric disabilities and undermine the goal of recovery.