DIRECT ACCESS TO HOUSING

Established in 1998, the San Francisco Department of Public Health's (SFDPH) Direct Access to Housing (DAH) program provides ***permanent housing*** with on-site ***supportive services*** for approximately 400 formerly homeless adults, most of whom have concurrent mental health, substance use, and chronic medical conditions.

SFDPH, with a budget of over $ 1 Billion annually, operates a large public hospital, the largest publicly funded skilled nursing facility in the country (1,200 beds), 26 primary care and mental health clinics, and contracts for a broad array of services through community-based providers. Finding appropriate housing for individuals who have few family or community connections is a major challenge for staff of these public or community-based organizations. Without access to a stable residential environment, the trajectory for chronically homeless individuals is invariably up the "acuity ladder" causing further damage and isolation to the individual and driving health care costs through the roof.

The DAH program was developed in an attempt to reverse this trajectory through the provision of supportive housing directly targeted toward "high-utilizers" of public health system. DAH is a "low threshold" program that accepts single adults into permanent housing directly from the streets, shelter, acute hospital or long-term care facilities. Residents are accepted into the program with active substance abuse disorders, serious mental health conditions, and/or complex medical problems.

I. Permanent Housing

Currently, the DAH program provides 483 units of permanent supportive housing in seven Single Room Occupancy (SRO) hotels and one licensed residential care facility ("board and care"). The seven DAH buildings range in size from 33 to 92 units. The majority of the units have private baths and shared cooking facilities. At the residential care facility, three meals per day are prepared for the residents.

SFDPH acquires sites for the DAH program through a practice known as "master leasing". The main benefits of this approach include the ability to rapidly bring units on-line and the reliance on private capital for the upfront renovation costs. In addition, the renovated buildings combined with on-site services stabilize properties that have often been problematic for the surrounding neighborhood.

The key components of SFDPH's strategy include:

1. Identifying privately-owned buildings that are vacant or nearly vacant where the building's owners are interested in entering into a long-term lease with SFDPH. These are triple net leases with the owner retaining responsibility only for large capital improvements.

2. Negotiating improvements to the residential and common areas of the building prior to executing the lease. It is the owner's responsibility to deliver the building with improvements completed and in compliance with all health and safety codes. Improvements typically include build-out of supportive service and property management offices, community meeting rooms, community kitchens, and additional bathrooms. All rooms are fully furnished prior to occupancy.

3. SFDPH contracts with one or more organizations to provide on-site support services and property management. Most buildings include a collaborative of two or more entities.

II. Supportive Services

All seven sites have between three and five on-site case managers as well as a site director. Most of the case managers are bachelors level social workers though some are formerly homeless peer advocates and some have advanced social work degrees. Site directors are generally masters level, licensed social workers or registered nurses. Case managers assist residents to access and maintain benefits, provide one-on-one substance use, mental health, life skills and family counseling, assist in accessing medical and behavioral health (mental illness and substance abuse) treatment, assist with accessing food and clothes and interface with property management to assist in preventing eviction.

All seven sites also have access to a roving behavioral health (BH) team made up of three BH specialists. The BH team is available to residents for scheduled one-on-one counseling and groups and can be available five days a week for rapid intervention and placement of residents in off-site mental health and/or substance use residential treatment. The primary goal of the BH team is to prevent eviction resulting from exacerbation of mental health and substance use disorders. The residential slots are "pre-paid" to circumvent the usual queuing necessary to access these services. While in residential treatment, a resident's permanent room is held for them for the duration of the treatment. BH counselors follow patients while in residential treatment and assist in reintegrating them back into the community after treatment.

All sites have access to some medical care. Most residents have primary care providers at one of the public health clinics. At the RCF, there is around the clock nursing services. One residential hotel has five-day-a-week nursing services, three-day-a-week urgent care medical services provided by an on-site nurse practitioner and a full time on-site licensed social worker. The two sites with nurses can offer residents directly observed therapy for psychiatric and HIV medications, as well as other medications, five days a week. The other sites have access to an on-call nurse practitioner for urgent care home visits. At all sites, staff meet monthly with the medical director for the DAH program to assist with medical treatment plans and to strategize on how to access appropriate medical and psychiatric care in the community.

III. Eligibility and Referral

Residents are specifically recruited into the DAH program if they are high users of the public health system and have on-going substance abuse, mental illness and/or medical problems. Residents do not need to be recipients of SSI or general assistance. Building staff work to "screen in" prospective tenant rather than looking for reasons to deny housing. People with a history of a felony conviction (including child sexual abuse or endangerment), fire starting, drug and alcohol use or undocumented status are not restricted from access to a DAH

facility. Many of the individuals housed in the DAH program have been unable or unwilling to maintain permanent housing for any extended period of time in their adult lives. Persons who are gravely disabled and/or have a skilled nursing need are not able to be accommodated in DAH housing. DAH works with specific "access points" that provide care to chronically homeless people. These referral points include street outreach teams, emergency shelters, high-utilizer case management teams, primary care clinics, and institutional settings. Each unit in the DAH buildings is "attached" to specific referral point. As new buildings come on line, the building's units are assigned to specific agencies depending on funding source for the building and the needs of the public health system at the time of rent-up. For example, the first DAH facilities were designed to house people directly from the streets and therefore a large percentage of the units are controlled by agencies such as Healthcare for the Homeless and other outreach teams that serve people who are street based or staying in emergency shelters. For the residential care facility, residents are referred from the city-run locked psychiatric rehabilitation facility, the public skilled nursing facility, and the acute psychiatric ward at San Francisco General Hospital.

IV. Practicing Low-Threshold Supportive Housing

All residents in the DAH facilities have tenant rights and all services offered to residents are voluntary. On-site support service staff actively engage residents and attempt to assist individuals in making choices that reduce their physical, psychiatric or social harm. Over time, as residents develop trust in the on-site staff, the resident is able to work with the staff to develop and adhere to an individualized treatment plan. For residents that are unable or unwilling to accept offered services and/or to reduce harmful behavior, staff continue to regularly engage residents in dialogue and continue to offer services. A considerable amount of staff meeting time and supervision is spent supporting staff to maintain empathy and engagement with residents despite some resident's poor choices and outcomes.

V. Financial Information

Funding for the DAH program comes predominantly from the city general fund. Other revenue sources for the project include state money targeted toward homeless mentally ill persons, Ryan White Care Funds, SAMHSA, and reimbursement through the Federally Qualified Health Center system for a portion of the medical and mental health related expenses. Approximately 80% of DAH residents receive SSI and Medi-Cal (California's Medicaid system) benefits. The buildings also receive revenue from tenant rent. Residents pay fifty percent of their income towards rent. Total cost to provide permanent housing and support services in DAH buildings (excluding the one licensed residential care facility) is approximately $1,200 per month per resident. The average rent received from residents is $300 per month therefore requiring a $900 per month subsidy from governmental sources.

VI. Outcomes

The main goal of the DAH program is to provide housing to a group of people that have rarely, if ever, maintained stable housing as adults. Since opening the first DAH site in 1998, almost two-thirds of the residents have remained housed in the DAH program. Of the remaining one-third of the residents who moved out of the program, half moved to other permanent housing. Only 6% of residents were evicted from the housing facilities. Evictions usually resulted from repeated non-payment of rent (despite money management), violence or threats to staff or residents or destruction of property. Not surprisingly due to the severity of medical illnesses among the population housed in DAH, 5% of DAH residents have died.

Given that DAH is funded by the health department, an important outcome measure is health care utilization before and after placement in the program. Overall, DAH residents used a considerable amount of health care services prior to entering the DAH facility. Each DAH resident averaged 12 visits to outpatient medical services in the year prior to placement in the facility. After placement, there

was little change in outpatient visits in part because on-site case managers encourage residents to maintain primary care appointments. On the other hand, emergency department use was reduced significantly after housing with a 58% reduction in emergency department utilization after entering the program. Similarly, in the first two years after entering the program, there was a 57% reduction in inpatient episodes after entering the program compared to the two years prior to housing placement.

About one-sixth of residents had exacerbations of their metal illness leading to psychiatric hospitalization both before and after placement in the program. However, the number of days per hospitalization decreased significantly after placement. This is not surprising as discharge from psychiatric hospitalization is often delayed due to lack of available appropriate community based housing. The DAH problem routinely holds a resident's permanent housing unit during a period of acute exacerbation of their mental illness.

For further information contact:

Marc Trotz, Director
Housing and Urban Health
San Francisco Department of Public Health
101 Grove St ,Rm. 323
San Francisco, CA 94102
Tel: 415-554-2565
E-mail: marc.trotz@sfdph.org

Josh Bamberger, MD, Medical Director
Housing and Urban Health
San Francisco Department of Public Health
101 Grove St., Rm. 318
San Francisco, CA 94102
Tel: 415-554-2664
E-mail: josh.bamberger@sfdph.org

Margot Antonetty, Director of Programs
Housing and Urban Health
San Francisco Department of Public Health
101 Grove St. Rm. 323
San Francisco, CA 94102
Tel: 415-554-2642
E-mail: margot.antonetty@sfdph.org

April 2004