THE SKID ROW COLLABORATIVE—2003–2007
PROCESS EVALUATION

Martha R. Burt

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Urban Institute
2100 M Street, N.W.
Washington, D.C. 20037
mburt@ui.urban.org

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INTRODUCTION

The Skid Row Collaborative (SRC) is one of 11 projects funded under the federal government's Chronic Homelessness Initiative (CHI) in fall 2003. This was the first attempt by federal agencies to combine funding for a national demonstration in the homeless arena. Its intent was to demonstrate the feasibility of moving chronically homeless disabled people directly from the streets to housing and helping them retain housing with a combination of health, mental health, substance abuse, and other supportive services. Demonstrations were intended to run for three years, from October 2003 through September 2006. Most of the 11 projects have had that time extended into the projects' fourth year because slow start-ups resulted in funds remaining to be spent at the end of the three-year grant period. The Skid Row Collaborative received a nine-month extension, so the project officially ended on June 15, 2007.

In addition to the demonstration's goals for the outcomes of individuals served, the CHI was also intended to bring local public agencies into the business of ending chronic homelessness by making them parties to each local demonstration. Health, mental health, and substance abuse agencies and the local public housing authority had to sign onto CHI grant applications to indicate their willingness to participate. The hope was that the demonstrations would stimulate system change in the direction of commitments to create and maintain permanent supportive housing programs, which need the resources of a variety of public agencies to operate at maximum effectiveness. Federal funding for all project components except housing subsidies (through HUD's Shelter Plus Care program) received less federal money each year as the CHI grant progressed, until all funding ceased at the end of the grant period. If they were to continue after the demonstration period ended, therefore, the CHI projects had three years in which to convince local public agencies to pick up all project funding, and less time than that to generate local funds to replace at least some federal services funding beginning in the projects' second year.

Most CHI projects have had difficulty securing local funding to continue these programs at the end of their three-year federal commitment at their original operating level. In not being able to secure support for its continuation from most of the public agencies that were partners to the demonstration, the SRC is in very good company. To understand why it has been so difficult to secure these health and mental health resources to continue the SRC, it helps to know the challenges that characterized its first years.[1]

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[1] It is beyond the scope of this report to assess the funding levels and sources that the other CHI sites have obtained for post-CHI continuation, or the issues they faced in finding funding. Suffice it to say that the barriers to obtaining continuation funding are many and varied; one or more have plagued all of the CHI projects, and only one of the 11 was fully funded for continued operation at the end of its CHI funding.

HISTORY AND EARLY DEVELOPMENT

CREATING THE CONCEPT—FROM GRANT ANNOUNCEMENT TO APPLICATION

Following its commitment to seek an end to chronic homelessness in 10 years, the federal government issued a Notice of Funds Availability (NOFA) for Chronic Homeless Initiative (CHI) demonstration projects on January 23, 2003. The CHI was a joint effort of three federal departments—HUD, the Department of Veterans Affairs, and several Department of Health and Human Services (HHS) agencies (the Center for Mental Health Services, the Center for Substance Abuse Treatment, and the Health Resources and Services Administration)—corresponding to the various housing and service elements thought to be essential for ending long-term homelessness for people with significant disabilities. Components that had to be part of each local CHI demonstration project included housing (subsidized by Shelter Plus Care vouchers through a local public housing authority), primary health care, mental health care, substance abuse treatment and support, veterans services (from the local VA office), and case management to integrate all the pieces.

From the federal perspective the CHI had three goals, ranging from the concrete to the abstract: (1) to help a specific number of chronically homeless people get and keep housing, (2) to demonstrate the feasibility of collaborative service delivery, and (3) to stimulate system change. To have a chance of winning an award under the NOFA, communities had to identify agencies that would take responsibility for each of the federal funding components, and also describe how those agencies would work together in a collaborative process that would integrate housing and services. With respect to system change, the federal intent was that the public agencies collaborating for the CHI project would become more committed to ending chronic homelessness, continue and expand their newly-developed collaborative mechanisms, and commit resources to the new approaches.

In the months before the CHI NOFA was issued, the executive directors of two Skid Row agencies, the Skid Row Housing Trust (SRHT) and Lamp Community, had been discussing ways in which they could work together. Both understood the need for *supportive housing*—that is, housing with built-in supportive services—because experience had taught them that neither housing nor services was sufficient by itself to end homelessness for the Skid Row population. As a developer of many supportive housing projects, SRHT needed funding for services at buildings being developed. Lamp perceived the need to expand mental health services in Skid Row (it was the only mental health provider in Skid Row other than DMH's Downtown Mental Health Clinic (DTMHC) and to link housing and services as it had done in its own housing projects. Lamp could provide the services in SRHT housing if the resources were available to pay for it. A recent experience of joint activity at the Pershing Hotel had whetted their appetite for joint work and given them some idea of what it would mean to commit their agencies to more collaborative efforts. When the CHI NOFA came out, the directors saw it as an excellent fit for both agencies' needs and desire to pursue joint activities.

The directors read the NOFA carefully and discussed its requirements with a number of advisors. After realizing the NOFA's orientation toward public service agencies rather than nonprofits as collaborative partners, they thought they would not have a chance of competing successfully, as public agencies were largely absent from the Skid Row environment where their organizations

functioned, relationships of the area's nonprofits with Los Angeles city and county public agencies were not well developed, and even Skid Row nonprofit-to-nonprofit agency relationships were shaky and did not involve joint activities.

Nevertheless, the two directors kept talking to each other, their advisors, and potential collaborators. They finally developed a plan that incorporated 12 public and nonprofit agencies as partners in a "Skid Row Collaborative," although only a few would get money for services under the CHI grants. The proposed structure was modeled on San Francisco's successful Health, Housing, and Integrated Services Network (HHISN). Commitment letters were included from all the partners, including the relevant public agencies, the Housing Authority of the City of Los Angeles (HACLA), the Los Angeles County Department of Mental Health (DMH), the Greater Los Angeles Veterans Health Care Administration (VA), and the Los Angeles Homeless Services Authority (LAHSA). The SRHT Grants Manager (who later became that agency's first SRC administrative project director) wrote the CHI application's Comprehensive Section for HACLA, JWCH, and the VA. With help from the Lamp executive director she also wrote the collaborative Substance Abuse and Mental Health Services Administration (SAMHSA) application. A JWCH staff person wrote the Health Resources and Services Administration (HRSA) application. The proposed project was 1 of the 11 projects selected nationwide from more than 200 applications.

Of the 11 CHI projects, the primary federal grant recipient in all but one was a local public agency, suggesting at least the beginnings of public commitment to an ongoing project. The Skid Row Collaborative (SRC) was the exception—the only one that had nonprofit rather than public agencies as the grant recipients, and the only one in which at least one public agency did not play a major role. The SRC had Lamp Community as its primary grant recipient for the services component with the Skid Row Housing Trust providing the housing, which in turn was supported by Shelter Plus Care vouchers through HACLA. The SRC as proposed also included several other nonprofit service agencies operating in Skid Row. Public agencies played a role in the SRC's oversight structure, but not in day-to-day functioning. This grassroots structure going into the project has made a big difference in how the SRC evolved, and is the essential underlying reality helping to explain its future prospects.

GETTING STARTED—THE FIRST YEAR OR SO

The Skid Row Collaborative provided the first opportunity for Skid Row housing and service organizations to target resources and expertise toward the same goal—providing coordinated services and permanent housing to chronically homeless individuals. As this was the first time these organizations had worked together, there were unique challenges to implementing the project. To understand the development of the SRC, we look at the Skid Row environment at the time it started, the SRC partners, and how the SRC governance structure worked.

The Skid Row Environment

Thousands of homeless people are packed into the 50 square blocks of an area just east of downtown Los Angeles known as Skid Row. They mostly live on the streets as far too few shelter beds exist to accommodate their numbers. For at least 20 years before the SRC began, in an "out of sight, out of mind" approach to the problem of homelessness and the circumstances

leading up to it, Los Angeles city and county public policy had been to concentrate shelters and services for homeless people in this area and to send homeless people there when they appeared in other parts of the city and county. Downtown Los Angeles was considered an undesirable place to work or live during this period, and little competition existed for the many old transient hotels, other structures, or vacant spaces in the area. During the 1980s the SRHT and a similar organization, the SRO Housing Corporation, saved may of the area's hotels from destruction and converted them into decent housing (mostly as SRO and efficiency units) for very poor people, including those whose homelessness was ended by being able to access a cheap hotel unit. Rents in most such housing units are rendered affordable even with incomes well below poverty level through various housing subsidy programs. When these organizations began, the problems of the area's population were viewed primarily in economic terms. Both organizations started as affordable housing developers, and learned only through experience that housing alone did not work for some part of the Skid Row community. Several missions, health care, and other service providers also have a long-standing presence in Skid Row. Despite the need, no year-round publicly funded emergency shelter was available in the area when the SRC began; only cold/wet weather shelter was provided, for four months each year, and not much of that.

Despite their seemingly common interests in serving a very needy population, coupled with the perpetual shortage of resources that would point toward collaboration as an efficiency measure if nothing else, Skid Row service providers did not have a history of working together. As a case in point, about five years ago USC's Michael Cousineau published an assessment of homeless people's need for and access to primary health care in the Skid Row area. He reported the pervasiveness of physical health problems among the area's homeless population, including the proportion experiencing serious chronic and life-threatening conditions. He also reported that care to meet this high level of need was scarce and that available care was fragmented. The three existing primary health care agencies did not communicate with each other. When homeless people were desperate, which was the only time they sought care, they went to whichever clinic was open that day, or where they thought they could get in. It was not uncommon for people to have been seen at all three primary care clinics in Skid Row, but no doctor ever knew what another doctor might have done for the patient sitting in the office now. Access to specialty care was very poor, and other problems abounded.

The Los Angeles Political-Organizational Environment

In the few short years since the SRC began, downtown Los Angeles has changed dramatically. The odds of its continuing to do so are putting tremendous pressure on the Skid Row area. When the SRC started Skid Row was still the area that elected officials and policy makers avoided, and the area where the rest of the city and county dumped the destitute, disturbed, and disturbing people that no one wanted to deal with. But skyscrapers were going up even then, several business districts were pressing to expand, and a variety of large residential developments were successfully attracting people with means back to downtown. None of these real estate ventures were pleased to be rubbing shoulders with Skid Row's homeless population, and were (and still are) pushing to "clean up" the area. At the same time, LAHSA conducted a first-ever countywide count of homeless people; the resulting estimate of over 90,000 shocked the city and county into a realization that Los Angeles was "the homeless capital of the country." Crusading media coverage stressed the plight of homeless people in Skid Row and built on the attention generated by the count. All of a sudden homelessness was "big news" in Los Angeles. This attention did

bring some additional resources to Skid Row, but it also brought more scrutiny of the area's service providers and a general public desire to identify "what works" and to seek out programs that could actually end homelessness. In the long run these changes will be good for the programs such as the SRC that can show they are effective. In the short term, however, the recognition that the rest of the city and county have not been doing their "fair share" to shoulder the response to homelessness has led city and county elected officials whose jurisdictions include Skid Row to block new programs in Skid Row until other areas step up to the plate. This resistance has made it harder for Skid Row agencies to pursue plans for expanded and improved services and additional housing despite the obvious continued need for these in Skid Row.

The SRC's Original Partners

Given the historically fragmented nature of housing and services in Skid Row, the SRC was attempting to do something fairly revolutionary—to bring Skid Row agencies together to work toward common goals across substantive, service type, and public-private lines. The 12 original partners were:

- Skid Row Housing Trust (housing and services),
- Lamp Community (case management and services),
- County of Los Angeles Department of Mental Health (mental health care),
- JWCH Institute (primary health care),
- Housing Authority of the City of Los Angeles (housing subsidy vouchers),
- Homeless Health Care-Los Angeles (HHC-LA—substance abuse services),
- Behavioral Health Services (BHS—substance abuse services),
- Clinica Oscar Romero (primary health care),
- Greater Los Angeles Veterans Healthcare System ("the VA"—veteran services),
- Corporation for Supportive Housing (CSH—general guidance and help with team development),
- Los Angeles Homeless Services Authority (LAHSA), and
- New Directions, Inc. (veteran services).

Attempting to involve 12 agencies in collaborative work is quite a challenge, so it is not surprising that there were some shifts and changes early in the process. With respect to primary health care, it was expected that JWCH Institute would apply for and receive Federally Qualified Health Center (FQHC) status early on, and therefore would be eligible for reimbursements adequate to support services for the health care needs of SRC tenants.[2] Clinica Oscar Romero was an FQHC already; its role in the SRC was to provide JWCH with an FQHC umbrella until such time as JWCH could qualify on its own. There was never the expectation that it would take an active role in providing primary care to SRC clients.

Three partners dropped out early on, for different reasons. New Directions was originally expected to provide the veteran services required by the CHI, but the VA received resources to

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[2] A Federally Qualified Health Centers (FQHCs) is a health care provider serving a medically underserved area that meets certain standards and qualifications specified by the federal Center for Medicare and Medicaid Services. FQHCs are able to bill at a rate that is significantly enhanced over regular Medicaid rates.

hire a staff person rather than to contract out for services, and chose to keep that staff person under its own roof.

The two agencies that were expected to provide substance abuse treatment to SRC participants were at the table when the SRC proposal was being written and attended initial partners meetings, but drifted away. Initially there were no clients to serve, as potential SRC participants did not start moving into project housing for several months after the federal funding was received. Even more important, the SRC funding structure did not include payment to these agencies for substance abuse treatment. Early on, as the SRC proposal was being written, it was expected that the SAMHSA component of federal funding would fund services from HHC-LA and BHS. But ultimately the Lamp director felt that there were enough substance abuse treatment resources in the community (both agencies have contracts with the county's Alcohol and Drug Programs Administration to provide substance abuse treatment), so the proposal asked only for mental health services funding from SAMHSA and expected substance abuse treatment services to be "in-kind." The relationship with HHC-LA never evolved. BHS involvement was more long-lived. BHS's executive director consistently attended the Operations Committee, and the agency placed a Recovery Specialist on site at the St. George for some months during the SRC's second year. But BHS staff were not used to working with chronically homeless people, people with a co-occurring mental illness, or people who were not fully committed to recovery from their addictions, so in the end they did not fit the SRC model and population well. A Lamp staff person ended up filling the Recovery Specialist position after BHS's Recovery Specialist left. More work on cross-agency "cultural competence" and ongoing on-the-job training and support would help ease this type of situation in the future, a lesson arising from the SRC experience with respect to many types of training and supervision, as we discuss later in this report.

Three-Level Governance Structure

The CHI grant supported two full-time directors—an administrative project director at SRHT and a programmatic project director at Lamp. In addition, the grant supported on-site health, mental health, and case management staff at the St. George Hotel, the SRC's primary housing venue.

The SRC had to assure that its participants got the housing and services they needed, which sounds like a direct service mission. But from the beginning it was very clear that it would take a good deal of work to get the procedures and practices of the various partner agencies to function in a smooth and integrated way for SRC clients. The three-level SRC governance structure adopted to assure that the necessary interagency arrangements actually happened was modeled on the successful governance structure of San Francisco's HHISN and included policy/oversight, operations, and direct services levels.

- The Policy/Oversight Committee included agency directors or higher-level policy people from the public and nonprofit agencies—people who could, once convinced that the SRC model was viable and useful to their clients, influence their agencies' commitments to continue and expand the model. The Oversight Committee was chaired by a CSH staff person.

- The Operations Committee included the two SRC project directors, a JWCH representative, the "doers" at each public agency, and a facilitator supplied by CSH for the project's first year. These were the people who could smooth the path of service delivery within their own agencies, such as developing streamlined procedures for approving Shelter Plus Care vouchers (at HACLA), modifying tenant selection criteria (at SRHT), assuring priority treatment for health care referrals from SRC (at JWCH), developing a death review protocol (when the issue of participant deaths became a "cause célèbre"), and so on. The Operations Committee was most active during the SRC's first year, as *many* interagency issues needed to be resolved on the way to developing a truly integrated collaborative structure. The Operations Committee, scaled down to the three main partners, has continued to meet throughout the SRC project period and is still active today.

- The direct service level functioned as a multi-service team, with the staff on-site at the St. George forming the team's core and people from the various partner agencies participating as appropriate. Anything the direct service level could do without difficulty it did; when the same systemic issues arose several times, the issue went up one level for the Operations Committee to resolve. This committee too is still active today.

Of these three levels of activity, all people interviewed for this report said that the Operations Committee was the most important, especially during the project's first years. Obviously people would not have been served without the direct service level, so the foregoing statement is not meant to disparage the direct service work. But the direct service staff encountered numerous, sometimes exceedingly thorny, problems as they sought to get their clients the services they needed. Without the Operations Committee to develop and implement approaches to cross-agency access to services, these problems would have continued and possibly escalated. The Operations Committee hammered out solutions that stayed in place and continued to work for SRC clients and staff through the life of the project and are still working today.

During its first year especially, the Operations Committee was called on to resolve many issues of actual program functioning, often having to do with negotiating the relationships and responses of the various partners to each other and to the needs of the project's tenants/clients. For example, each organization came to the project with separate service philosophies and processes. Regular meetings and organizational site visits helped to move separate systems into systems that incorporated the expertise of each partner and were coordinated through outreach, housing placement, and service delivery. Participants noted that after about a year of real effort to understand each other and each other's agencies, they had a clear indicator of their progress each time they attended larger meetings with staff from other service provider agencies. They could tell that they understood far more about interrelated issues of accessing housing, health care, mental health care, outreach, and the like than their counterparts who had not been engaged in cross-agency work, and could help interpret agency cultures and practices for those without their experience.

The success of the Operations Committee, most agree, owed much to the contributions of two people who devoted a great deal of time to assuring that the needed procedures and policies got worked out within and across each participating agency. The facilitator (during the SRC's first year) and the first SRHT administrative project director (for the SRC's first three years)

committed themselves wholeheartedly to the project development process. As with so many demonstration or pilot projects that attempt to do new things in new ways with new partners, the quiet, persistent bridge-building work of one or two mid-level people serving as coordinators was all-important for the SRC. The SRHT's administrative director felt that the most important contribution to success of the SRC demonstration grant was its funding for full-time coordinator positions. Many people interviewed for this evaluation felt that without that coordination the SRC would have accomplished far less. This view is in line with other research (e.g., Burt and Anderson 2006; Burt and Spellman 2007) that identifies the crucial role played by a full-time person charged with the role of coordinator in moving systems toward realizing new goals.

This section on the SRC's three-level governance structure would not be complete without discussing the Oversight Committee. None of the public agencies had a serious institutional commitment to the SRC when it began. HACLA received additional Shelter Plus Care vouchers to cover rent subsidies for SRC tenants, and had only to process them. The VA received additional resources from its national level to support the social worker it dedicated to the project. DMH agreed to let the SRC grant pay for the time of one of its psychiatrists, but thought of the project as a local activity relevant only to Service Planning Area 4 (SPA 4), which includes the Skid Row area, not something relevant to countywide policy. LAHSA agreed to contribute resources for the evaluation.

In addition, the public agencies in the SRC themselves underwent significant administrative problems and leadership changes in the SRC's early years. HACLA had major problems during this time arising from fraud and corruption charges that led then-mayor Hahn to appoint a new person to run the agency. This person committed all of his time to rooting out corruption, and as a result never had a personal commitment to the SRC or saw it as an important HACLA issue. LAHSA experienced a major fiscal crisis during this period, was spending most staff time dealing with audits, and was for a time without a director. DMH faced large budget deficits—a periodically recurring situation in that agency, but one that made future commitments to the SRC problematic. Given their internal problems, it is not so surprising that these agencies did not take much interest in the SRC.

The situation of the three public agencies most involved in the SRC reveals the challenge of creating meaningful system change in the Los Angeles context—the region is so huge, the problems so big, and the crises faced by public agencies so never ending, that public leaders rarely have the time to attend to the results of pilot projects and think through their implications for the future. For these and other reasons, the Oversight Committee did *not* evolve within the time frame of the demonstration into a body whose members worked toward shifting their own agencies' priorities and policies or committing their own resources to continue the SRC or adapt the model it has established for use in other Skid Row or countywide venues. None of the public agencies had to alter any of their own priorities or shift any of their existing resources to support the SRC during its demonstration period.

Early Challenges

Of the many challenges that always arise when a new programmatic concept is being operationalized, a few stand out for the SRC. These include the financial constraints on the

SRHT to rent up the St. George quickly once it was available for occupancy, issues related to client difficulty, and payment arrangements for the staff psychiatrist.

- **Need to rent up**—The St. George Hotel was initially expected to house all SRC tenants. The St. George has 88 units, and the SRC had resources to house 62 tenants at a time. However, the nature of the St. George's capital funding meant that it had to be entirely leased up in a very short time period following the end of renovation. This timetable clashed with the time needed for the SRC to recruit potential participants and move them successfully through HACLA's Shelter Plus Care voucher application process. The SRHT felt its financial exposure made it impossible to hold rooms empty in the St. George until the first 62 SRC recruits qualified for housing vouchers. Although developing a faster HACLA qualifying process was one of the first things the Operations Committee worked on, it could not happen quickly enough to resolve this problem. The result was that only 26 of the original St. George occupants were SRC tenants, and only 41 of the 101 people who were ever housed by the SRC lived at the St. George. The remaining program participants were housed in other SRHT housing (36) and in properties operated by other agencies (24).

- **Client difficulty**—federal sponsors set up the CHI as a demonstration of the Housing First approach to ending homelessness, and identified the hardest-to-serve, longest-time homeless, most disabled people as the target population for CHI demonstrations. Both of these starting premises have implications that federal sponsors may have approved in the abstract but really did not appreciate in their totality what they would mean in practice.

  A Housing First approach means getting people into housing *before* their various conditions are stabilized, so it means there will be tenants who are still abusing substances and tenants whose mental illnesses are still not under medications control. Housing First means that tenants have tenancy rights, and may *choose* to participate in services but cannot be forced to do so. Housing First means that project staff do not control tenants, but must ask for their cooperation.

  A focus on the hardest-to-serve means that the people a CHI project seeks as tenants will have many co-occurring conditions and those conditions will be serious. Skid Row certainly contains a huge number of people that fit that description, and the SRC set out to bring them into housing. It succeeded. Once it *did* succeed, however, things happened that were not so surprising given the people in the project, but that proved alarming to federal sponsors.

  SRC tenants did not immediately cease to be who they were just because they moved into housing. It takes a while to stabilize people, attend to their health care needs, help them work to reduce their substance use, get treatment for their mental illnesses, and learn to live indoors. The people recruited into the SRC were often very sick as the result of long years living on the streets. Several SRC tenants died while in SRC housing. One was from a drug overdose; the others were from chronic conditions (e.g., end-stage renal failure). Upon careful checking with the other 10 CHI projects, it turned out that all had had deaths, at approximately the same rate as SRC. So did LA's HOPE, another CHI demonstration whose focus has been on housing and work (three participants died while

in the program). But the death from a drug overdose came close to bringing the whole SRC project to a sudden halt. The VA and HUD, in particular, were extremely distressed—the former because of the responsibility it feels as a healthcare system for understanding any death, and HUD because of legal constraints on uses of HUD funding. Some suggestions from federal officials would, if they had been accepted, have turned the project into something more closely resembling a jail than a housing project. Federal reactions suggested that, although the federal government was officially committed to housing and serving chronically homeless people, there was little appreciation of the reality—that chronically homeless street people are very sick, in many ways. Homelessness exacerbates their health conditions and street homelessness increases their odds of dying to 30 to 50 times that of housed people of similar ages (based on Boston Health Care for the Homeless statistics).

At the same time, SRC ultimately benefited from the furor. The Operations Committee took on the task of developing a death review process, which examined the circumstances of every death and determined whether anything could have been done differently that might have led to a different outcome. In setting up this process the SRC benefited from VA protocols and practice to improve its own procedures and establish its own policies.

- **Arranging for a staff psychiatrist**—SRC's grant included funding to cover all the time of an on-site psychiatrist during its first year, half of the psychiatrist's time during its second year, and none of the psychiatrist's time during the grant's third year. The federal presumption was that local funding would cover the balance—in the case of the SRC, that funding would have come through DMH. DMH's Downtown Mental Health Center (DTMHC) assigned one of its staff psychiatrists to work half-time at the St. George—an arrangement that lasted for most of the SRC's life.

  SRC reimbursement to DMH for this psychiatrist's time, in accord with the terms of the SRC grant, proved to be impossible. Two issues were involved. First, DMH did not have a procedure through which it could bill for and receive funding from a private nonprofit entity such as the SRC—all of its revenue streams come from public sources. Second, DMH was able to and did bill Medi-Cal for the psychiatrist's services to every SRC client who was Medi-Cal eligible—about two-thirds of the SRC clientele. So DMH was capturing some income from the psychiatrist's work, just not from SRC. DMH was not able to determine, or to estimate, how much it was recapturing through Medi-Cal, and therefore could not determine how much it should subtract from any reimbursement request it made to the SRC.

  For the three years of its federal grant, the SRC rolled over the funds designated for DMH, with SAMHSA's permission, while requesting DMH to invoice for psychiatric services unreimbursed by Medi-Cal. DMH ultimately developed a mechanism for billing, to become effective for the SRC's third year, authorized by the County Board of Supervisors. However, DMH never developed a way to avoid double billing (accounting for and subtracting the funds DMH recovered through Medi-Cal), and thus never submitted an invoice. Toward the end of the SRC's third year, so as not to lose the resources initially intended for DMH, SRC partners SRHT and Lamp sought approval

from SAHMSA to use those resources for SRC staff, which supported the project for an additional seven months, through June 15, 2007.

THE MODEL AND HOW IT HAS WORKED

SRC has developed a model that really works for the most long-term homeless, multiply disabled single adults who frequent Skid Row. It combines housing in SRO and efficiency units in three closely linked downtown hotels with intensive on-site services that include case managers but go well beyond the usual case management approach. From project inception, office space at the key project hotel has been provided for a psychiatrist, psychiatric nurse, and caseworkers. The nurse has been on site full-time and the psychiatrist 20 hours a week for most of the project period. The VA devoted a full-time social worker to the project starting a few months after people began to move into housing; he also has an office in the building. All three of these staff have been with the SRC for its entire existence. The grant includes positions for several additional caseworkers, which have been filled with a variety of people during the project period—keeping staff in these positions has been one of the challenges the project has faced.

THE DYNAMICS OF SRC SERVICES

The SRC structure of services integrated with housing has helped to keep small tenant lapses from becoming major ones. During the SRC demonstration period the nurse was on-site full time, the psychiatrist half-time, the VA social worker was available full-time, and these three key staff were supported by several case managers officed in the St. George. Some specialty staff were also sometimes available, such as a post-traumatic stress counseling specialist who joined the staff late in the demonstration as the need to address PTSD became very apparent. Staff saw tenants regularly. The nurse dispensed all medications and was thus the first to know that someone has stopped taking needed meds, and would ask the person to "drop by and see me." Most of the time this approach resulted in resumption of medications as well as discussion of what might have been going on that induced the tenant to think of stopping. If the nurse's intervention was not enough to resolve the issue, the nurse and psychiatrist were able to work together to develop an approach that was almost always successful. The intensive supervision that results from this program structure has let the SRC staff help even people with potentially extreme behavior to keep their housing and deal with their issues. One example was a firesetter who always started out small (such as a piece of paper in her room). The minute matches started disappearing, the nurse and the psychiatrist knew the tenant was starting to go off of medications and took steps to get the tenant back on track. It was the staff's opinion, including that of the psychiatrist, that the SRC was able to house much sicker people successfully with the services in place than it could have done with less intense and less integrated services.

DOCUMENTING EFFECTIVENESS

The primary goal of the SRC is to end the homelessness of chronically homeless, very disabled people by providing housing and the supportive services that help them stay in housing. To assess the SRC's effectiveness, we looked at the project's own statistics on housing placement and retention, and compared these to housing retention among disabled formerly homeless people living in the Simone and the Pershing (two other SRHT hotels) with subsidies from Shelter Plus Care housing vouchers.

In interpreting the results, it is important for the reader to keep two things in mind—the SRC tenants were significantly more disabled than tenants in the comparison group, and they were homeless for considerably longer than the comparison group tenants before they obtained housing. Simone and Pershing Shelter Plus Care tenants had to be homeless and disabled to qualify for their housing unit. Their disabilities were HIV/AIDS, substance abuse, or mental illness. In contrast the SRC tenants had to be chronically homeless (either living on the streets or in an emergency shelter for over a year, or four episodes of homelessness in three years) and severely mentally ill, with or without a co-occurring substance abuse disorder. In reality the average length of homelessness for the SRC tenants was eight years before coming into housing, and almost all had co-occurring substance abuse disorders. The SRC staff believed the project's tenants to be much more ill and in need of much more direct and ongoing support than the Shelter Plus Care tenants in the Simone and Pershing hotels. As one senior SRHT staff person put it:

> We screen people applying for a unit in our hotels. The screening process allows us to "flag" a person's circumstances that we know from past experience mean the person will have trouble retaining housing. Too many flags and we don't take that person. For the SRC, everyone recruited had so many flags that we would never have offered them housing if we had followed our normal procedures. But we took them all into the SRC….and to my amazement, it has worked. We've done better with harder people. I've personally done a 180 on thinking that housing and services should be co-located.

Thus if the SRC retention patterns are similar to those in the Simone and the Pershing, it means the SRC is achieving the same results for considerably more difficult clients. If the retention patterns are better for SRC tenants than for Simone and Pershing tenants, it means the SRC is doing better with harder clients. Either finding would speak well for the SRC.

Meeting Housing Retention Milestones

The SRC is able to house 62 people at one time, and has housed 101 people since January 1, 2004, the date its first tenant moved in. During that same period 139 new Shelter Plus Care tenants moved into the Simone and 65 new Shelter Plus Care tenants moved into the Pershing. We treat these 204 tenants as a comparison group. We established a length of stay for each tenant by calculating the number of days between his or her move-in date and the date he or she moved out or May 31, 2007, the day we chose as the end date for measurement, whichever came sooner. In a few instances a tenant had more than one period of residency with a gap between during which he or she was out of housing. When this happened we combined the number of days during each residency to determine a total number of days in housing.

The first way we examined the SRC's success in housing retention was to calculate the average length of stay for SRC and comparison group clients. Results indicate that the average length of stay for SRC clients is 614 days, which is about 200 or 210 days longer than the average length of stay for Simone and Pershing Shelter Plus Care tenants—close to 7 months longer.

However, this approach fails to take into consideration when each tenant moved in, and therefore whether he or she had a chance to stay for a long time. A tenant moving in on January 1, 2004
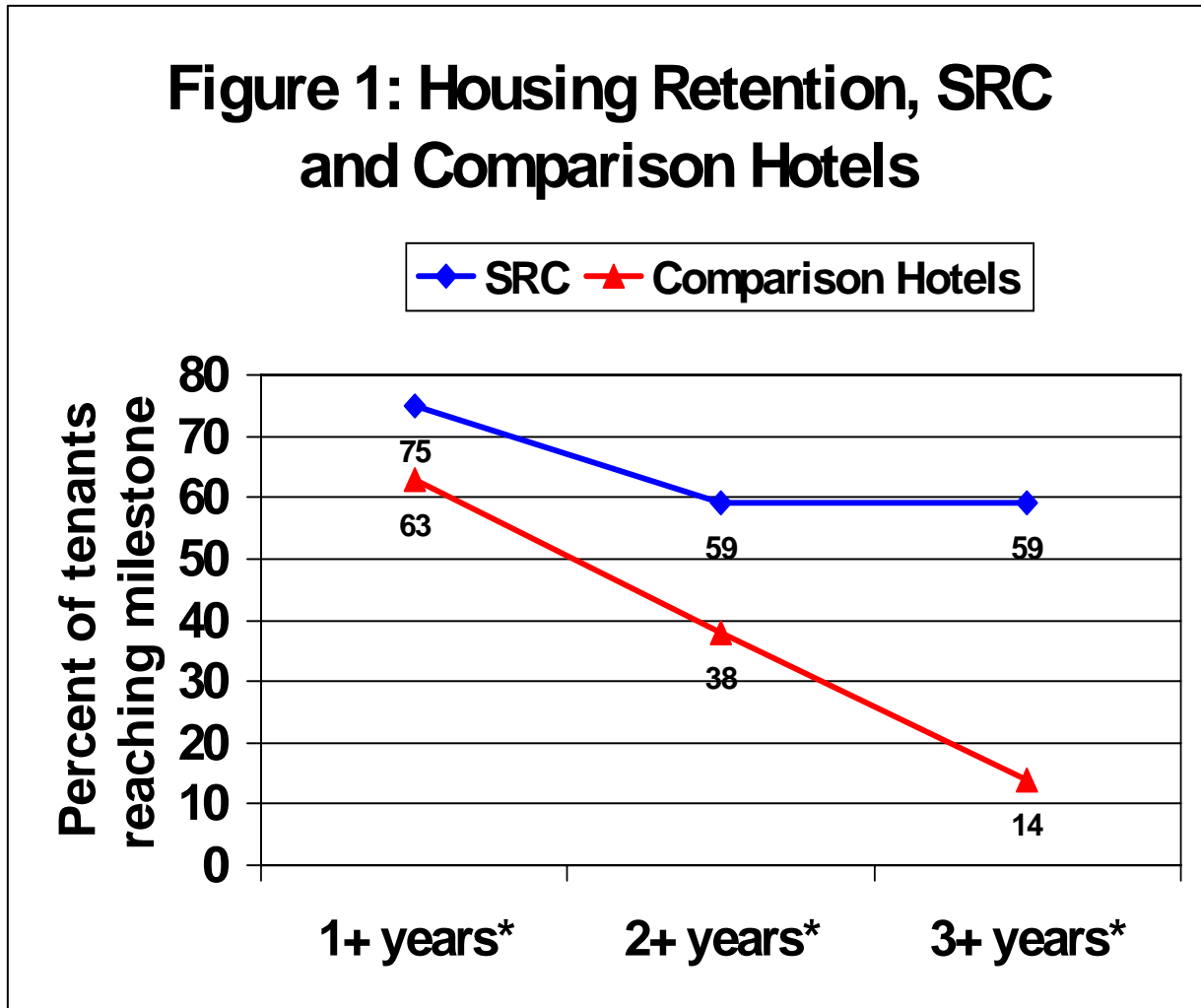
had a chance to stay in housing for three years and five months, whereas a tenant moving in on January 1, 2007 only had a chance to stay for five months. The most appropriate, and revealing, way to examine housing retention is to look at those who achieved a specific milestone such as still being in housing after one year, assuming they were eligible for that milestone. By "eligible," we mean the following: to be eligible for consideration as having reached the one-year milestone, a tenant would have had to move in at least one year before May 31, 2007. To be eligible for consideration as having reached the two-year milestone, a tenant would have had to move in at least two years before May 31, 2007, and so on. Since the SRC only started a little more than three years ago, the number of eligibles for each milestone gets smaller as the milestone requires longer housing retention.

Table 1 presents the relevant data, examining the milestone achievement of people who moved into SRC housing or the Shelter Plus Care-supported housing at the Simone and Pershing hotels from January 1, 2004, through May 31, 2007. Figure 1 displays the percentages in table 1's final, shaded, column in graphic form.

Table 1: Housing Retention for SRC Tenants Compared to Shelter Plus Care Tenants at the Simone and Pershing Hotels (move-in on January 1, 2004 or thereafter, through May 31, 2007)			
Client Group	Number of eligibles-- tenants whose move-in date was at least 1, 2, or 3 years before 5-31-2007	Number of eligible tenants who reached the milestone of 1, 2, or 3 years in housing	Proportion of eligible tenants who reached the milestone
Skid Row Collaborative tenants			
One or more years	92	69	75[a]
Two or more years	69	41	59[b]
Three or more years	32	19	59[c]
S+C tenants in comparison hotels			
One or more years	155	97	63[a]
Two or more years	106	40	38[b]
Three or more years	37	5	14[c]

[a] Percentages so marked are significantly different from each other at $p < .05$.
[b] Percentages so marked are significantly different from each other at $p < .01$.
[c] Percentages so marked are significantly different from each other at $p < .001$.

Table 1 reports the number of tenants eligible for each milestone and the number and proportion of those eligible who reached the milestone. For the milestone of one-year housing retention, 92 SRC tenants were eligible, of whom 75 percent (69 tenants) met the milestone. This is significantly higher ($p < .05$) than the milestone achievement of people in the comparison hotels, among whom 155 were eligible and 63 percent (97 tenants) met the milestone. The difference in housing retention increases in favor of SRC tenants at each subsequent milestone. At the two-year milestone it is 59 percent for SRC tenants versus 38 percent for comparison hotel tenants ($p < .01$); at the three-year milestone the difference is 59 versus 14 percent ($p < .001$).

Figure 1: Housing Retention, SRC and Comparison Hotels

SRC — **Comparison Hotels**

Percent of tenants reaching milestone

- 75
- 63
- 59
- 38
- 59
- 14

1+ years* 2+ years* 3+ years*

•Data points represent proportion of tenants reaching milestone, of all those moving into housing early enough that they *could* have reached milestone (I.e., at least 1 (2, 3) years before May 31, 2007.

The level of staffing committed to helping SRC tenants retain housing is considerable. Within SRC, the staff-to-tenant ratio is 1 to 20. Case management ratios for the Simone and the Pershing are 1:82 and 1:67, respectively, and the specialized SRC staff (psychiatrist, nurse, VA specialist) are not available. One might look at the data in table 1 for one-year retention and think that performance of the Simone and Pershing is really not too bad. Considering the significantly lower availability of supportive services, their retention rate for the one-year milestone is only 12 percent lower than that achieved by the SRC (63 vs. 75 percent). However, the rates of those eligible for and reaching the two- and three-year milestones tell a different story. For those eligible for the three-year milestone, SRC retention is stable at 59 percent while retention at the comparison hotels has fallen to 14 percent. If both the SRC and Shelter Plus Care are programs intended to provide *permanent* supportive housing and to assure that people have the ability to remain in it, then the SRC model is clearly preferable.

We also examined the issue of differences *within* the SRC, specifically between tenants housed in the St. George Hotel where service staff have offices within the building and those housed elsewhere but served by the St. George-based support staff? That is, does being in the same building as supportive services staff do more for tenants than just having those staff available in a nearby location? The answer is "no"—there are no significant differences in housing retention between SRC participants housed in the St. George and those housed elsewhere, after taking into account each tenant's eligibility for reaching a retention milestone.

HOUSING-RELATED LESSONS LEARNED—IMPLICATIONS OF FINANCING CONSTRAINTS FOR LEASE-UP REQUIREMENTS

Given the difficulties encountered early in the SRC demonstration with respect to lease-up (see p. 7), any future projects should think through in advance any requirements imposed by their capital funding sources, especially as to when capital loans have to close and when building have to be completely occupied. If rent-up has to happen within a specified time period, and if rent-up depends on prospective tenants qualifying for housing subsidies, then procedures need to be worked out with the voucher-qualifying agency in advance to be sure the applications get processed in the time required. Other possible negotiations could be done with the capital funding source(s), which sometimes have been known to flex their post-development time restrictions if there is a good reason and clear plans to accomplish full rent-up within a known, reasonably short, expanded time frame. In addition, the project has to have a pipeline of available prospective tenants who can immediately begin applying for and receiving housing subsidies. Developing this pipeline can sometimes be a delicate balancing act between recruiting people too early and losing them while project construction nears completion versus recruiting them so late that they cannot get through the subsidy application process in time to satisfy lease-up requirements.

STAFFING-RELATED LESSONS LEARNED

Having Experienced Professional Staff on Site

Key informants who have had lots of experience with different models of permanent supportive housing attest to the difference it has made to have the SRC nurse, psychiatrist, and VA social worker on site, and that they have stayed with the program. Their physical presence in the building has promoted more interaction with tenants, which in turn allows staff to catch potential problems before they become full-blown crises. Having staff-tenant relationships lasting several years contributes to the same effect, in part due to increased staff knowledge and in part due to increased tenant trust and openness with staff. Tenant stability in housing has been one consequence, as has improved health conditions. To paraphrase one interviewee:

> At first I was against it. Housing is supposed to be housing, not a service site. People should live where they live, I thought, and go to clinics for services. But seeing the difference it has made to have the nurse and the psychiatrist in the St. George has taught me a lot, turned me totally around, made me a believer in having services in housing. Not only has it made it possible for us to house a more seriously disabled group of people than we had tried before, but we have done it with fewer problems and less housing loss than in some of our other buildings. It

also demystifies services for tenants, as they can see that the nurse and the psychiatrist are not monsters. It makes it easier for them to accept help.

Finding and Retaining Staff

The SRC was lucky to have the SRHT administrative project director and its three most important on-site staff people—the psychiatrist, nurse, and VA social worker—involved for the entire length of the project. Not only were they a source of continuity and stability throughout the project, but they came to the project with a wealth of pertinent experience and an explicit *preference* for working with the very difficult population of SRC tenants. The nurse had worked for 14 years in hospital psychiatric wards before coming to the SRC. The psychiatrist, who was new to Los Angeles but not to community psychiatry, sought out Skid Row as the place with the population she *wanted* to work with—those with the most difficult chronic conditions and complications. The VA social worker had just finished his master's degree, along with a project in which he conducted long interviews with homeless veterans and got to know their issues and experiences. When the SRC job became available, it was just what he wanted.

The SRC was not so lucky with its other staff. Initially there were two project directors, the programmatic project director at Lamp and the administrative project director at SRHT. The Lamp project director position turned over three times in less than three years. Its first occupant was excellent organizationally, working with other Operations Committee members to establish functioning relationships among the various public and private partner agencies involved in the SRC. However, he left toward the end of the project's first year. The other two did not leave a significant mark on the SRC.

One of the challenges with finding the right person for the LAMP project director position was that the grant was written for this person to be a licensed clinical social worker (LCSW). The majority of LCSWs interviewed and hired did not have the management and problem solving skills to oversee a team and manage a program that was so dynamic. The majority of services provided by SRC involve problem solving rather than counseling or therapy. Most of the LCSW candidates did not have the organizational skills needed to fulfill this position, nor were they used to working with a population with as many interacting issues as existed with many of the SRC tenants. Late in the project (November 2006), this position was filled with a person who had a bachelor's degree in social work but who had the needed management skills and level-headedness for the position. The expectation for the SRC model going forward is to have the psychiatrist provide the clinical oversight of the team and the Lamp programmatic director provide the day-to-day coordination, staff supervision, and training. Lamp staff felt that to provide the needed level of staff support the tasks of the programmatic project director needed to be split into clinical and staff supervision components. Only the future will reveal whether this restructuring will improve staff retention as well as services to clients.

Recruitment and retention of direct service/case management staff has been particularly difficult. People interviewed for this report described three rough categories of staff, each of which had its own difficulties relating to the realities of Skid Row and of the tenants on their caseloads. One category was "young, bright, newly-graduated social workers who want to cure everyone." When that does not happen, due to the histories of the people recruited to be SRC tenants, they burn out and move on. A second category was "paraprofessionals, including peer counselors and

others who had only recently left homelessness themselves." Staff in this category could relate to the tenants but did not have the skills, or the distance needed, to help direct tenants toward more stable behavior and settled residency. A third category, probably overlapping the first one, was "people who couldn't take the Row." These were staff will no prior experience of the Skid Row environment, who were overwhelmed and often scared, and who did not get the guidance and training they needed to work well at the SRC.

Several interviewees reflected on what it takes to "find the right people." Lessons learned from the folks who did not work out well were: (1) try to get people who have some experience working with people like those in the SRC, (2) provide adequate and regular supervision one-on-one as well as in case review groups, to help guide new workers and to reinforce with more experienced workers the things they are doing well and what needs improvement; and (3) develop and deliver considerably more training in all aspects of the job than was initially envisioned.

Finally, underlying all other issues and criteria are the very low salaries that SRC and other service agencies in Skid Row are able to pay. At these salaries, only the most dedicated staff will stay and work in Skid Row. The most dedicated staff are what Skid Row needs, but Skid Row agencies including the SRC need to do more to create that dedication, as most people they are able to attract will not come with it and will need some significant amount of help and guidance to do their best and by doing it, develop the dedication.

This is where the need for training comes in. The SRHT has learned an important lesson from the SRC experience, and now offers training to its direct service staff in the SRC and its other buildings every Friday. Training covers the basics of "what is mental illness," harm reduction, addiction, permanent supportive housing, stages of change, and other pertinent issues. Once a month, training is devoted to case presentations—staff bring real cases that the group reviews from a stages of change perspective. Participants figure out the person's baseline, what might change and why, what change would mean, when and how to intervene, and other essential issues. In addition to these training meetings, SRHT now holds weekly meetings in its residential buildings of the relevant property management and services staff. Other research has shown that property management staff often become aware before services staff of tenant behavior that could escalate into serious problems. By sharing information about tenants and about strategies to help in a timely and appropriate way, property management and services staff work together to prevent the escalation of small signs into major problems that would lead to housing loss.

Good staff supervision is as important as training; one is not a substitute for the other and in many ways supervision is an extension of training and helps it solidify into daily practice. The training lesson appears to have been learned. SRC staff have also recognized the need for more extensive and specific supervision. Recent changes noted above are intended to provide the level of support needed by caseworkers and other SRC staff. With the psychiatrist providing clinical oversight and supervision and the Lamp programmatic director providing day-to-day coordination, staff supervision, and training, staff will have venues in which to discuss complicated client issues, work out approaches to try, discuss what worked and what did not, and articulate the lessons to draw from the experience.

Changing Agency Management

Not only did the SRC's direct service staff experience significant turnover during the pilot period, but the executive directors of two of its core agencies, Lamp and SRHT, changed as well. Less than a year and a half after getting the SRC grant, the two people who had wanted their agencies to work together were gone. Each had worked in Skid Row for many years and had established strong relationships with key stakeholders and track records of being able to attract and work with, or house, the local homeless population. The original Lamp executive director had a strong personal relationship with the head of DMH and had often been able to negotiate special considerations for mental health care in Skid Row given the unique nature of the population to be served and Lamp's unique ability to engage the population. Just at the time when negotiations with public agencies needed to start in earnest if future funding commitments were to be secured, changes in agency leadership as well as changes specifically in SRC staff broke the continuity of earlier relationships.

The departure of long-time agency heads and turnover among SRC staff left meant that new directors and staff had to develop relationships with key public agency personnel at the same time that they were trying to obtain new resources to assure the SRC's future. At the same time, the public agency that SRC needs most, DMH, has a huge budget deficit and is trying to protect its own staff and programs. This has not been the best of times to be trying to get new financial commitments from DMH. It has taken some time for Lamp, as the services provider in the SRC partnership, to negotiate changed relationships with DMH. As detailed below, DMH and Lamp have now reached agreement with respect to Lamp developing the capacity to charge Medi-Cal and DMH allowing some of Lamp's DMH contract resources to be used as county match. The two agencies are working to develop approaches that will give Lamp the resources to support its work with SRC clients as well.

FUNDING-RELATED LESSONS LEARNED

The difficulties surrounding use of grant resources for a psychiatrist employed by DMH contain some important implications for future procedures. If a federal grant is structured to pay for services being supplied by a local public agency, mechanisms must be in place to assure that the local agency will be able to access the funds, whether by contract or invoice for services delivered. In the SRC's three years, DMH was never able to work out a mechanism that would let it accept its share of SRC funding. Even after a billing procedure was finally approved, in the SRC's third year, the problem still could not be resolved because DMH was not able to account for and deduct from its bill services for which it had been reimbursed by Medi-Cal. Had everyone been aware of this issue going into the project, it is likely that recordkeeping could have been structured to keep track of what was billed and received on behalf of SRC clients, and DMH could have received its share of SRC resources.

Another example of financially-related difficulties is the on-again-off-again cost-avoidance study that was supposed to be a joint project of LAHSA and SRC. Perceptions differed as to the competence and achievements of the firm initially contracted to do this study, but it now appears that before it was diverted to work on LAHSA audits and dropped out of the cost-avoidance picture, it had been able to connect to the relevant departments, learn about the structure and availability of needed data sets, and begin negotiations to be able to work with those data sets. LAHSA's own financial difficulties then delayed progress for a considerable time. Even once

LAHSA was under new management there was a period during which it was not clear that the cost-avoidance study would proceed. The study has now been revived, but it has still taken some time for everyone to agree on what was to be studied, what the sample would be, and who would be involved.

SUSTAINABILITY

The SRC has proved to be a successful model of housing plus services for the Skid Row population of chronically homeless multiply-disabled people—a model that could be adopted more widely in Skid Row as a tested and documented approach for ending the homelessness of Skid Row's street homeless population.

However, its status as nonprofit driven and the fact that the Oversight Committee and its members never developed into champions of the SRC model left it in an awkward position with respect to its own continuation. SRC agencies have spent a lot of time and effort negotiating with the relevant public agencies to find the resources to continue the SRC. They will definitely need help if the SRC model is to be adopted as an important one for public agencies to fund elsewhere in the county.

Some commitments have been made. The VA will continue to provide a part-time case manager. All services continue to be provided thanks to six months of funding for services from the Corporation for Supportive Housing. JWCH has become an FQHC and is able to bill Medi-Cal; it is also using this year to establish special rates so reimbursement for the depth of service needed by Skid Row residents and SRC tenants will come closer to covering actual costs. Lamp has made the changes needed to become a Medi-Cal billing agency. So in the near future FQHC Medi-Cal billing should cover most of the costs of primary health care and psychiatry. The big pieces still missing are funding to cover case management, substance abuse treatment, and other mental health services.

AN INTEGRATED VISION FOR THE FUTURE—MEDICAL HOME CO-LOCATED WITH HOUSING

At this time the SRC has regrouped with three primary nonprofit partners, SRHT, Lamp, and JWCH. It is being supported by HACLA's commitment to continue subsidizing the housing component with the Shelter Plus Care vouchers that came with the SRC and a part-time VA case manager. The elements currently missing are supportive services, including health and behavioral health care and general case management. Ultimately, the intent is for Lamp to supply expanded case management services to tenants in SRHT buildings, and for JWCH to establish "medical homes" in three or four of those buildings, through which all tenants in SRHT's more than 1,000 units will receive primary care and mental health services and be linked to other services as needed. These medical homes will essentially be satellite locations for JWCH clinicians. This is a very ambitious but also very sensible vision of the most effective configuration of services and housing for the hardest-to-serve street homeless people in Skid Row. To bring this vision to fruition, the partners need funding for supportive services. At the moment, the primary approach being pursued is the ability to bill Medi-Cal; other possible sources are SAMHSA or funds through Los Angeles County's Homeless Prevention Initiative.

Medi-Cal as a Source of Services Funding

JWCH Institute. As of spring 2007, JWCH is working to qualify for enhanced Medi-Cal reimbursement rates under its FQHC status, and to be authorized to serve Skid Row's homeless people who are not Medi-Cal eligible as presumptively eligible for "medical indigent" status, for which Medi-Cal could also be billed. Success at these strategies will provide the resources necessary for JWCH to be the primary provider of health, mental health, and substance abuse treatment of SRC clients as well as other Skid Row residents.

Lamp Community has had a DMH contract for many years, which supports its case management/supportive services work with its own clients who have major mental illnesses in its AB 2034, PATH, and other programs (this contract does not cover Lamp's work with SRC tenants). Lamp has spent considerable effort to develop the internal systems necessary to be able to bill Medi-Cal, and began billing Medi-Cal for relevant services on September 1, 2007. To make this capacity meaningful, Lamp required DMH's participation *and* a DMH funding commitment, as the match for billing for mental health services under Medi-Cal comes out of the DMH budget. Negotiations with DMH have been resolved by allowing Lamp to identify some of the funding it receives under its existing DMH contract as the required match. There will not be any new DMH money involved for Lamp under these circumstances, but Medi-Cal billing will allow Lamp to generate new federal dollars to support and enrich existing services. It makes the agency eligible for additional MHSA dollars. This capacity is meaningful *for SRC*, because Lamp's Medi-Cal certification dramatically increases the likelihood that DMH will allocate additional funds to Lamp Community for the Skid Row Collaborative. Lamp does need an additional financial commitment from DMH in order to draw down Medical/FFP funds.

If both Lamp's and JWCH's efforts succeed, they could potentially provide significant resources for the services needed by SRC tenants and other housed and still-homeless residents of Skid Row. It is anticipated that the JWCH and Lamp changes will take 12 to 18 months to bear full fruit in the form of adequate funding for the supportive services, and to work out the mechanisms whereby that funding can be used to support SRC tenants. The latter should not be a problem for JWCH, but might be a problem for Lamp. This leaves a substantial time period during which the SRC needs funding to continue its health and mental health services at the St. George and possibly expand services to the Rainbow and one or more other hotels. The SRC applied to CSH for a grant to help them bridge this time gap and received enough to support the staff at the St. George for six months after the demonstration ends, which would carry the on-site services through the end of 2007. An application is also pending with SAMHSA, which announced the availability of services funding in spring 2007. Thus there is a looming services funding crisis and the final resolution may still be as much as a couple of years away.

Three issues with respect to Medi-Cal billing must be understood as part of the picture of what the capacity to bill Medi-Cal will do for the SRC. The first issue is Medi-Cal coverage, the second is reimbursement rates, and the third is which agency will receive the reimbursement.

Coverage. For a health care provider to be able to bill Medi-Cal for treatment, the person treated must be Medi-Cal eligible. For the Skid Row homeless population, that basically means that people must be SSI recipients. It is *possible* that up to two-thirds of street homeless people in Skid Row could qualify for SSI based on the severity of their disabilities, but getting them qualified can be a lengthy and difficult process, and the proportion could be lower. No more than

two-thirds of SRC tenants receive SSI, so only two-thirds of them would be able to receive Medi-Cal reimbursable services. Thus health and mental health supportive services for at least one-third and possibly as many as one-half of the Skid Row homeless population would not be billable to Medi-Cal; their care would have to be supported by other funding. JWCH is negotiating with Medi-Cal to be able to bill for all treatment for homeless people in Skid Row, plus formerly homeless people in Skid Row housing, on the presumptive eligibility basis of their being medical indigents. This may prove a winning strategy for JWCH, and would thus be a major benefit for Skid Row's homeless and formerly homeless population, but this option will not be available to Lamp Community.

Reimbursement rates. Medi-Cal reimbursement rates to health care providers (and Medicaid rates generally around the country) are notoriously low—for instance, the billing rate is only about $15 for a psychiatric visit. That might be fine if a psychiatrist can see one patient every 5 or 10 minutes, just to monitor medications. But that level of care and patient involvement is clearly inadequate and inappropriate for treating the severely disabled people recruited as tenants for the SRC or most of the other disabled homeless people on Skid Row. FQHCs are able to bill at significantly enhanced rates, but it takes a year or more to establish what those rates should be, based on actual experience of treating the population in need and get them approved. An initial expectation of the SRC proposal was that JWCH, one of the primary health care providers in Skid Row, would apply to become an FQHC and thus be able to supply medical and mental health care at rates high enough to support the types of staff that would be needed for the project once federal funds ran out. JWCH's application was rejected on its first submission, setting this part of the plan back at least a year. JWCH recently qualified as an FQHC. Now it has to go through a period of a year or so during which it serves patients and documents the cost of care, after which it can apply for the enhanced rates available to an FQHC. Once its enhanced rate structure is approved, JWCH will receive significant resources through Medi-Cal billing. It will still have to develop sources of matching funds for the Medi-Cal financing, which could be public (county, state, federal) or private (foundations, general fundraising). Locking in these matching resources should be an important area of endeavor during the year or more in which the FQHC rate structure is being established. But FQHC status entails a basic federal grant, access to staff through the National Health Services Corps, and reduced-price medications, among other benefits to an FQHC's budget and patients. So it is a very promising direction for JWCH to be heading.

Who gets reimbursed? Both JWCH and Lamp will receive the Medi-Cal reimbursement for services they provide and bill for. Thus JWCH will have the use of that income to support patient care. Its Medi-Cal billing ability will also bring Lamp more money, as Lamp will receive all of the FFP Medi-Cal reimbursement. Lamp does not plan to use these additional funds to serve more people; rather, the funds will increase the agency's budget and its ability to serve its current clients more effectively. Lamp staff hope that Medi-Cal's ability to pay for targeted case management will be an effective way to provide and sustain services in permanent supportive housing. However, as Lamp's current DMH contracts do not fund SRC services, DMH would have to invest several hundred thousand dollars more than it now does to allow Lamp to cover its SRC clients with case management under Medi-Cal. Lamp is working on getting that commitment.

BEYOND MEDI-CAL—PROSPECTS FOR STABLE LOCAL FUNDING

Funding for services through Medi-Cal is necessary, but for reasons stated above can never be sufficient to support the array and intensity of services needed. Complementary additional funding will have to come from local public and private sources. To get these resources, SRC officials will have to act as a good partner, demonstrating competence and winning the respect and trust of the people and organizations that can commit funding for the future.

Looking at prospects from the SRC's primary public partners, the Shelter Plus Care vouchers that HACLA receives as part of the SRC demonstration were for five years, so they are continuing past the demonstration period. The expectation is that they will be renewable when their term expires, so the project has secured ongoing support for the number of housing subsidies that came with the original federal demonstration grant, and that are essential to keep project participants stably housed. HACLA has also devoted other Shelter Plus Care vouchers to the Rainbow (now open) and the Abbey (under construction), both run by SRHT. These vouchers will serve a similar population, but will not be matched with the same level of service because the funding is not available.

The VA provided the SRC with a social worker during the federal demonstration period, because it received a directive from the national level to do so, accompanied by funding for the position. The VA has made the commitment to continue this position at the SRC now that the demonstration is over and, equally important, is keeping the same person in it who has served the SRC for three years. He will, however, only be available to the SRC for part time rather than the full-time commitment he was able to make during the demonstration. In addition, the VA has had, and still maintains, its own downtown clinic to serve any homeless veterans in the area who want health care, and VA staff interviewed for this study indicated that the clinic's availability fulfills the VA's obligations to the many veterans among Skid Row's street homeless population. But clinic services do not have the same effect as an on-site social worker, as the SRC experience shows.

The third of the SRC's government partners, DMH, has always treated the SRC as a *district* commitment, not a commitment of the entire county department.[3] The DTMHC, part of DMH's Service Planning Area 4, is available to serve people in Skid Row who have serious mental illness. From its beginning, the SRC has benefited from the services of a psychiatrist assigned from DTMHC to work with its tenants on site at the St. George Hotel. Once the federal project ended, however, DTMHC first halved and then eliminated the on-site psychiatrist position due to its own budget crisis, which left it with no psychiatrists other than the one who had been working at the SRC. DMH and Lamp are currently discussing options for funding the JWCH staff psychiatrist now working with Lamp.

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[3] The county is divided into districts, or Service Planning Areas (SPAs), each with a district director and a budget to address client needs within the district. The overall departmental position on continuation funding for mental health services for the SRC has been "it's up to SPA 4, negotiate with them." This is quite a different attitude from the one that DMH takes with respect to another federal demonstration, LA's HOPE, which it initiated along with the City of Los Angeles's Community Development Department.

A missing component in the SRC's mix of committed services has been substance abuse treatment. The two organizations originally expected to provide substance abuse services for SRC clients (Behavioral Health Services and Homeless Health Care-LA) never became integrated into the SRC. Through its own resources, Lamp provides support for substance abuse recovery, including counseling by qualified substance abuse counselors and peer approaches such as Alcoholics and Narcotics Anonymous. But actual treatment dedicated to SRC clients, whether outpatient or inpatient, is still the missing link in the SRC, as well as in many other supportive housing projects.[4]

THE BOTTOM LINE

On a number of important issues, people interviewed for this report had widely disparate perceptions depending on their agency, position, or period of involvement with the SRC. When this happens in an evaluation, the evaluator's first instinct is often to keep digging to find out "the truth." But almost always in situations like this, there is no single truth, and a search for it quickly gets turned into an attempt to say who is "right" and who is "wrong" about some past event or decision or some future commitment that has or has not materialized. Such attempts only exacerbate the fundamental problem—findings of widely disparate perceptions on important issues are evidence of communications difficulties or failures and a lack of trust in one another's good will and good intentions to work together toward what should be a common mission. Apparently this level of distrust characterized almost all interactions among Skid Row providers and public agencies when the SRC began, and has long made it difficult for collaborative work to gain a foothold.

Concerted efforts are breaking down some part of that distrust in Skid Row. The SRC has made significant progress among SRHT, Lamp, and JWCH. Other activities, especially the Skid Row Homeless Health Initiative, have been working to break through distrust to make progress in the area of primary health care delivery and have enjoyed some measure of success. Los Angeles County public agencies that have become more open during the past few years include the Department of Health Services and the Community Development Commission. And under its new leadership LAHSA is much more amenable to working with Skid Row agencies and helping them get more funding. DMH as well as the county's Alcohol and Drug Programs Administration remain among the biggest challenges. What is needed is for all parties to stifle any impulse to try to "win" the battle of perceptions, as without a change of attitude and intent the battle cannot be "won." Instead, all parties need to make a commitment to re-open communications and establish trust.

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[4] The way the county's Alcohol and Drug Programs Administration (ADPA) funds substance abuse treatment may have something to do with the problems encountered by efforts to incorporate substance abuse treatment into housing programs or even into the type of primary care/mental health care/dental care structure envisioned by the Skid Row Homeless Healthcare Initiative (SRHHI). Most ADPA funds are disbursed through contracts with treatment providers, which might not be insurmountable except for the fact that the contracts are renewed repeatedly without new requests for proposals. As these contracts have not been re-competed since the late 1980s, there is no opportunity for new providers to apply, or for new approaches to treatment to gain support. Harm reduction and other approaches developed in response to changing circumstances and challenging populations have virtually no foothold among most providers with ADPA contracts.

Another important impact of the SRC is that four years ago, not one public agency had given much thought to the idea of permanent supportive housing. As a result of their experience with the St. George, all SRC public partners are permanent supportive housing supporters today. They may not always show this support with funding to the SRC in particular, but every public partner is looking at ways to fund more permanent supportive housing. HACLA has dedicated project-based vouchers to the city's permanent supportive housing program. LAHSA is looking at ways to require their contractors to get a certain percentage of clients into permanent supportive housing. DMH is looking at funding services in housing. The VA is partnering with New Directions (a homeless service provider) and A Community of Friends (a developer of housing for people with mental illness) to provide permanent supportive housing to veterans. This newfound support for permanent supportive housing is helping the SRC partner agencies in a number of ways other than direct continuation support for the SRC itself, allowing partner agencies to expand and develop more permanent supportive housing.

When all is said and done, everything depends on relationships. System change always aims for official changes that do not depend on which individual is in what organizational position. But the reality is that people can either make things happen or block them; cooperate, ignore, or resist; take things on as their personal mission or just muddle through; get a charge out of making things work better or just collect a paycheck. For something like the SRC to become institutionalized, many changes must happen in several organizations' values, commitments, ways of obligating money, and even technologies. Making that happen is hard work. It takes a team effort, and everyone involved has to be able to put achievement of the overall shared goal ahead of momentary difficulty or advantage.

The final public partner in the SRC is LAHSA. LAHSA has no funds of its own with which it could help the SRC during this crisis period. But its very neutrality may make it that "third party" that could provide boundary-spanning facilitation for the SRC partners and the relevant public agencies. For the SRC to achieve a stable long-term existence with major support from local public agencies, the most likely route is bringing the stakeholders together with some neutral third party to play the role of a very skilled facilitator, setting aside past feelings and issues and working sincerely to craft a structure of mutual supports and commitments that all can and will honor. Whether through LAHSA or some other third party, this new start appears to be necessary if the controversies along the way are to be left behind and the solid achievements of the SRC are not to be lost.

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