Chapter 3

How HHS Mainstream Service Programs Align
With the Treatments and Services That Address
Chronic Homelessness

Mainstream HHS Service Delivery Programs

In 1999, the General Accounting Office (GAO) examined the extent to which Federal programs designed to assist low income and disabled persons responded to homelessness.[1] The report identified up to 50 programs in eight Departments and Agencies that provided relevant assistance. Almost one-third of these programs were specifically targeted to homeless persons (16 of the 50)[2], while the balance constitute some of the largest and best known of the Federal assistance programs such as Food Stamps, Medicaid, Public Housing, and Supplemental Security Income. Collectively, these programs serve millions of individuals. The report referred to these as non-targeted programs, but the phrase 'mainstream programs' has been widely used to embrace them.

GAO identified 12 relevant mainstream programs in HHS. The Work Group took these 12 programs as a starting point to explore improved access, coordination, and prevention activities related to chronic homelessness. Three were eliminated as being less applicable to chronic homelessness. Specifically, Head Start, the State Children's Health Insurance Program, and the Maternal and Child Health Services Block Grant were dropped from further consideration because they were not likely to address single, disabled, poor adults who primarily make up the chronically homeless population. Two others were collapsed into one program, based on advice from the Health Resources and Services Administration which administers them. Specifically, Migrant Health Centers were not treated as a separate

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1. General Accounting Office. "Homelessness: Coordination and Evaluation of Programs Are Essential." GAO/RCED-99-49. Wash, DC: 1999.

2. HHS is responsible for five programs specifically targeted to homeless persons. Three of these were acknowledged in the GAO report:
Health Care for the Homeless, providing primary care services to homeless persons;
Runaway and Homeless Youth programs, providing street outreach, transitional living, and basic service centers for this population; and
Projects for Assistance in Transition from Homelessness, assisting States to provide a variety of services to homeless persons with serious psychiatric problems.
HHS is also responsible for a Federal Surplus Real Property program that transfers surplus Federal land and buildings to organizations that use it to provide homeless assistance. Since the latter program was not a direct service program, it was not included in the 1999 GAO study. Finally, in 2001, HHS added its newest targeted program: Cooperative Agreements for the Development of Comprehensive Drug and Alcohol Treatment for Systems for Homeless Persons, stressing service delivery to those with substance use problems. All of these programs emphasize service responses to homelessness and cumulatively report assisting more than 600,000 homeless persons annually. In this report, the emphasis was on the contribution the non-targeted HHS programs can make to reducing and ending chronic homelessness. The Department acknowledges the vital contributions the targeted programs are already making in addressing chronic homelessness and the de facto role they will play in a comprehensive approach.

program as GAO had done, but were subsumed within the Consolidated Community Health Centers cluster. This left 8 mainstream programs as the focus of the Work Group.[3]

Mainstream HHS Programs Selected for Their Relevance to Chronic Homelessness:

❑ Medicaid
❑ Temporary Assistance for Needy Families (TANF)
❑ Social Services Block Grant
❑ Community Services Block Grant
❑ Community Health Centers
❑ Ryan White Programs
❑ Substance Abuse Prevention and Treatment Block Grant
❑ Community Mental Health Services Block Grant

Are HHS Mainstream Programs Responsive to Chronic Homelessness?

Each of the eight programs was asked to provide responses for the following information:

> ***Coverage of each core and supportive service***.

> ***Access to the service*** by homeless and chronically homeless persons.

Concerns or opportunities program officials noted that might influence the applicability of the program to chronic homelessness.

Administrative features of each program that might affect the ability of the program to respond to chronic homelessness.

All of these circumstances were integrated into an inventory that was completed by each of 8 mainstream programs. The compilation and review of these service inventory responses was carefully reviewed and contributed substantially to the Work Group's recommendations. In addition, experiences shared by States, municipalities, and providers in the Listening Session and lessons from a site visit to a homeless health care clinic by members of the Interagency Subcommittee members were considered.

Findings

1) Availability of Core and Supportive Services

Each program was asked to indicate for each core and supportive service whether that service was required or optional (e.g., could be selected from a menu of options; offered at State's discretion). Several findings are noteworthy.

❑   As these programs have been authorized, there is substantial flexibility in the services that can be supported. Four of the 8 programs give the State discretion in selecting what services will be supported. The others feature both required and optional services that the State, city or community-based recipient may offer. Therefore, in administering these 8 programs, there is considerable opportunity for the State or grant recipient to tailor service responses to the unique circumstances of the service beneficiaries. These opportunities extend to including the services the

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3. This is not meant to convey that other HHS assistance programs are not relevant or applicable to chronic homelessness. The selection of these eight was consistent with expectations established by the earlier GAO study and provided a diverse sample of HHS programs for consideration.

identified in the previous chapter as effective in helping people break a cycle of chronic homelessness. (See insert and Table 1.)

❑ In all of the programs, there are also restrictions on offering certain services. The most common exclusion was on support for inpatient care. Only Medicaid is authorized to provide inpatient services.

❑ The only core service to be offered in all 8 programs was information and referral, but outreach, supportive case management and substance abuse services are available from at least 7 of the 8 programs.

Number of Mainstream Programs Supporting Core Services	
Information and Referral	8
Outreach and Engagement	7
Alcohol and Drug Abuse Services	7
Supportive Case Management Services	7
Health Related and Home Health Services, Including HIV/AIDS	6
Intensive Case Management Services	6
Discharge Planning	6
Mental Health and Counseling Services	5
Residential Treatment Services	5
Income Management and Support	4
Inpatient Services	1

❑ Three of the 8 programs can support 10 of the 11 core services (inpatient coverage is excluded in each): TANF, Ryan White titles, and the Community Mental Health Services Block Grant. However, these programs also serve the most highly specified target groups – by family status or diagnosis. They may be accessible only by certain persons who are chronically homeless.

❑ None of the 8 programs offers all of the core and supportive services. This fact contributes to the frequently cited complaint of community and faith-based providers that they must juggle multiple funding sources to sustain a program that provides comprehensive services to their clients. For example, in one northeastern state, an average homeless shelter uses 17 sources of Federal support and 5 State sources to compile the array of services needed by its clients.[4]

This factor also has implications for homeless people. They are most likely to encounter *providers who are not able to offer the comprehensive set of services.* Negotiating such fragmentation is especially challenging for a person dealing with impairments.

❑ For supportive services, coverage appears to be somewhat better. Five of the 8 programs cover all of the supportive services. Transportation, primarily as it relates to accessing treatments and services, is covered by all 8 programs. However, as Table 1 shows, variability in coverage remains a pattern and it reinforces the fragmentation issue noted above.

Number of Mainstream Programs Supporting Supportive Services	
Transportation	8
Education and Training	6
Life Skills	6
Child Care	6
Employment Services	6
Legal Assistance	5

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4. Personal communication to W. Leginski from L. Hatton, May 2002.

2) Use of Available Services by Chronically Homeless Persons

Two inventory questions are relevant here.

❏ In describing the administrative features of each program, program officials indicated whether homelessness was mentioned as a circumstance that received consideration in the program. One program – the Community Services Block Grant – reported this to be the case.

❏ In addition, officials were asked if factors that characterize chronic homelessness – a disabling condition or the pattern of homelessness – would affect a person's eligibility for the program. Two of the programs – Medicaid and the Mental Health Block Grant – indicated that a disabling condition would be critical for program eligibility. No programs indicated that a pattern of long term or repeated homelessness presented a barrier to accessing a service, nor would it suggest that a priority consideration for access to one of the mainstream programs be given.

Thus, while the majority of the programs do not identify homelessness as a circumstance for consideration, the characteristics of chronic homelessness appear to create few barriers for access to these services.

For each core and supportive service, the inventory also asked whether persons experiencing chronic homelessness used the service and if data were available on the extent of use. Since homelessness was generally not identified as a circumstance for consideration for receipt of services by these programs, it is not surprising that their administrative systems would not flag homelessness or former homelessness as a characteristics on which data could be tabulated.

Consistent with the observations in the 1999 GAO report – which found that mainstream, non-targeted programs could not document access by homeless persons – 70 percent of the inventory responses about service use by homeless persons are unknowns. The programs report that they have no data to inform them about access. Thirty percent of the responses are positive, indicating homeless persons do use the service. But officials were not able to provide hard data on utilization. [5]

Clearly, it is a challenge for HHS to provide a baseline to demonstrate current access to mainstream services by persons experiencing long-term homelessness. The challenge will have to be addressed in any Department attempt to document that efforts to reduce the prevalence of chronic homelessness or end it are successful.

3) Concerns and Opportunities

To benefit from the insights of program officials about the relevance of their program to addressing chronic homelessness, the program officials were invited to offer observations about concerns or opportunities in five areas:

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5. The authorization for some of these mainstream programs may restrict whether the Department can obtain specific data on homelessness. Only the Community Health Centers reported data for the service of primary health care, indicating that the service was provided to 80,000 homeless persons.

Regulation or administrative issues *(e.g., flexibility and limitations in designing service content, role of States in designing program, eligibility specifications, opportunities to apply for waivers or expansions, legal/civil rights concerns)*

Patterns of funding *(e.g., how traditions influence fund distribution toward new issues, services, client groups, or groups of providers)*

Capacity issues *(e.g., resource trends in the Program, treatment gaps, models of effective interventions, competencies of provider staff)*

Fragmentation of services *(e.g., degree of specialization by service or funding, program culture on client referral and linkage, prevalence of one-stop service approaches, integration of providers into HUD's continuum of care planning processes)*

Priorities, incentives and motivations *(e.g., priority placed on addressing homelessness in the Program, emphasis on cost containment, emphasis placed on the underserved, nature of the performance that is incentivized)*

Several of these areas yielded information from program officials that was even more clearly expressed in the July 2002 Listening Session with States, municipalities and providers.

❑ Funding Silos: Each of the 8 mainstream programs was created to respond to a unique need or population and its implementation is most often driven by its authorization. The consequence of this evolution is an assortment of assistance programs covering health and social services, and administered by a variety of State and local entities. The administering entities are not required to assemble these programs into a coherent pattern that might result in an improved response to the overlapping, multiple needs of the targeted populations. In addition, the administering entities may find that the authorizations for these programs make such a coordinated approach difficult.

The problem is often captured by the phrase "funding silos." The implications are not unique for homelessness. For example, in discussions of TANF reauthorization in June, 2002, both the Administration and the House of Representatives included provisions that addressed the impact of such silos on serving needy families. Specifically, it was proposed that States receive flexible authority to build integrated service delivery systems for TANF families involving as many as nine separate assistance programs.

Fragmented funding led to the following issues for chronic homelessness:

➤ *Coordination Issues:* Funding silos mean that Federal assistance moves to different agencies within State government, sometimes going directly to the community level. There is no requirement for coordination across these programs. One multi-State report summarized this as:

"...the federal government thinks about policy in terms of specific programs and categorical funding streams...States, on the other hand, increasingly think about how a coherent and seamless service delivery system might better assist disadvantaged [persons]."[6]

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6. "Eliminating the Silos" January 2002. The Midwest Welfare Peer Assistance Network: Madison, WI. p. 2.

While States and community organizations are required to submit applications and plans when seeking HHS assistance, it has been several decades since HHS required any degree of joint planning or coordination across the assistance programs it supports. Thus, a State's TANF plan may discuss the State's plan to address substance abuse among eligible families. But there is no requirement that the State plan show a relationship to the assistance offered by the State under its Substance Abuse Prevention and Treatment Block Grant, nor demonstrate consultation and collaboration with the State's substance abuse administration.

The proposal noted above to give States authority for flexibility under TANF reauthorization was intended to address this difficulty by mandating close coordination among the programs it would cover. Another relevant parallel is the success HUD has had requiring that its applicants demonstrate a rational plan for the range of assistance HUD offers: A consolidated plan for all HUD assistance is required. In addition, HUD requires communities to develop a coherent, prioritized approach for the homeless assistance that HUD offers. This 'continuum of care' plan is a well-known homelessness planning strategy in over 400 communities in the U.S.

➢ *Eligibility Gaps*: For chronically homeless clients, particular those with multiple diagnoses, funding silos mean they may be eligible for some of the services they need from one program, but not be able to secure the remainder of their services because they are not eligible under the rules of those other programs.

The most telling example of this involves homeless persons with substance use disorders and co-occurring psychiatric and primary health care problems. They may have access to limited substance abuse treatments supported by the Substance Abuse Prevention and Treatment Block Grant. But, they may find that they do not meet eligibility criteria for receipt of Medicaid coverage, nor qualify as having a serious and persistent mental illness for access to services supported by the Community Mental Health Services Block Grant.

Such problems in accessing services reimbursed by other funding sources are not uncommon. The Listening Session further underscored the obstacles States, municipalities and providers face in using multiple funding sources to address the multi-problem nature of chronic homelessness.

➢ *Flexibility:* Many service providers have learned to live with funding silos and pursue funding from multiple assistance programs to be able to offer comprehensive services to their clients. But they report that they are challenged in trying to work flexibly across these silos.
– Privacy provisions may mean that information in client records is not accessible across programs serving the same clients.
– Audit teams have different rules and visit at different times so that providers are continually making adjustments to comply with each new visit.
– Cost allocation rules governing Federal funds require that States and providers which are using multiple funding sources to serve a client group must establish a reasonable methodology for how much of each funding source will be used. One basis for reasonable allocation is the size of the benefitting population. Cost allocation rules may mean that the relatively low representation of chronic homelessness (or the absence of a priority to identify such consumers) in a large mainstream caseload restricts the resources that providers may be able to devote to this group.

– Adjusting or securing service funding to match a client's need for treatment and support as the client moves out of homelessness may be so difficult that gaps in services occur and jeopardize progress. One example of this involves clients losing a case manager at each stage of progress that requires them to shift to a different provider or service reimbursement source.   At the Listening Session, one representative noted clients who had worked with more than a dozen case managers as they exited homelessness.

– Lastly, attempts at collaboration with other providers, including those who offer housing, are often considered overhead – a cost of doing business. In cash-strapped human services programs, this can become a disincentive to engage in planning for seamless service delivery systems.

❏   Capacity Issues: The capacity of the programs to respond to chronic homelessness was expressed in several forms.

➤   *Funding:* Program officials uniformly expressed that resources were finite and their application to particular population groups was usually a priority left to the State or provider. There is considerable variety in the scale of funding and how extensively each program is relied on as a source of service dollars. Some, such as Medicaid, come with a requirement for matching funds that requires substantial investment of a State's own funds. Any expansion of programs has implications for the program partners that have to be considered carefully.

Funding trends also varied in the 8 programs. In a few, such as the Social Services Block Grant, the trend line has been down. In others, such as the Community Health Centers, Administration and Congressional interest has led to current and promised future expansion.

Under any of these funding conditions, HHS does not mandate what the State or grantee must do. The Department's approach has been to encourage States and community-based grantees to capitalize on existing flexibility, issue letters of guidance, offer technical assistance, and promulgate evidence-based practices. The recommendations to the Department are consistent with this approach.

➤   *Staffing:* An important aspect of quality of services is the availability and qualifications of staff to deliver health and social services. Program officials reported staffing shortages that led to waiting lists and high case loads under existing service demands. They voiced that working with chronically homeless groups would present substantial challenges to mainstream systems because of the multi-problem nature of this group, current workloads, and staff readiness to work with such a clientele.

Many mainstream staff are not prepared to provide the outreach and engagement services to chronically homeless persons who have not yet re-engaged with treatment services. In addition to the fact that these services often occur out-of-office, reimbursement practices associated with managed care may limit the extensiveness or intensiveness of these services.

When staff do work with such clients, they may not be prepared to modify some of their clinical practices for a clientele whose lack of a stable residence makes a treatment regimen impossible – the classic example is prescribing a refrigerated medication. As clients change from homeless to housed, mainstream staff may not be sufficient or prepared to provide needed services in non-office based settings,

such as the client's home, or deliver services that are critical to the person's successful placement, e.g., helping a client gain skills at budgeting or working a microwave.

➢ *Knowledge and Technology:* HHS has invested uniquely in research that demonstrates effective, evidence-based treatments and supports for persons experiencing chronic homelessness. Outside of the homeless-specific service delivery system, these findings and service models are not widely known, practiced, or reimbursed. Consequently, homeless-specific providers frequently report that the mainstream programs in their cities often direct homeless persons to their systems because of concerns about service reimbursement or not knowing what to do with such clients. For mainstream providers to be more receptive to this group of clients, much needs to be done to convey what is known about effective treatment and to encourage action.

Another concern relates to the technology of administrative information systems. Such systems provide documentation of treatment for billing, linking a client's records over time, and program accountability. As noted previously, mainstream program officials were not able to provide data to demonstrate their programs served chronically homeless persons.   Providers could benefit from guidance in identifying how a treatment plan for a person with long term or repeated homelessness is formulated, implemented, documented, and assessed. A consequence of such capacity would be in supporting the establishment and documentation of performance measures on homelessness.

Finally, an important area is privacy and civil rights issues. Expediting coordination of services across multiple providers has to be balanced with protections of civil rights (e.g., commitment statutes), privacy, and significant challenges to how information can be better linked. The goal of ensuring access to needed services should be enhanced while giving careful consideration to protecting each client's rights.

Implications of the Findings

The findings presented above represent a consolidation of statements, tabulations, or observations accumulated during several months of information seeking. Few of the findings are unique to any one service program; they tended to cover concerns and opportunities involving multiple programs and agencies. The next chapter briefly describes the processes used to distill the accumulated information and to develop recommendations for a comprehensive approach for the Department.

TABLE 1
HOMELESS-RELEVANT SERVICES AVAILABLE IN HHS ASSISTANCE PROGRAMS[a]

Services Provided⇒ HHS Mainstream Assistance Programs	CORE SERVICES												SUPPORTIVE SERVICES						
	Out-reach	Primary Health Care	Alcohol & Drug Abuse Services	Mental Health & Counseling Services	Inpatient Services	Supportive Case Mgt	Intensive/ ACT Case Mgt	I & R	Income Mgmt & Support	Residen-tial Treat-ment	Discharge Planning	No. of Core Services Offered	Life Skills	Child Care	Educa-tion & Train-ing	Employ-ment Services	Legal	Trans-portation	No. of Supportive Services Offered
Community Mental Health Services Block Grant (CMHSBG)	●	●	●	●		●	●	●	●	●	●	10	●	●	●	●	●	●	6
Community Services Block Grant (CSBG)	●		●				●	●				4		●	●	●	●	●	5
Consolidated Community Health Centers (CHCs)	b	●c	d	d	b	b		●	●e		●f	4			●g			● h	2
Medicaid [k]	●l	●m	●n	●o	●	●p	●q	●r		s	●	9	●t			● u		● v	3
Ryan White Act	●	●	●	●		●	●	●	●	●	●	10	●	●	●	●	●	●	6
Social Service Block Grant (SSBG)	●	●	●	●		●	●	●		●		8	●	●	●	●	●	●	6
Substance Abuse Prevention & Treatment Block Grant	●		●			●	●	●		●	●	7	●	●				●	3
Temporary Assistance for Needy Families (TANF)	●w		●x	●x		●w	●w	●w	●	●w	●w	10	●w	●w	● w	● w	● w	● w	6
No. of Programs Offering Service	7	6	7	5	1	7	6	8	4	5	6		6	6	6	6	5	8	

[a] Services provided refers to those that are required, eligible or covered in each program .

[b] A supplemental service available to some but not all centers.

[c] In-home services not a requirement of the program.

[d] Mental health service include services of a psychiatrist, psychologist, & other appropriate mental health professionals. These services are supplemental; most centers do not have extensive mental health services.

[e] Through referrals to other providers.

[f] Patients are followed in the hospital either directly with privileges or through appropriate referral mechanisms.

[g] Limited to health education

[h] Transportation, as needed for adequate patient care. Residents of catchment area served by the Center with special difficulties of access to services provided by the Center may receive such services.

[I] Outreach & engagement are required in Head Start, but are not specific to homeless persons.

[j] Not used.

[k] All provided Medicaid services are State administered and limited in amount, duration, and scope.

[l] As administrative expense (50 percent match).

[m]Physician, outpatient hospital, home health for persons eligible for nursing facility services, rural health clinic services, lab & x-ray, FQHC services. Eligible/covered include clinic, optometrist/eyeglasses, prescribed drugs, prosthetic devices, dental.

[n] Eligibility requires meeting categorical requirements other than substance abuse.

[o] If physician service or in-patient hospital. Eligible/covered: prescription drugs & additional services under a waiver program.

[p] State option

[q] Service may be created using State plan option(s).

[r] May be part of case management services or service provided by managed care organizations.

[s] If inpatient hospital, nursing facility, intermediate care facility for mental retardation, or psychiatric residential treatment facility for persons under 21 years of age.

[t] Particularly under a waiver program.

[u] Specialized therapies only (e.g., occupational, speech, & physical).

[v] May be covered to receive medical care as program or administrative costs by a state.

[w] State option, but families are the clients, not individuals.

[x] Service must be non-medical in nature.