Minutes

Supportive Housing Subcommittee

July 26, 2016
12:00 – 2:00 p.m.
1 Civic Center, 9th Floor Conference Room

Type of meeting: 2nd Meeting

Members Present: Betty Valdez, Constance Banuelos, Hedi Jordan, Gina Bell, Robert Baade, and Sister Agnes Kaczmarek

Members Excused: Britt Baca Miller, Michelle Valencia Stark, Ricki Bloom

Staff Person Present: Cathy Imburgia

Technical Advisors Present: Karen Meador

Meeting Observers: Craig Pacheco, Lisa Simpson, William Mutidjo, Jeffery Hertz, Ilse Biel

Call to Order

The first portion of the meeting consisted of a joint meeting with the Community Supports Subcommittee. Betty Valdez called to order the joint meeting. Following introductions, approval of the minutes and agenda, and two presentations — Case Management by David Ley and Supportive Housing by Catia Sharp — the two subcommittees met individually.

Discussion to Approve Agenda

Agenda was approved with no discussion.

Discussion to Approve Minutes

Minutes were approved with no discussion.

Key Items of Discussion

- The joint subcommittee meetings included two presentations to provide background information on supports, including Case Management and Supportive Housing models. It was noted that there are challenges to access the needed level of services due to not knowing how to navigate the system and that varying funding streams and diagnosis requirements create additional barriers Included is the document distributed during David Levy's presentation (Attachment 1).

- The Community Connections Permanent Supportive Housing proposal for recommendation, a jail re-entry diversion initiative for those with serious mental illness that is a City/County collaboration, was distributed during the meeting. Community Connections is the initial Supportive Housing Subcommittee project for consideration to the ABCGC. Included is the proposal (Attachment 2).
- The subcommittee will hear a presentation by Lisa Simpson on the project at its next meeting to more fully understand the project and to provide input to the proposal. Lisa will also provide additional project information prior to the next meeting for review.
  ACTION: Committee members are to review the additional information and Community Connections proposal in preparation for the next meeting.

Next Meeting and Adjourn

Next meeting: August 10 at 5:00 – 6:30 p.m.at 1 Civic Plaza – 9th Floor.

- Betty adjourned the meeting at 1:35 p.m.

Attachment 1:

Albuquerque/Bernalillo County BH Task Force
Case Management Subgroup
(September 2014)

EXECUTIVE SUMMARY

The Albuquerque and Bernalillo County area have a complex array of behavioral health and social services, with a great many different funding streams contributing to services. Unfortunately, it is quite challenging for citizens and individuals in need to penetrate this complex system, and connect with the right services, at the right time, in the right situation. Because funding for most services is based on eligibility, or limited to certain programs or categories of need, it is very frustrating and challenging for most individuals to be able to effectively access the appropriate services and benefit from them.

Case Management is a general term used to describe an array of overlapping services, all of which provide general paraprofessional assistance to individuals in accessing and connecting with services, programs, supports, and benefits. Case managers often act as "navigators" to help people in need to find their way through our complex system, connecting people in need to the right services and resources, and helping them to obtain or meet categories of eligibility, such as obtaining Medicaid, etc. Case Managers help in a holistic manner, assisting people in addressing both social, as well as medical/behavioral health issues. Thus, Case Managers help people to obtain psychiatric assessment and treatment, but also help them to fill critical social needs such as housing, employment, education, childcare or social activities.

In a highly fragmented, "siloed" system of care, such as exists in the Albuquerque/Bernalillo County area, case managers/navigators are a critical and necessary stopgap intervention to assist people in need to access necessary services. Unfortunately, while our area has a wide array of programs and services which include Case Management, these programs are equally siloed, with category and eligibility restrictions. Such services are often short-term in nature, and extremely specific and limited to certain issues or areas, and there is not a high level of community awareness that these programs exist. Even within systems such as UNM or the Medicaid-provider system, there is little internal communication or coordination between various overlapping case management services. Medicaid/State funding of Case management services within the Albuquerque/Bernalillo area is extremely limited, to restricted providers who serve a limited group of clients.

Increased access to Medicaid for adults has not yet resulted in a significant change in access to services such as case management, or expansion in capacity of services which are available. Despite attention towards integration of mental and physical health, there has been little on the ground work to support Case Managers and other paraprofessionals in addressing medical needs along with behavioral health.

Recommendations:

- **Immediate Local Actions:**
  - Increase city and county funding of case management services, based on determination of need, rather than eligibility. Program strategies such as the UNM Pathways Program and the UNM Fast Track programs offer models which could be replicated and expanded, and may better serve the community if they were more widely available and marketed.

- Support a systemwide Albuquerque-area BH resource database/list, which is maintained and kept up to date;
- Support a low –level referral/coordination system, ie, a 311 information system to provide basic service contact information to callers;

- **Mid-Range Local Actions:**
  - Support development of a "one-stop shop" or Central BH Hub/clearinghouse of BH coordination within the City/County;
  - Support the efforts of Community Engagement Teams (CET) to assist individuals in connecting with services prior to emergency;
  - Create a City/County statutory body, entity, or committee which is tasked with monitoring and monitoring the effectiveness of the local behavioral health system of care;
  - Encourage MCO's to add Case Management as a Value-Added Service (VAS) in the interim period to State restoring it to Fee Schedule;
  - Encourage CNM to develop and implement a "Community Health Worker" certification program which integrates behavioral health Case Management;
  - Support enhanced rates for services provided in a language other than English;
  - Identify ways in which Community Health Workers can be reimbursed through local and State funds.
- **Long-range State Initiatives requiring advocacy to state legislature and HSD/BHSD for:**
  - Resume provision of Targeted Case Management as a Medicaid-billed service to provide short-term assistance to clients in accessing and engaging in services;
  - Expand provision of Medicaid- and BHSD-funded CCSS, either through expansion of CSA system, or allowing non-CSA providers to apply for CCSS.
  - **Payment reform – Encourage development of more performance-based forms of reimbursement**
  - Support of access services such as Community Engagement Teams, Crisis Stabilization Unit and other non-emergent means by which consumers may access and engage services;
  - Incorporate Community Health Workers and Case Management services/needs into State plans for Health Home and BH/Medical integration.
  - CCSS services may need to be redefined at a State level to focus on provision of Section 2703 ACA services, including care management, individual care coordination and health promotion, transitional services, consumer and family advocacy, and linkage to community resources.
  - Investigate technology that may be used to offer greater appointment access and support, and explore methods of reimbursement for such services.

Consumer/Community Comment

We had our son go to a private psychologist from 16 - 18. She tested him and was not able to make a diagnosis but a list of issues. We thought that we had a "bad kid". We sent him to live with an uncle to get him away from his "friends" and finish high school out of state. While on a trip after graduation he had a manic attack where within a week he was in an outpatient

psychiatric hospital in Sacramento, Ca. After an all day analysis with 3 doctors, he was diagnosed Bi-Polar. He now sees a private psychiatrist. The doctors and psychologists were not much help with finding family support. We researched online and found DBSA and NAMI. Both groups have bent over backwards to help with information and direction. We have been surprised at the lack of knowledge from the professionals on how to help the family, who helps direct services for the family member. The focus is on the patient who may not have the foresight that they need help. HIPAA is a disaster in terms of helping the patient. People with mental illness need help from family and friends to assist with medication and patient care. They do this in the dark once the patient turns 18.

I am the father of a 27 year-old son diagnosed with schizophrenia. Our son is unable to admit to needing or seeking help to make his life peaceful and meaningful, and is anxious about issues involved with initiating help. He has been living with us for almost a year, and we are at a loss as to effectively find needed resources, while our inquiries to help are hindered by the current system for patient protection and insurance issues. We ourselves are not clear on the actions it would take to get the help we need to help our son and our family to deal with his mental health. We are currently in the NAMI "Family to Family" program that has helped us to understand the disease and some of the resources available, and we have gotten some insight through contact with mental health resources and community meetings. I've made many calls to services, but can't seem to get a definitive path to begin help, especially since our son is protected under HIPAA, and unless we take more drastic measures than persuasion, he is resistant to seek help. Unless he is a direct threat to himself or others, our hands are tied to call law enforcement, which feels extreme, and I'm afraid may cause more harm than good. I feel that we need to categorize community services and develop a pathway to them. We also need to have a more robust non-crisis intervention resource to help families like mine that can work with families to get those that need help, be able to get it—difficult, but necessary. Our son has looked for help, but has been lost in the process. Develop one-stop shops; that allow easy application for Medicaid, and easy entrance to the system—keep it consistent and advertise it with flyers, banners, and the web.

Medicaid:
Prior to 2007, Case Management was a Medicaid service. CMS reportedly was concerned about the abuse of Case Management, and the service being used in open-ended, non medical-necessity situations. Around 2007, HSD amended State Plan Amendment, removing Case Management as a service, and replacing it with Comprehensive Community Support Services.
(Targeted Case Management is still on NM Fee schedule/State Plan Amendment, but is limited to the activities of CYFD for children in foster care)
Case Managers typically assisted clients in accessing benefits and resources, coordinating therapy appointments, enroll in educational and/or vocational programs, helped clients apply for SSI, welfare, coordinated housing services, etc. Because many of these needed services weren't explicitly related to medical/mental health conditions and didn't fit well into current medical model billing, there were concerns that Case Management was more of a "social service" than a medical one.
There were concerns at the time that Case Management services were not focused on client's strengths, or on recovery/resiliency. Goal of CCSS was to "teach client to do for themselves," rather than doing for client. There was/is an implicit assumption that some Medicaid/State-funded clients lack initiative or skills to achieve and access services, as opposed to acknowledging the institutional and systemic barriers. CCSS focuses back on the client's deficits, rather than the system's.
CCSS was implemented and restricted, in terms of units/amounts per client, and per agencies authorized to perform service, limited to Core Service Agencies (CSA). Many agencies which could provide Case Management were unable to provide CCSS after the change. Despite significant reductions in out-of-home care and increased Medicaid enrollment, there hasn't been an increase in CCSS capacity, but instead, a reduction.

> Core Service Agency (CSA) is a statewide initiative, which limits certain services (including CCSS) to specific agencies, and creates access standards for agency. Many State (non-Medicaid) BH funds are limited to CSA. Initially intended to create a youth "CMHC," the project's scope was extended to the adult system, and to create a "clinical home," which followed clients and ensured coordinated care. CSA was named in regulations and Centennial plan, but no regulations are promulgated for CSA, no current CSA requirements are in place, and access standards are not currently enforced. Per contract, MCO's are limited from naming new CSA's until after 2nd year of Centennial. It is unclear as to how much the CSA system is currently meeting goals and needs.

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individuals who are not Medicaid-eligible, though the CCSS rules are identical to those of Medicaid. Under CYFD-funding, CCSS may be provided to some individuals who meet "at-risk" category.
CCSS allows/includes peer support services, though the extent or full use of this capacity remains low and under-developed.
Comprehensive Community Support Workers (CSWs) are not case managers. CCSS activities specifically address independent living, learning, working, and social and recreational efforts. They embody particular core values:
-Individuals and families are the experts (on their own lives).
-Personal choice should be supported.
-CSW's are collaborators, not directors.

-CSW's demonstrate respect.
-CSW's assist in identifying strengths.
-CSW's assist in identifying solutions to barriers that negatively impact the achievement of previously identified goals.

Comprehensive Community Support Workers (CSWs) may perform the following services and activities:
-Help the client define what recovery means to them individually and set appropriate and attainable goals.
-Assist the individual to develop and coordinate a recovery and crisis management plan.
-Assess, support, and recognize symptoms of a potential crisis situation and early signs of relapse.
-Coordinate programs to assist gaining access to rehabilitative, medical, and other services.
-Support clients in identifying strengths and barriers in developing skills necessary for recovery and resiliency.
-Assist in developing interpersonal and functional skills, including adaptations to home, school, and work environments.
-Assist in developing natural supports in the work place, social, and school environments.
-Assist in building symptom management skills, including behavior management, knowledge of medications and their side effects, and development of skills to take medication as prescribed.
-Assist with practical and vocational skills such as financial management, obtaining & maintaining stable housing, and school/employment performance.
-Monitor progress to determine if services meet the individual's needs.

In Bernalillo/Albuquerque, CCSS providers are:

- Adult- UNMH, St. Martin's, Agave. FQHC's (First Choice, First Nations, and AHCH can bill/provide CCSS but are not for the most part). TLS provides some CCSS for clients within their housing. YDI and Open Skies are both authorized to provide CCSS to adults, but are doing so at limited levels, under initial plan of "transition-aged" individuals.
- Child – UNM (CPH), YDI, All-Faiths, Open Skies.

Case Management remains an activity within some Medicaid services, such as Assertive Community Treatment; MultiSystemic Therapy; RTC; Inpatient psychiatric/medical; TFC, etc., where same-day CCSS billing is prohibited and case management services are expected to occur within umbrella service.
Forensics Case Management services at UNM-Psychiatric Center also provides limited case management services to the jail diversion target population who may be referred from Metro Court, District Court or Community Corrections who have not received a Psychiatric assessment within the last 12 months or have a mental health diagnosis but it does not qualify as an SMI. The program mission is as follows:

- To maintain a Jail Diversion program, in order to divert consumers from the criminal justice system and to direct persons in the target population into more appropriate services. Appropriate services may include referral to psychiatric and/or substance abuse

treatment, medical services, educational and vocational resources, and other community, state and federal resources.

- To assist the consumer in not only the completion of their legal supervision, but also in their recovery, and the pursuit of their personal, social, educational, and vocational goals. The Forensic Community Support Worker seeks to engage the consumer with mental health and/or substance abuse problems in the process of recovery through increasing their ability to cope with mental or emotional difficulties that arise, through learning to independently access and maintain treatment and other services, through the development independent living skills as well as the development of natural social supports.
- To coordinate with criminal justice system, including pre-trial services, mental health courts, state probation and parole, to thereby assist the consumer navigating their way through the criminal justice system.
- Currently UNM has 5 CSW's that serve the Jail Diversion population and one CSW who supports the Fast Track program out at MDC. Each case load is approximately 20-30 clients with the average monthly census of 106 clients within the Forensics Case Management department.

Case management is a covered service under Medicaid waivers for Developmental Disability, and Home and Community Based Services.
Care management, care coordination, and other functions still reside within Managed Care, and provide some limited Case management type functions, but focused solely on accessing health services.

Non-Medicaid:

- AMCI reimburses for Case Management under voucher for substance abuse services – limited to 4 hours per voucher. **Case Management:** is a professional helping process whereby adult and/or adolescent clients participating in a program receive non-counseling services appropriate to their needs either at the program or, if necessary, through facilitated referral. Typical case management services include such activities as helping clients to secure access to educational services, employment services, job training programs, health and welfare services and others based on the secondary needs identified in the client's initial assessment at AMCI and supplemented with other needs identified during their time in treatment. Case management services can be provided by a primary counselor, a nurse, or a position employed specifically to be a case manager. *(See Case Management Definition, City Minimum Standard,).* **(Maximum of 16 units per voucher)** Time spent for billing for services is NOT a case management function, nor are providing reports to the court for DWI or criminal justice clients, rescheduling appointments, or other administrative activities, or dispensing medications, or writing progress notes or other documentation.
- Value-Added services from MCO – do not currently include Case Management
- HIS facilities can provide CCSS. Unclear if they do so, or provide Case Management instead under separate funding

- Medicare and commercial insurances don't reimburse for Case Management
- UNM – Pathways and Project Echo: Provide Case Management within these programs
- Some City grants include Case Management for people enrolled in program, eg. NM Solutions' Co-Occurring Disorders Programs
- Housing programs such as Supportive Housing, Heading Home have Case Management services embedded within or required.
- Some programs such as DVR, TANF do limited case management
- CYFD provides Case Management often as a part of Child-protective services
- Police and Sheriff's departments have limited case management (CIT, COAST, etc), though many police officers often end up engaging in limited case management
- Jails have Case managers for discharging
- Case managers at MATS
- Community Engagement Teams – was a part of a 2014 legislative bill, and is part of a current NAMI-initiative, to develop and pilot a non-emergency program designed to use peer and professional supports to assist individuals living with mental illness to access services.
- Many therapists do case management as an unreimbursed part of therapy, because their clients are unable to access other supports for case management
- DD waiver case management

UNM Pathways Program, through Health Sciences Center. Operating since 08. Funded by County Mill Levy, serving approx. 450 clients per year. Provides case management/navigation on "pathways"/tracks of need. Strong model which could be expanded and better publicized.

Gaps:

- **Funding:**
  - The majority of Case Management services are provided solely "within-program," based upon category, program-eligibility, or funding limitations.
  - Medicare, commercial insurances don't reimburse for Case Management
  - Medicaid limitations on medical necessity, allegations of fraud, etc., limit provider willingness or availability to expand CCSS services
  - Medicaid restrictions on agencies who can provide CCSS (CSA, CMHC, FQHC, HIS) make more sense in a rural environment, where there are few providers, than in Albuquerque.
  - Unclear overlaps between case management, CCSS, care coordination, and MCO activities confuse clients and providers.
  - Hodge-podge nature of system of funding for Case Management leads to different rules, eligibility, access strategies, service provision strategies, client expectations and experiences, which can be bewildering to clients and citizens.

    - There is no association of Case Managers, licensing or certification of case managers, no overarching umbrella over these various entities, services, etc., to ensure best practice, good care, or to facilitate information sharing and resource/referral development for case managers in different programs.
    - Peer support services are inconsistently and unclearly supported from a Statewide level, and from varied providers.
    - Redundant funding and services – many people interact with numerous case managers in different programs
    - Funding/legal limitations restrict use of many technologies such as social media, teleconferencing, etc.
- Clients who would benefit from Case Management to assist in accessing resources and benefits, often have difficulty obtaining case management, or even knowing that it exists;
- Within Albuquerque, Case Management remains quite siloed between Mental Health and Substance Abuse divisions. For example, the AMCI voucher is intended for substance abuse services and case management services are largely focused on this. Medicaid-funded CCSS is predominantly focused on Mental health issues, with some limited co-occurring disorder attention.
- Case managers all develop their own individualized resource lists, recognizing that these lists of services, contacts, processes, benefits, etc., are constantly evolving and changing.
- Siloed system of services and funding hinders integration of medical and BH services/needs
- The strength and successes of Case Management are rarely celebrated or acknowledged. These are folks in the trenches, whose work rarely gets identified or held up, though they usually have far more contact with individual clients, as opposed to therapists and psychiatrists. CM work often results in greater changes to basic needs, strengthening a person's whole life.

Recommendations:

- Needs-Based Provision of Case Management, rather than eligibility (funding stream) based system
- Development of City/County-wide, updated, monitored Resource/Guide list for services, benefits
- Use City 311 system to update resource guide, direct clients to it, and to Case Management resources
    - Could we support a phone number/resource system of its own? "424" = 4BH
- City/County funding of Case Management may be used for Medicaid match, through partnership with HSD.
- Pursue/encourage greater support of Peer Support/Peer Specialist models of CCSS/Case Management

- Support integration of Case management services within Health Home/Patient Centered Medical Home model of integration with Physical and Behavioral Health.
- Delineate “levels” of Case Management services, distinguishing between short-term “quick and dirty” case management, versus longer-term case management/coordination needed to support stability.
- Work with HSD/CMS to restore Targeted Case Management to Fee Schedule
- Work with HSD/BHSD and MCO’s to expand CSA system or open access to CCSS to non-CSA agencies/providers.
- **Pie in the sky – Could an Albuquerque/Bernalillo County Waiver/Carve-out be possible, with blended funding? (similar to Milwaukee Wraparound)**
- **Pie in the sky – Are there technological innovations (Apps, texting, teleconferencing, social media) that could be utilized for Case management/coordination?**
- Clients networking with other clients to share resources using technology could be beneficial. Again, this could go through a 4BH (424)—(for Behavioral Health) number and web service.
- Also, a “for behavioral health” contact could be a repository for all health/social services and resources - behavioral issues are often interwoven with needing jobs, food, shelter, and other BH-related services. Breakdown could be Social Services, Jobs, Behavioral Health, etc.
- Encourage MCO’s to add Case Management as a VAS in the interim period to State restoring it to Fee Schedule.
- Support a “one-stop shop” or Central BH Hub/clearinghouse of BH coordination within the City/County
- Support the efforts of Community Engagement Teams (CET) to assist individuals in connecting with services prior to emergency.
- CCSS services may need to be redefined at a State level to focus on provision of Section 2703 ACA services, including care management, individual care coordination and health promotion, transitional services, consumer and family advocacy, and linkage to community resources.

Attachment 2:

MEMO: **Community Connections Permanent Supportive Housing**
DATE: **July 26, 2016**
TO: ABCGC: Subcommittees on Housing and Community Supports
FROM: Katrina Hotrum

Executive Summary

- Intervention: Permanent supportive housing.

- Target population: Individuals with behavioral health/co-occurring issues, history of involvement with the criminal justice system and whose living situation is not conducive to stabilization and sober living.

- Services: Intensive case management with -wrap around supports; independent housing through existing area landlords.

- Evidence base: Studies, including cost-benefit analyses of programs, have found reduced criminal justice involvement resulting in reduced law enforcement encounters and reduced days incarcerated; reduced use of emergency health care services; increased use of primary care and recovery services; reduced use of detox services; reduced abuse of alcohol; and increased housing stability for individuals served.

- Proposed outcome metrics:
    - Reduced involvement with law enforcement
    - Reduced use of jail
    - Reduced use of emergency rooms and inpatient hospital stays
    - Reduced use of detox
    - Reduced use of NM Behavioral Health Institute
    - Reduced use of substances
    - Improved family outcomes
    - Increased employment

- Budget: $1.3 M annually.

- Proposed language of recommendation: The ABCGC Subcommittee on Housing recommends that Bernalillo County permanently finance the Community Connections program using the behavioral health gross receipts tax revenue.

Intervention

Permanent supportive housing is a critical service for the highest-need subset of the behavioral health population that is currently accessing expensive remedial services like the criminal justice system, hospitals, and detox facilities. According to the New Mexico Coalition to End Homelessness (NMCEH), of all individuals entering any type of federal Department of Housing and Urban Development (HUD)-funded housing in 2014, over 2,000 had a mental illness and almost 1,500 had a substance use disorder.

The Link Between Criminal Justice and Homelessness

Homelessness among individuals with behavioral health issues costs the government, including the county and the city, money and resources. These individuals are more likely to be arrested, incarcerated, and to use the emergency room than the general population. Researchers have found that an estimated 25-50% of the homeless population has a history of incarceration. In Bernalillo County, "Homeless/drunk" is the 16th most frequent emergency call code responded to by the Albuquerque Police Department. Permanent supportive housing has been shown in studies to produce improved outcomes for these high-need individuals, which in turn produces savings in health care and criminal justice systems.

A study of 6,953 jail inmates found that individuals with homelessness in the year prior to incarceration had symptoms associated with mania, depression, psychosis, and substance use at 10-22% higher rates than inmates without prior unstable housing. Another study of 3,769 arrestees and jail inmates with serious mental illness found that being male, homeless, not having outpatient mental health treatment, and having an involuntary psychiatric evaluation were independently associated with increased odds of misdemeanor arrest and longer periods of incarceration.[1] Incarcerated individuals find many barriers to accessing services upon release. There are many inmates who may not meet the HUD definition of homeless but are precariously housed. This may include housing they cannot sustain, housing from which they have been asked to leave or evicted at any time, or housing in which drug use or criminal activity is prevalent. This barrier to successful community reentry often contributes to the risk of criminal activity and increased recidivism.

Individuals with behavioral health needs are also prevalent in this community and even more prevalent in our jails. A 2006 Bureau of Justice report estimates that 64% of jail inmates had a mental health problem. While 21% had recent treatment and/or diagnosis, 60% reported symptoms that met the DSM criteria. A more recent study by the Policy Research Associates concluded that jail administrator can anticipate that the prevalence of serious mental illness will be between 11 and 18.9% among men and between 21.7 and 42.1% among women. In addition, impacting incarceration rates of those with mental illness, a local study by the New Mexico Sentencing Commission found that having received mental health services in the jail

[1] "In Focus" A Quarterly Research Review of the National Healthcare for the Homeless Council, Volume 2, Issue 2 November 2013, p. 1.

corresponded with increased lengths of incarceration in jail. 40% of the Metropolitan Detention Center (MDC) population received some level of psychiatric services while in custody. This population could be under estimated. A report by the Vera Institute of arrested individuals in Washington, D.C. found that 46% of individuals with mental health needs were not identified by any criminal justice agencies having contact with them.

Homelessness in Bernalillo County

According to the 2015 Point in Time (PIT) count, a count of street dwellers on one night in January required of all jurisdictions by the HUD, the Albuquerque metro area is home to 1,287 homeless individuals. That includes 260 chronically homeless individuals, 311 severely mentally ill individuals, 266 chronic substance abusers, and 188 veterans. 20% of Albuquerque's homeless individuals are American Indian and 12% are African American, both much higher proportions than seen in the general population of New Mexico.

Housing and services for this population in the Albuquerque area is inadequate to meet the needs identified above. According to the Behavioral Health Needs and Gaps Report published in 2002, only 19 percent of the adults needing public sector mental health services are currently being served. A 2004 report by the Arizona State University Applied Behavioral Health Policy group found that according to estimates from the National Survey on Drug Abuse, New Mexico had the largest treatment gap of any state with 3.5% of the population needing drug treatment services but not receiving treatment. The statewide Gaps Report noted that New Mexico has a higher than average jail population for its census and that this, as well as the prison population, is critically in need of specialized services. The report noted that the service needs of these groups are difficult to meet due in part to the inadequate transition process from jail or prison and to the lack of services designed for the unique needs of individuals with legal constraints, family reunification issues, and specialized housing and employment needs According to the 2015 Housing Inventory Count (HIC), also produced by HUD, the Albuquerque metro area has 302 units of shelter, 307 units of transitional housing, and 872 units of supportive housing. Compared to cities with a similar population, Albuquerque has only about 50% of the permanent supportive housing stock, about one third of the adult and family shelter units, and less than one third of the youth transitional housing stock.

For this reason, Community Partners, Inc.'s Behavioral Health Business Plan and the City/County Behavioral Health Task Force both recommended implementing additional permanent supportive housing in Bernalillo County as a critical component of an enhanced system of behavioral health care.

The County and City are jointly running the Community Connections program to support 100 units of permanent supportive housing. 55 to 60 units are funded by the County and 30 are funded by the City.

Target Population

The target population for Community Connections is individuals and families who have behavioral health needs, are homeless or precariously housed, and have a history of criminal justice involvement. The program attempts to target individuals who are likely to discharge from

jail to homelessness and those who may be delayed from discharge due to homelessness. Individuals must have income at or below 30% of the area median income (AMI). The program takes referrals from criminal justice actors including the district attorney, prosecutors, court staff, and jail staff, as well as self-referrals. Referrals are first screened for the four minimum criteria:

1. That the individual has income below 30% AMI;
2. That the individual is homeless or precariously housed, or that their housing situation is currently causing criminal justice involvement or other bad outcomes;
3. That the individual has a history of involvement with the criminal justice system; and
4. That the individual has behavioral health needs.

In addition to this set of minimum qualifications, some additional criteria help to prioritize referrals for participation in the program to ensure that the limited resources offered by the program are targeted at those most in need:

- Number of bookings at MDC;
- Severity of mental health and/or substance use disorders, as identified by the mental health unit of the referring entity.

Finally, providers interview referred clients to determine if the provider feels they can take the client.

Services

The program includes housing and wrap-around supportive services.

Individuals are most frequently referred to the program while in the custody of the MDC. Discharge dates from MDC can be unpredictable, and program staff may not be able to locate a permanent apartment for clients in time to discharge directly into stable housing. Therefore, the program operates two transitional housing units where individuals live while searching for a permanent apartment.

Permanent housing is provided through vouchers administered by the Bernalillo County Housing Department. Housing vouchers pay for apartments through area landlords. Tenants hold standard leases for apartments.

Permanent supportive housing services are characterized by voluntary participation, and are aimed at keeping the client stably housed while promoting recovery. Services may include:

- Case management
- Medical services
- Mental health services
- Substance abuse treatment services
- Peer support
- Parenting skills
- Education
- Vocational and employment services
- Money management services
- Life skills training

- Housing
- Lease compliance
- Eviction prevention assistance

Evidence Base

Permanent supportive housing has been shown to improve health and wellbeing of individuals with severe behavioral health needs and to reduce their usage of criminal justice and emergency health services in the community. Supportive housing proactively engages members of the household in a flexible and comprehensive array of supportive services, without requiring participation in services as a condition of entry or of ongoing tenancy. Research suggests that permanent supportive housing leads to a reduction in psychiatric symptoms[2] and better physical health outcomes[3].

According to a study by the National Gains Center, recent evidence from more than a dozen studies concluded that comprehensive integrated efforts help people with dual disorders, reduce substance abuse and attain remission. These approaches are also associated with a reduction in hospital visits, accessing psychiatric emergency services, reduce contact with law enforcement and unnecessary incarceration. A recent July 2012 Task Force under the leadership of Bazelon Center for Mental Health Law recommended that providing more supportive housing was the top priority for addressing the needs of the system system involved individuals with mental illness.

A Denver study found that 50% of supportive housing residents experiences improved health status, 43% had better mental health outcomes and 15% reduced their substance abuse.[4] A 2013 study of the Albuquerque Heading Home Initiative by the UNM Institute for Social Research (ISR) found that publicly funded costs, including housing, shelter, emergency room visits, inpatient medical and mental health stays, outpatient medical and behavioral health visits, social services like case management, emergency rescue and ambulance transports, and jail incarceration, were 32% lower after individuals spent a year in permanent supportive housing than in the year prior to being housed. That amounts to about $12,830 in system savings per individuals per year resulting from the permanent supportive housing intervention, net of costs of the program.[5]

Proposed Outcome Metrics

Outcome and cost savings metrics proposed for the population to be served include but are not limited to the following. Some outcomes may not be applicable to some individuals. Subcommittee input on outcome metrics and how to measure them is specifically desired.

- Reduced involvement with law enforcement

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[2] Rog, D.J., Marshall, t., Dougherty, R. H., George, P., Daniels, A. S., Ghose, S. S., & Delphin-Rittmon, M. E. (2014). Permanent Supportive Housing: Assessing the evidence. Psychiatric Services, 65(3), 287-294.

[3] G

[4] Perlman, J., Parvensky, J. (2006). Denver Housing First Collaborative Cost Benefit Analysis and Program Outcomes Report.

[5] Guerin, Paul and Tonigan, Alexandra (2013). City of Albuquerque Heading Home Initiative Cost Study Report Phase 1.

- Reduced use of jail
- Reduced use of emergency rooms and inpatient hospital stays
- Reduced use of detox
- Reduced use of NM Behavioral Health Institute
- Reduced use of substances
- Improved family outcomes
- Increased employment

Outcomes should be measured through the most rigorous evaluation methodology possible. The County and City will work with the Harvard Kennedy School Government Performance Lab and a contracted evaluator to design an appropriate evaluation of the services. The evaluation will then be implemented by the contracted evaluator.

In addition to evaluating the efficacy of the program at achieving outcome metrics and cost savings, the County and City will track process goals on a regular basis. Process goals will include but are not limited to:

- The ability of the selected service provider(s) to enroll referred individuals who are identified as appropriate for the program;
- The ability of the selected service provider(s) to keep clients stably housed for a year or more.

Budget

The County's 55 to 60 units of permanent supportive housing programming, as well as County staff that manage intake and transition into the program, were paid for in FY 2016 out of the budget for the Public Safety Division. This proposal would shift funding for the program for FY 2017 onto the behavioral health gross receipts tax at the County. The County funding is proposed at $1.3 M annually.

Proposed Language of Recommendation
The ABCGC Subcommittee on Housing recommends that Bernalillo County permanently finance the Community Connections program using the behavioral health gross receipts tax revenue.

Community Connections Budget	
County Operational Expenses	
Staff	$ 152,906.00
Copier lease	$ 1,800.00
Office Supplies	$ 2,000.00
Cell Phone Svs	$ 500.00
Database	$ 2,500.00
Total	$ 159,706.00
Transitional Housing	
Transitional Units	$ 13,890.00
Transitional Unit Utilities	$ 2,280.00
Transitional land Lines	$ 1,727.00
Unit Cleaning transitional	$ 3,692.86
Motel Vouchers	$ 3,000.00
Client Supplies	$ 2,948.30
Repair reserve	$ 5,000.00
Total	$ 32,538.16
Housing	
Utilities	$ 3,960.00
Rental Vouchers	$ 524,374.00
Deposits	$ 22,942.86
Application Fees	$ 2,000.00
Housing Administration Fees (9%)	$ 49,794.92
Total	$ 603,071.77
Services	
Services	$ 505,173.50
Total	$ 505,173.50
Total Program Budget	$ 1,300,489.43