

Deconstructing Philadelphia's "Blueprint" Project: A Unique and Effective Multiyear Partnership to Expand Permanent Supportive Housing

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Introduction

The Philadelphia Blueprint Project is a historic partnership among the city's Department of Behavioral Health and Intellectual Disabilities (DBHIDS), the Office of Homeless Services, and the Housing Authority that aligns resources between affordable housing and Medicaid Supportive Services to create a unique and effective Supportive Housing Program that has housed 1,200 people since 2008.¹ The Blueprint program has had an 87 percent success rate in preventing a return to homelessness for men and women who have serious mental illness, substance use disorders, and/or concurrent disorders and who have had long-term or chronic homelessness.

The multi-year agreement between the City of Philadelphia and the Philadelphia Housing Authority (PHA), known as the Blueprint, provides for a portion of affordable housing resources to be targeted to the community's most vulnerable population—those sleeping on our streets—and combine them with services, creating a homegrown Permanent Supportive Housing² program. The "city" encompasses both the Office of Homeless

1. *The Philadelphia Blueprint Voucher Program: A Critical Resource in Ending Homelessness*, <http://www.phila.gov/hhs/PDF/Permanent%20Supportive%20Housing%20Program%20Evaluation.pdf>.

2. Permanent Supportive Housing (PSH) is a term of art that the U.S. Department of Housing and Urban Development (HUD) defines as long-term, community-based housing that has supportive services for homeless persons with disabilities. This type of housing enables special needs populations to live as independently as possible in a permanent setting. More recently, the word permanent has been removed as long-term subsidy and services has reduced need for intensive behavioral health

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Services and DBHIDS, both of which deliver most services through an extensive network of community providers, primarily not-for-profit treatment and housing organizations for the homeless. "The Blueprint" is the shorthand for this extensive network organized into a Permanent Supportive Housing system. Only with the expertise and multi-layered resources of the health care delivery system was the partnership able to succeed and effectively house over 1,200 persons, the vast majority of whom were formerly homeless on the streets.³

Like much of the United States, homelessness in Philadelphia is a challenge for far too many vulnerable residents. The most recent Point in Time Count⁴ found over 800 people sleeping on Philadelphia streets in the month of January 2017. Caused primarily by deep, long-term poverty, homelessness has grown as affordable housing resources are stretched thin as the result of funding cuts to the U.S. Department of Housing and Urban Development (HUD). Housing costs continue to increase and the growing crisis of substance use disorders, specifically heroin addiction and other opioids, has exacerbated the crisis. Yet even with these challenges, Philadelphia continues to have one of the lowest rates of street homelessness among cities with a population of over one million people. The Blueprint is one reason for this success.

This article deconstructs the history, structure, and financing that have made this unique partnership possible.

Setting the Stage: Local Leadership and Collaboration

The Blueprint was built out of dedicated city leadership; a tenacious, high-quality and active provider community; and a uniquely structured behavioral health system.

Successful partnerships are built on trust, data, accountability, and the dedication of time to make collaboration possible. Long-standing partnerships between the city's Office of Homeless Services (OHS) and DBHIDS had already created the trusting relationships and collaborative structures that the project built upon. Solid data systems and analytics allowed all

supports over time. For ease of reference to the literature, we continue to use the term Permanent Supportive Housing or PSH throughout this article.

3. Julia Paradise & Donna Cohen Ross, Henry J. Kaiser Family Foundation, *Linking Medicaid and Supportive Housing: Opportunities and On-the-Ground Examples* (Jan. 27, 2017), <http://kff.org/medicaid/issue-brief/linking-medicaid-and-supportive-housing-opportunities-and-on-the-ground-examples/>.

4. HUD defines the Point-in-Time (PIT) count as a count of sheltered and unsheltered homeless persons on a single night in January. HUD requires that Continuums of Care conduct an annual count of homeless persons who are sheltered in emergency shelter, transitional housing, and Safe Havens on a single night. Continuums of Care also must conduct a count of unsheltered homeless persons every other year (odd numbered years). Each count is planned, coordinated, and carried out locally.

stakeholders an assurance that the resources were being dedicated to the most in need in the community. Data continues to be the backbone of the program. A strong human services provider network ensures high quality services for program participants. A vocal and effective advocacy community highlights strengths and weaknesses of the partnerships and holds public systems accountable. Finally, each partner took the time to learn other partner's systems and work together, always with the person being served at the center of all activities.

The city's Office of Homeless Services leads the city's efforts to end homelessness. While the city receives significant funding from the federal, state, and local governments, the need far outweighs the resources. In partnership with other city departments, the Office of Homeless Services has worked to use resources from HUD more efficiently by cost shifting service funding to mainstream resources, most commonly Medicaid.⁵ Through this mechanism, the Office of Homeless Services can then use the funding for that most scarce resource in a community, rent subsidies that make housing affordable. With the support from mainstream service systems, the newly available funding can be paired to provide the services coupled with rent subsidies to create additional Permanent Supportive Housing and help more vulnerable Philadelphians exit homelessness. For example, Philadelphia reached functional zero on veterans' homelessness in November 2015.

Recovery Transformation

One of the most significant contributing factors to the success of the Blueprint model is that Philadelphia has a single-payer structure for the publicly funded Behavioral Health System (Medicaid) through the establishment of Community Behavioral Health (CBH).⁶ CBH is a not-for-profit 501(c)(3) located under DBHIDS. This means that the system of providing and financing behavioral health services is organized to meet the needs of the community without the profit motive of a private provider. In fact, any efficiency creates revenue known as "reinvestment dollars" by providing required services at lower cost than the state's capitation rates. With the approval of the state that the intended use provides medically necessary services, reinvestment dollars are then able to be directed to public benefit. This provides flexible funding to advance the strategic goals of the city, specifically, to provide Permanent Supportive Housing to people with significant disabilities who are experiencing homelessness.

5. Medicaid pays for the physical and behavioral health services of indigent people. It is through this core function that the behavioral health services provided through the Blueprint are connected to a publicly supported rent subsidy.

6. PHILADELPHIA DEPARTMENT OF BEHAVIORAL HEALTH AND INTELLECTUAL DISABILITY SERVICES (DBHIDS), <http://www.dbhids.org/>.

Because CBH exists for the public benefit and is run efficiently and effectively, the overhead costs are well below state and national averages.

This structure is possible because the State of Pennsylvania's Medicaid plan carves out behavioral health services, allowing each county the opportunity to manage the full-risk contract. Philadelphia took advantage of this opportunity beginning in 1997 to build a strategic financing structure that allows one city department to manage all federal, state, and local funds for the provision of mental health, addiction, and intellectual disability services regardless of funding source. In Philadelphia, this is DBHIDS. This strategic funding structure has allowed the behavioral health system to take on the responsibility for funding and managing services in much of the city's Permanent Supportive Housing Program.

In addition to this financial structure, Philadelphia's behavioral health system made the philosophical transformation to a recovery-oriented system of care (ROSC).⁷ ROSC is a federally recognized best practice that transforms behavioral health care from a medical model to a partnership among persons in recovery, their service providers, and their communities. ROSC assumes that the person has the ability to recover from all challenges if the right supports are in place.

Historically, the system of services made requirements of the person requesting assistance before offering care. For example, consumers might be required to be clean and sober before being able to access housing. ROSC, and the Philadelphia transformation in particular, highlights that system resources should not solely be directed toward formal clinical treatment, as had been the case, but also be dedicated to four new domains of innovative community practice: Assertive Outreach and Engagement, Continuing Support, Early Re-Intervention, and Community Connection and Mobilization. These domains of the *DBHIDS Practice Guidelines for Resilience and Recovery Oriented Treatment*⁸ reflect the evolution of Philadelphia's behavioral health system. Together people in recovery, their family members, treatment providers, advocates, and system administrators have developed a shared vision that has been blended with the lessons learned from Philadelphia's transformation efforts over the past thirty years. The guidelines apply to all treatment providers and individuals who are reimbursed for working in a provider organization at all levels of care. They have transformed the system to be more engaged with the community and consider more broadly the intersection with the Social Determinants of Health (SDOH).⁹

7. SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, <https://www.samhsa.gov/recovery>.

8. Phila. Dep't of Behavioral Health & Intellectual Disability Servs., *The Practice Guidelines for Resilience and Recovery Oriented Treatment*, <http://dbhids.org/practice-guidelines#tab-id-1>.

9. *Id.*

SDOH is the conceptual model within the health care delivery system that acknowledges that many of the factors influencing health outcomes are not directly impacted by clinical care.¹⁰ As tools develop that can validly measure the health of a community (e.g., rate of infant mortality or diabetes), health care system leaders in general and payers in particular are demanding an improvement in the health, not just of individuals, but also of communities. As the health care system is slowly learning, those other factors, the SDOH factors, also have a strong influence on the health of a community. Permanent Supportive Housing for people who have experienced chronic or long-term homelessness is integral to improved community health outcomes, reduced acute health care costs, and population health.

The cornerstone for housing affordability for the Blueprint Project is dedicated resources from the Housing Choice Voucher Program. The Housing Choice Voucher Program is the federal government's major program for assisting very low-income families, the elderly, and the disabled to afford decent, safe, and sanitary housing in the private market. Since housing assistance is provided on behalf of the family or individual, participants are able to find their own housing, including single-family homes, townhouses, and apartments. The participant is free to choose any housing that meets the requirements of the program and is not limited to units located in subsidized housing projects. Housing choice vouchers are administered locally by public housing agencies (PHAs). The PHAs receive federal funds from HUD to administer the voucher program.

By pairing the all too scarce Housing Choice Vouchers (formerly known as Section 8)¹¹ with a behavioral health network composed of over 300 community based service providers, the Blueprint Project was able to expand the community's supportive housing capacity by more than 200 units a year.

Persons are referred first to supportive services to match the challenges they face. Persons with serious mental illness have access to Targeted Case Management (TCM),¹² Psychiatric Rehabilitation Services (PRS),¹³ and Certified Peer Specialist (CPS) Services.¹⁴

10. World Health Organization, *What Are the Social Determinants of Health?*, http://www.who.int/social_determinants/sdh_definition/en/.

11. U.S. Dep't of Housing & Urb. Dev., *Housing Choice Vouchers Fact Sheet*, https://portal.hud.gov/hudportal/HUD?src=/topics/housing_choice_voucher_program_section_8.

12. Phila. Dep't of Behavioral Health & Intellectual Disability Servs., *Targeted Case Management (TCM)*, <http://www.dbhids.org/about/organization/office-of-mental-health/coordinated-consumer-services-ccs/targeted-case-management-tcm/>.

13. *Rehabilitative/Rehabilitation Services*, HEALTHCARE.GOV, <https://www.healthcare.gov/glossary/rehabilitative-rehabilitation-services/>.

14. Phila. Dep't of Behavioral Health & Intellectual Disability Servs., *Peer Specialist Certification Training*, <http://www.williamwhitepapers.com/pr/Philadelphia%20Peer%20Specialist%20Job%20Description.pdf>.

Targeted Case Management is a primary, direct service provided to adults or children with serious mental illness or emotional disorders who live in the community. TCM is designed to ensure that individuals and their families gain access to needed medical, social, and educational services as well as to other agencies whose functions are to provide the support, training, and assistance required for a stable, safe, and healthy community life.

Psychiatric Rehabilitation Services (PRS) are health care services that help individuals keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Certified Peer Specialists (CPS) are paid staff people who are willing to self-identify as living with a serious behavioral health disorder (mental illness, substance use disorder, or co-occurring disorder) and who is in recovery. To be certified as a CPS, the person must have received specific training in the role, functions, and skills for the position. The purpose of this position is to aid, teach, and support others in their recovery process. This relationship between peers is characterized by mutual trust and respect, sharing of experience and learning about the recovery process, supporting the peer in setting and achieving goals, and moving toward a more meaningful life in the community.

Persons whose only diagnosable behavioral health challenge is an addiction are able to access case management services because Philadelphia has chosen to offer that service to a defined, capitated population.

Once services are in place, the newly assigned case manager works with the person who is homeless to complete an application for a Housing Choice Voucher. With provision of these extensive supportive services described above, the administrative burden on the housing authority is lessened. Over time, the behavioral health providers have become more familiar with the processes of the housing authority.

While Permanent Supportive Housing has a robust evidence base, especially as a solution for persons experiencing chronic homelessness, the blending of funding and resources, especially across systems, is often challenging.

Through the leadership of the Mayor's office, the commitment of the public officials leading the relevant city agencies, an engaged and effective provider network, an active mental health consumer network, and an organized advocacy community, the Blueprint partnership has been able to withstand a variety of political, funding, and sustainability challenges.

The city and the housing authority signed a memorandum of understanding memorializing the Blueprint in 2008. The partnership has been sustained through regular structured communication, regular reporting, funded staffing, ongoing collaborative goal setting, and bench marking. Quarterly leadership meetings, combined with weekly meetings of managing staff, built the relationships needed to ensure consistent communication

and long-term effectiveness. Annual reconciliation of data ensures that three separate service delivery systems (and three separate data systems) managed by DBHIDS, Office of Homeless Services, and the Philadelphia Housing Authority are able to stay on track together. Regular reporting among the partners allows outcomes to be closely tracked and leadership to clearly understand what each is receiving from the partnership. All of the above strategies are recommended for any project in which funding for the project as a whole can be "braided" rather than integrated into one project budget, i.e., the relevant components are woven together while maintaining the integrity of each individual system, which has a broader purpose beyond that of the project.

Outcomes

The Blueprint Project began in the summer of 2008. As of January 2017, it has housed 1,401 individuals. Review of service data indicates that 89 percent remained housed for at least one year in their unit and many persons have now reached over five years in Permanent Supportive Housing. At lease signing, 89.4 percent are Medicaid eligible, enabling the city to be reimbursed by Medicaid for the services they receive; over half receive Supplemental Security Income or SSI benefits for a permanent disability. Almost all (97 percent) had some billable Medicaid services in both the year before lease-up and the year following lease-up.

The Blueprint has reduced Medicaid costs. One year before lease-up, 38 percent utilized high acuity, inpatient services, 81 percent utilized community-based services, and 86 percent paid claims for the tenancy supportive services portion of PSH. One year after lease-up, the percentage of individuals using high acuity services decreased to 32 percent and community-based use decreased to 72 percent while tenancy based supportive services increased to 92%.

The city established the Journey of Hope Project (JoH) as an innovative approach to the chronic homelessness of those with substance use disorders. JoH was created in 2007 as a result of collaborative efforts among DBHIDS, the Office of Addiction Services (OAS), and the Office of Homeless Services (OHS) to transform six inner city substance use disorder residential treatment programs into programs that are equipped to more effectively serve chronically homeless individuals. Unlike traditional treatment, JoH offers low-demand, long-term treatment stays of six months to one year and serves individuals with histories of homelessness who are living with substance use or concurrent disorders (mental health and addiction). Each site incorporates motivational interviewing techniques, cognitive behavioral strategies, behavioral modification, psycho-educational seminars, and other evidence-based practices into their innovative modified therapeutic community settings.

Local transitional, supported, and permanent housing programs, as well as case management services, are utilized for program participants upon discharge as additional layers of support as they re-integrate into

the community and continue with their recovery process. Connections to alumni groups, recovery community centers, clinical services, peer mentoring, and ongoing follow-up are also utilized to help support long-term, sustained recovery in the community.

Between 2012 and 2015, 386 individuals participated in the transformed JoH addiction treatment programs. Of the JoH participants, 93 percent were eligible and enrolled in Medicaid as of discharge date from residential treatment. Many were able to receive Medicaid due to Governor Tom Wolf's decision to expand Medicaid in 2015.

For those discharged from JoH to stable outcomes, such as Permanent Supportive Housing, living with friends, family, or spouse, fewer individuals utilized high acuity inpatient services one, two, and three years after discharge compared to one year before admission to JoH. However, those who did not complete the program were more likely to utilize high acuity inpatient services. Early access and engagement in behavioral health services and investment at point of entry to the JoH program suggests cost shifting over time. There was a significant reduction in Medicaid costs as individuals progressed through the program. The proportion of spending shifted from high acuity services to community-based and core services specifically for those with supportive housing upon discharge from residential treatment.

In 2008, before the start of the Blueprint Project, Philadelphia Point in Time count showed 457 unsheltered persons with a total of 3,479 people experiencing homelessness. The count also considered disabilities and in 2008, the number of persons experiencing serious mental illness (SMI) was estimated at 1,519 while those experiencing substance use disorders (SUD) was estimated at 1,678. By 2014, after five solid years of work with the Blueprint, the unsheltered total decreased to 361 persons, the estimates of persons with SMI decreased to 1,192, and those with SUD decreased to 1,344. Unfortunately, after sequestration was implemented and the housing authority and the city's housing system services suffered significant funding cuts, the level of available funding slowed the pace of voucher issuance and progress has been harder to sustain. The lack of affordable housing resources will continue to make homelessness a challenge that low-income persons and communities struggle to address.

Policy Implications

The results from Philadelphia are clear. When public sector systems work together, each building on the strengths of the other, successful community-wide outcomes are achievable. The policy questions we raise focus on the lack of alignment of funding or incentives for differing branches of government and units of the same government. Without these alignments, the examples of differing sectors working together is likely to remain few and far between and achievable community-wide outcomes will seem out of reach.

Housing funding tends to flow from the federal government directly to the local communities. Housing authorities have local boards, and urban areas tend to have their own community development funding streams. State housing finance agencies also have resources, primarily in the Low Income Housing Tax Credit program. In contrast, in the health care system, Medicaid is a state and federal partnership, often administered at the local level by private sector payers, such as managed care organizations. None of these players reports to the same hierarchy and all have their own plans, goals, and objectives. While all serve a similar low-income population, there are no requirements for coordination or collaboration, much less integration.

The Philadelphia example highlights the importance of strong local leadership and suggests that similar leadership at the federal level can incentives to coordinate community resources for a place-based success, such as what Philadelphia has achieved.

Data driven strategies have been critical to Philadelphia's success. Use of data to determine which persons receive an all too scarce resource has resulted in community-wide collaborations. Today, the provider community, together with the city, has developed a list by name and is implementing the use of the Vulnerability Index-Service Prioritization Decision Assistance Tool, augmented by local criteria, to prioritize access. Bi-weekly meetings of decision makers working on housing operations are critical to communication and smooth operations.

The city established a Supportive Housing Clearinghouse through which all housing referrals are prioritized and assigned. This clearinghouse facilitates an automated matching of prioritized individuals based on vulnerability and readiness for placement with appropriate housing resource opportunities, as they are available. The clearinghouse is one of many functions funded through the Medicaid reinvestment dollars, again deriving the public benefit of efficient and effective program design and administration. Regular reconciliation of the data ensures that all partners remain working together with identical numbers and clear communication. Regular joint reporting on the Blueprint credits all key partners and contributes to the sustainable partnership. Success for one is success for all. Each partner has learned the trends, strategies, priorities, and goals of each of the other partners and all are stronger in their roles as a result. The saying among key leaders is that data "will keep us honest."

Future Directions

The continuation and expansion of Permanent Supportive Housing for people experiencing street homelessness with significant behavioral health challenges continues to be a goal for the City of Philadelphia. It is an evidence-based practice that locally has been proven to prevent a return to homelessness and reduce medical costs. With declining federal investment in housing affordability, the city is exploring new ways to expand the model of combining behavioral health services with rental

assistance. Among these is the dedication of a set-aside of a percentage of subsidized units financed with Project-Based Section 8; the Low Income Housing Tax Credit; and other local, state, and federal financing sources to chronically homeless individuals. This is a feasible approach both because the service match is already guaranteed and the partnerships already exist through the Blueprint. The model has worked for nine years and appears to provide a resilient framework that can be adapted as external forces change and as evidence amasses that can transform the system to be more effective. Permanent Supportive Housing is a viable and proven solution to chronic and long-term homelessness. Through the investment and partnership of three large public systems committed to one goal, Philadelphia has made progress that can serve as a model for other communities.