Principle Allies

Gap Analysis & Recommendations to Support People with Complex Service Needs at Risk of Homelessness

Health & Housing Proviso Study
SB 5950, Section 208(11) DSHS

DECEMBER 1, 2024

Prepared by Principle Allies for and in partnership with the Washington State Department of Social and Health Services

Acknowledgements

Principle Allies would like to offer deep gratitude to the team at Washington Department of Social and Health Services Facilities, Finance and Analytics Administration's Research and Data Analysis that guided this study: David Mancuso, PhD; Anita Rocha, PhD; and Bridget Pavelle, PhD. You served as trusted and engaging thought partners in this work.

We would also like to extend our appreciation to all the state agency and community stakeholders that offered their insights and guidance to this project. Your participation in a multitude of online meetings offered practical insights and validation that we hope you will see reflected herein.

Finally, a special thank you goes to those individuals with lived experience who shared their perspectives and journeys. You informed many of the recommendations set forth in this document and brought a crucial human perspective to our work.

Principle Allies

Milena Stott, LICSW, SUDP

Tasha Irvine, MBA

Gaye Barrett, RPA

Samantha Floersch, SUDP

Alexandra Weil

Table of Contents

Executive Summary 3

DSHS Health & Housing Proviso Study 6

- Purpose of Study 6
- Methodology 7
- Guiding Principles 8
- Study Limitations 9
- Populations of Focus 10
- Sample Complex Service Needs Scenarios 12
- Overview of Environmental Scan & SWOT Analysis 14
- Solutions Rubric for Complex Service Needs 19
- Promising Model Case Studies 22
- Current Health & Housing Solutions Gap Analysis 28
- Recommendations 33
  1. Systems of Care Recommendations 34
  2. Transitions to Care Recommendations 36
  3. Access to Care Recommendations 37
- In Conclusion 38

Appendices 39

- Appendix A: List of Stakeholder Organizations 39
- Appendix B: Gap Analysis of Current Solutions for Complex Service Needs 42
- Appendix C: Unabridged System Gap Analysis 54
- Appendix D: Landscape Assessment of Promising Models & Pilots 59
- Appendix E: Recommendations Cross-walked with Existing Initiatives 66

Executive Summary

Overview

Access to adequate housing and services addresses critical health-related social needs. An absence of both stable housing and appropriate services can threaten personal well-being. Individuals with complex service needs face specific barriers to safe and stable housing. These individuals may require significant, intensive, or immediately responsive medical and/or behavioral health support in order to achieve housing stability. This study, funded by legislative proviso in the 2023-2025 Fiscal Biennium Supplemental Operating Appropriations, examines the populations in need against the gaps in the current system of care and offers recommendations to address people at risk of homelessness with complex service needs.

DSHS estimates that individuals with high medical and behavioral health care needs account for 28% of adults experiencing homelessness in the state (approximately 32,000 in 2019).[1] This group is anticipated to grow with an aging population. Approximately 900 patients are waiting to be discharged from acute care hospitals across the state on any given day, but there is an insufficient number of appropriate community-based settings available for placement.[2] Medicaid patients account for a third of those awaiting post-discharge placements. Furthermore, people who have cognitive impairments, intellectual or development disabilities and/or use substances face additional barriers to accessing housing in the community.

At the same time, individuals are facing crises in their current housing environment. Harm reduction approaches can open the door to engagement and connection toward health goals, but a system of person-centered, high-touch interventions are necessary to ensure a successful transition and long-term stability. The critically needed supports can be absent from current housing-assistance settings, with various levels of quality and fidelity to the Permanent Supportive Housing (PSH) model impacting both the success of residents and the stability of the community as a whole.[3]

Study Approach

A comprehensive literature review, engagement with stakeholders and people with lived experience, as well as an evaluation of promising models revealed the successes and opportunities as well as the challenges and weaknesses of the current system. While programs that successfully integrate health and housing solutions exist, other programs face a fragmented system of housing and care, are under-resourced, and operate over capacity. A lack of a comprehensive and systematic statewide approach to assessments, discharge planning and case management can contribute to inadequate integration of health and housing solutions.[4] Moreover, generalized pressures from a scarcity of affordable housing limit unit availability, while

---

[1] *Homeless Single Adults in Washington State A Typology Based on Categories of Need*, DSHS, April 2021.

[2] *Quarterly Surveys of Hospitals*, Washington State Hospital Association, 2024.

[3] Washington State RCW 36.70A.030 (31) defines Permanent Supportive Housing and its services.

[4] Note that the definition and roles of case management and care coordination can differ greatly across programs. The distinction is addressed in *Case Management Gap Analysis* below. For the purposes of this study, we view case management as personalized one-on-one assessment, planning, education, advocacy, resource coordination, crisis resolution, and sometimes clinical support.

a shortfall in a skilled workforce impedes access to services even when housing is available. An investment in integrated services, enhanced care coordination, and collaboration is vital to supporting people with complex service needs.

This study identified six key characteristics of successful solutions in a *Solutions Rubric for Complex Service Needs*: 1) coordinated assessment; 2) transition settings and services; 3) ongoing case management; 4) access to health services; 5) rental assistance; and 6) specific population add-on supports. Critical success factors of the environment include adequate system capacity, community connection, staffing and training, transportation, flexible funding, and risk management.

Recommendations

Solutions were developed by leveraging stakeholder expertise alongside existing studies and initiatives such as Ruckelshaus' *Pathways to Housing Security in Washington* (2023), Washington Department of Commerce *Five-Year Homeless Housing Strategic Plan* (2024), *Washington Complex Discharge Task Force and Pilot: Interim Recommendations* (2024) and *Behavioral Health Housing Action Plan* (BHHAP) facilitated by the Washington Low Income Housing Alliance (2022). Recommendations align with the continuum that a person experiences with systems of care, transitions to care, and access to care:

In **Systems of Care**, capacity, funding, coordinated assessment among health and housing providers, risk management and workforce are addressed by the following recommendations:

- Conduct a quantitative Community Needs and Capacity Inventory Assessment.
- Expand capacity, eligibility and awareness of programs with successful outcomes.
- Ensure that the competitive application process for Permanent Supportive Housing (PSH) sites incorporates an assessment of plans for sustainability, quality, partnerships and commitment to population-based needs.
- Establish a quality initiative aimed at improving PSH provider ability to implement and sustain quality metrics and fidelity standards.
- Allocate more funds to be used for operations, maintenance, and services to preserve the current level of appropriate housing stock.
- Develop and utilize standardized assessments and processes to support information sharing and alignment between organizations.
- Create a coordinated entry pathway system that cultivates operational connections.
- Expedite recruiting, onboarding and training for caregivers, peers, and community health workers (CHW) while providing meaningful wages through reimbursement reform outlined in "Access to Care" recommendations.

- Improve working conditions, training, wages and supports for current frontline workers who provide direct housing assistance and services.
- Establish universal core competencies in culturally responsive, anti-racist, and trauma-informed practices.
- Support legislation or agency rule changes to reduce barriers to housing.
- Study specific collaboration and risk management requirements of landlords.

With **Transitions to Care**, transition services and transition settings are addressed by the following recommendations:

- Strengthen housing connection upon discharge from inpatient settings and connection to services by increasing state-funded benefit for pre-transition services.
- Invest in the capacity of supervised and supportive home-like settings.
- Extend the Complex Discharge Pilot through June 2027.

In **Access to Care,** services, care coordination, and case management are considered in the following recommendations:

- Address network gaps with reimbursement strategies that promote access to care, including enhanced and bundled payment models for complex services.
- Update current tiered payment rates for Supported Living/Community Residential Living and establish add-on payments to support community living.
- Expand Medicaid contract rates for transportation and emergency services in order to support increased capacity
- Streamline and coordinate client assessment process and ensure reimbursement to support ongoing case management and the development and implementation of all complex service plans.

With additional resources and improved coordination of services, the components are in place to significantly reduce the risk of housing instability among individuals with complex service needs.

DSHS Health & Housing Proviso Study

Purpose of Study

In 2024 the Washington State Legislature included a proviso in the 2023-2025 Fiscal Biennium Supplemental Operating Appropriations (SB 5950, Section 208(11) DSHS - Administration and Supporting Services Program Proviso[5]) that instructed the Department of Social and Health Services (DSHS) to complete a gap analysis of the existing housing and health care system with particular focus on a review of existing models related to individuals experiencing:

> (i) Housing instability who have significant medical and/or behavioral health needs, including the inability to stay in or return to their current housing;
>
> (ii) Homelessness and/or a significant history of being unhoused, including permanent supportive housing residents; and
>
> (iii) Significant health-related social needs that are not severe enough to qualify for placement in existing facilities, but are too significant to be met in a shelter or permanent supportive housing.

In addition, the study was also instructed to review:

> (i) Hospitals with patients that have resolved the acute hospital-level needs of the patient, but cannot discharge patients to the community because there is no appropriate lower level of care available; and
>
> (ii) Permanent supportive housing and shelter providers with residents whose medical needs exceed the location's ability to provide care.

Finally, the proviso instructed the department to provide recommendations to fill the gaps identified in the above analysis. Solutions may include the creation of complex care locations and enhanced behavioral health supports until an individual qualifies for either a higher or lower level of care.

This report's gap analysis and recommendations are the department's response to the proviso requirements.

[5] Wash. S.B. 5950, Sess. 2023-24: *Making 2023-2025 Fiscal Biennium Supplemental Operating Appropriations*.

Methodology

DSHS contracted with consulting firm Principle Allies to conduct the analysis over a five-month period from July 2024 to November 2024. Together DSHS and Principle Allies focused on existing data, reports and studies, as well as stakeholder engagement in its approach. Throughout the study, an Advisory Group of relevant state agency representatives reviewed and informed the process. Stakeholder engagement, including surveys and focus groups of People with Lived Experience (PWLE), was guided by the Institutional Review Board (IRB) process and best practices, for which this study qualified as exempt human subjects research, appraised as posing no more than minimum risk to study subjects.

Stakeholders included state agency staff members, researchers, housing providers, healthcare providers, and representatives of all five Medicaid-contracted Managed Care Organizations (MCOs) and all ten Behavioral Health-Administrative Service Organizations (BH-ASOs). See *Appendix A* for a list of Stakeholders consulted.

Major steps in the analysis are outlined in *Figure 1* and included:

1. **Identification of the typologies of needs** of the population outlined in the proviso through a review of data and reports from DSHS-Research and Data Analysis (RDA) and community-based organizations, as well as through stakeholder interviews.

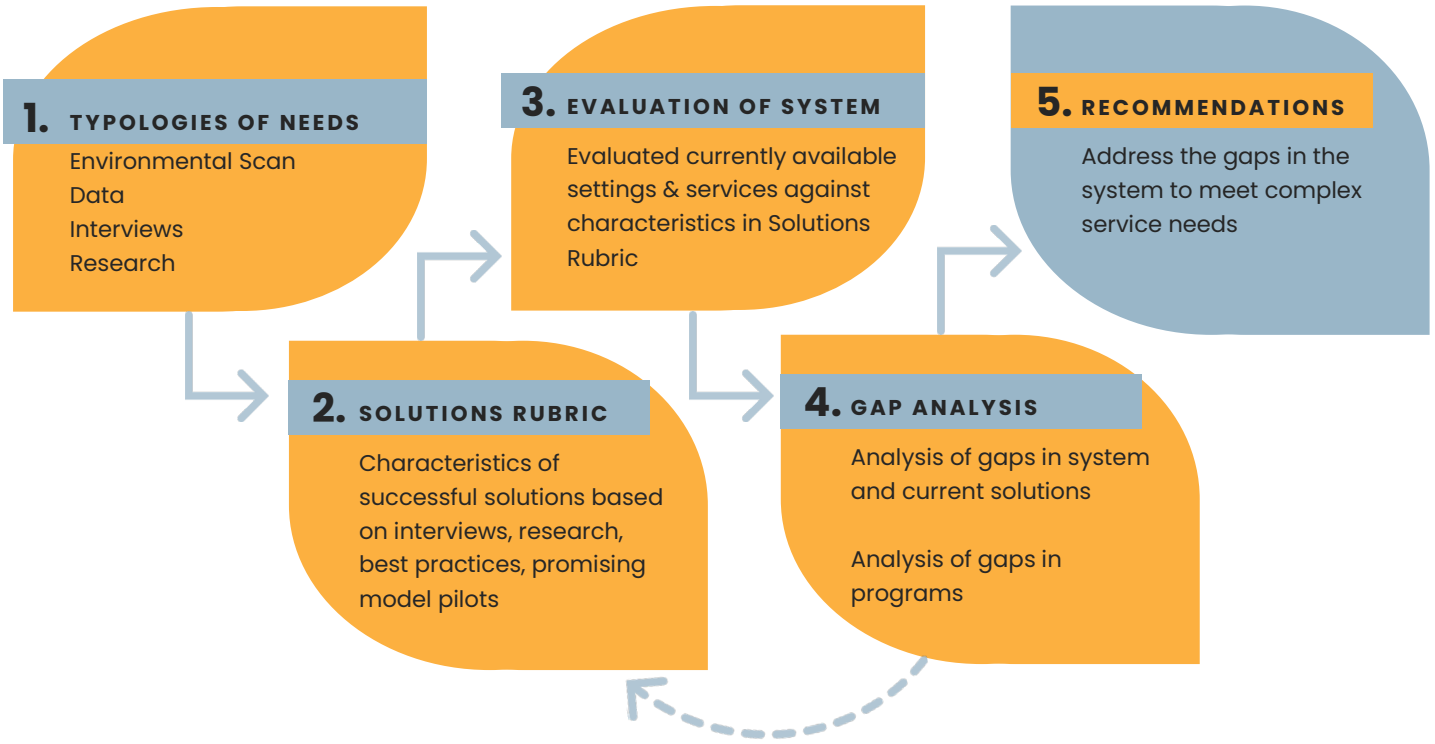
2. **Investigation of best practices, promising models and existing pilots** to determine characteristics of successful solutions for the populations of focus. This analysis was conducted through an environmental scan, literature review and stakeholder interviews to develop a *Solutions Rubric for Complex Service Needs* that outlines key characteristics and critical success factors. (See *Appendix D* for a review of the Promising Models & Pilots considered.)

3. **Evaluation of the current system of settings and services** against the *Solutions Rubric*, developed in *Step Two* above, to determine gaps between available services and meeting the needs of the unstably housed population with significant medical and/or behavioral health needs.

4. **Development of the Gap Analysis** based on the strengths, opportunities, weaknesses, and threats (SWOT) of the current system. The gap analysis was reviewed closely with a Stakeholder Workgroup representing cross-sector providers of health and housing services. (See *Appendix A* for a list of the Stakeholder Workgroup Members).

5. **Recommendations** leveraging existing initiatives to address the gaps identified were developed based on a crosswalk of the *Solutions Rubric*, gap analysis, existing studies and reports as well as feedback from Stakeholders and People with Lived Experience (PWLE).

Figure 1: Outline of Steps in Study Methodology



Guiding Principles

Throughout this study the overarching guiding principles of Housing First, Harm Reduction, Person-Centered Care, and Individual Choice were used. The five principles of Housing First are: consumer choice, separation of housing and treatment, providing services to match needs, recovery-oriented service philosophy, and social community integration.[6] Client choice in both housing and services is more likely to make a person successful in remaining housed and improving their life.[7] Washington State's PSH program has been developed with these principles in mind.[8]

---

[6] Pathways Housing First Institute, *Five Principles*, accessed November 2024.

[7] *Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals with a Dual Diagnosis* by S Tsemberis, L Gulcur, M Nakae, April 2004.

[8] *Implementing Housing First in Permanent Supportive Housing* by U.S. Interagency Council on Homelessness, June 2014.

Study Limitations

While the team endeavored to conduct as thorough an analysis as possible, some limitations of the study should be noted. The timeline did not allow a thorough quantitative analysis of the demand and supply of housing types and services studied. As a result, follow-up quantitative research is a key recommendation. While the team conducted more than 100 interviews, we were not able to reach every type of provider in every county, but we sought diverse representation in those we engaged. The needs of Veterans and Tribes were addressed through representatives although direct listening sessions would have been ideal, had time allowed. Finally, it is challenging to engage vulnerable populations in their first-hand experiences, particularly the transient, sick, and elderly. While we talked with more than 50 people with lived experience, we would have benefited from more conversations with individuals in these populations. We also did not engage directly with minors or people with autism or intellectual or developmental disabilities in our stakeholder interviews, but instead we spoke with their advocates.

Client choice in both housing and services is more likely to make a person successful in remaining in housing and improving their life.

Populations of Focus

The populations identified in the proviso encompass a broad range of typologies and needs with a common challenge – those that may remain longer in facilities because their needs may not be met in the community or cannot remain in the community because their needs cannot be met. However, through discussions with the State Agency Advisory Group and the Stakeholders, a deeper understanding of the segmentation of complex needs of the population became apparent. They include:

- Persons experiencing **housing instability who have significant medical and/or behavioral health needs**, including the inability to stay in or return to their current housing
- Persons in **acute care hospitals with barriers to discharge**
- Persons discharging from **community psychiatric inpatient settings**
- Persons discharging from **state psychiatric hospital civil commitment settings**
- Persons discharging from **substance use disorder (SUD) inpatient & residential treatment facilities**
- Persons residing in **Aging and Long-Term Support Administration (ALTSA), Developmental Disabilities Administration (DDA), and Long-Term Services & Supports (LTSS) settings with barriers to placement stability**
- Persons **exiting carceral settings**

DSHS Demographic Data

In 2021, DSHS-RDA research identified four broadly descriptive categories of need of the nearly 114,000 homeless single adults in the state. Utilizing 2019 integrated homelessness data that combines information from the Washington State Department of Commerce's Homeless Management Information System (HMIS), the Economic Services Administration's Automated Client Eligibility System (ACES), and the Washington State Health Care Authority's (HCA's) ProviderOne system, these categories ranged from low to high acuity and complexity of conditions among those experiencing homelessness:

I. Low Need (30% or 24,758)
II. Serious Mental Illness (18% or 20,044)
III. Substance Use Disorder and Criminal Legal Involvement (24% or 27,159)
IV. High Medical and Behavioral Health Care Needs (28% or 32,008)

Category IV approximately aligns with the population of focus in this study. The integrated homelessness data analysis characterized the Category IV population as potentially presenting with:

- The Highest Rate of Traumatic Brain Injuries
- Two or more Chronic Health Conditions
- The Highest Rate of Serious Health Conditions
- A Serious Mental Illness
- A High Rate of Psychotic, Mania and Bipolar, and/or Post-Traumatic-Stress Disorder
- A Substance Use Disorder
- A High Rate of Stimulant Use
- The Highest Hospitalization Rates
- One or more Felony Convictions
- Experiencing Chronic Homelessness

- The Highest Shelter Utilization Rate[9]

Another DSHS-RDA study in June 2024, *Forecasts of Forensic and Long-Term Civil Commitment Bed Need,* notes that the number of people with psychotic disorders residing in ALTSA community residential settings has increased 70% since March 2018. The caseload of these clients has increased by approximately 2,700 people when previously there was relatively little change in the use of these service settings to support people with schizophrenia and related disorders.[10] Based on information gathered for this report, this change is a consequence of a purposeful State strategy to divert and discharge persons at risk or in state hospital civil settings into LTSS settings.

Furthermore, the number of homeless or unstably housed adults, aged 65 and above has more than doubled over a 5-year period, from 2,445 in 2017 to 5,927 in 2022, driving demand for residential Long-Term Services and Supports (LTSS).[11]

While a majority of ALTSA clients are typically age 65 and older, the currently trending age of ALTSA clients with a recent history of housing instability or homelessness is under 65. Anecdotal accounts from stakeholder interviews attribute this trend to a more defined and systematic assessment and housing identification process of Home and Community Services (HCS) case managers versus the narrower focus of the Coordinated Entry (CE) process. Whereas HCS is a streamlined gateway to a broad array of DSHS medically based services for which assessments occur, CE focuses on prioritizing based on a singular vulnerability homelessness index and may not take into account all individual service needs.

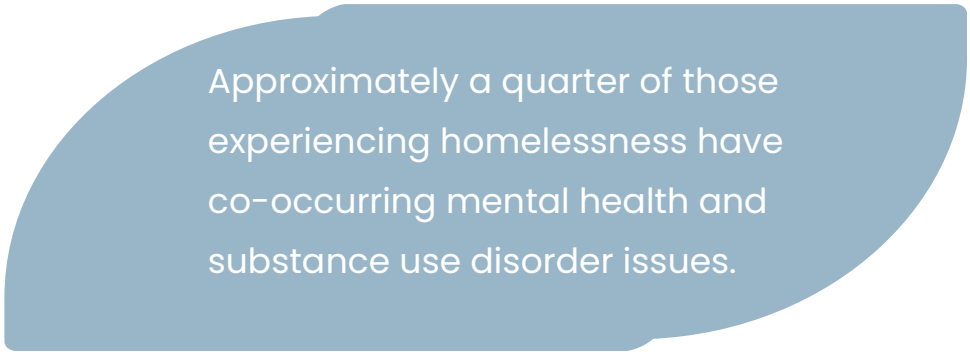
Community-based organizations shared select data that sheds light on the complex service needs of this population. This data finds:

- 53% of chronically homeless individuals suffer from a traumatic brain injury (TBI). That is nearly five times the rate for the general population.[12]
- About 900 individuals across the state are ready for discharge from an acute care hospital but are unable to be placed in a more permanent location, according to a 2024 survey by the Washington State Hospital Association.[13] Note that there is not a requirement to accept these patients and barriers to placement include absence of funding for medical transportation, durable medical equipment, one-to-one sitters, behavioral health support, medical supplies, caregiver support, and home health support.
- Aging-in-place factors, such as mobility, dementia care, and medication management, also prevent chronically homeless seniors from being able to safely return or stay in their current housing. While LTSS has in-home support for mobility and medication management, the caregiver shortage and coordination challenges have created barriers to access.

---

[9] *Homeless Single Adults in Washington State A Typology Based on Categories of Need*, DSHS, April 2021.
[10] *Forecasts of Forensic and Long-Term Commitment Bed Need*, DSHS, June 2024.
[11] *Demographic Trends Impacting Need for Long-Term Services and Supports*, DSHS, October 2023.
[12] *Traumatic Brain Injury and Homelessness: from Prevalence to Prevention* by Young, Jesse T et al. *The Lancet Public Health*, December 2019.
[13] *Quarterly Surveys of Hospitals*, Washington State Hospital Association, 2024.

- According to Catholic Community Services of Western Washington, a supportive housing and behavioral health services provider, up to 10% of their PSH residents need additional medical and/or behavioral health supports beyond the support level provided through PSH services. This experience is consistent with reports from other PSH providers across the state. They describe that additional medical and behavioral health services beyond those currently available are needed to support housing stability. Further quantitative study would illustrate the prevalence of the need across the state.
- Statewide, among people with intellectual or developmental disabilities, those with autism are at greatest risk of being unable to discharge from a medical setting due to lack of a safe and supportive discharge plan.[14]
- According to Commerce's January 2024 Snapshot of Homelessness in the state, approximately a quarter of those experiencing homelessness (50,304) have co-occurring mental health and substance use disorder issues. Of all adults experiencing homelessness, 44 percent (69,812) have a mental health disorder, and 39 percent (61,498) have a substance use disorder.[15]



[14] DSHS-DDA Hospital Tracking Database System Report, August 2024.
[15] *Snapshot of Homelessness in Washington State for January 2024*, Department of Commerce, January 2024.

Sample Complex Service Needs Scenarios

Given the significant diversity of individuals with complex service needs, person-centered scenarios illustrate the circumstances where supportive living environments must address both healthcare and housing needs. The following are a few anonymized examples shared from stakeholders over the course of our interviews:

1. **Person Living with SUD and Mental Illness in PSH:** Joe is a middle-aged adult who struggles with mental illness and occasional psychotic episodes. He uses substances to cope with the stresses of daily living and has had difficulty adjusting to life in a PSH building, particularly planning his budget, managing meals, and housekeeping. Joe was deeply traumatized when one of his neighbor friends died of a fentanyl overdose. Though he declines formal treatment services when offered in weekly visits from his case manager, Joe speaks openly about his challenges to his peer support specialist. During three recent psychotic episodes Joe lit fires in the building. The PSH managers called emergency services. After a brief time with the police, they returned Joe to his apartment where his behavior continued to be a safety threat to other residents. Since the recent crisis, it has been a challenge to get services locally or on-site to prevent future episodes. Local providers have long waitlists, assessment requirements, and do not provide outreach services. Crisis and 911 services only respond to imminent risk, and there is variability in the extent to which building support staff are trained in de-escalation and have the expertise to manage and engage individuals in need of complex services.

2. **Senior with Dementia and Diabetes:** John is 75 years old and has been living in PSH for nearly 10 years. He's been able to manage his diabetes, medical appointments, and finances successfully until his recent dementia diagnosis. John is often disoriented and confused and can no longer monitor his nutrition and insulin requirements. John requires nursing oversight several times a day and assistance accessing appropriate daily meals. Because he lives in a rural community and wants to continue living at home, his PSH provider has had challenges with accessing specialized medical and behavioral supports on-site to support John's health and safety.

3. **Young Adult with Autism:** Jane is seventeen, has autism and is enrolled in DDA services. She struggles with maintaining safe behaviors in her family home. Jane contracted Covid and ultimately, pneumonia, causing her to struggle with her breathing. Jane's family admitted her to the emergency room of the local community hospital, where she remained for two weeks until her pulmonary issues subsided. Jane's family is no longer able to care for her due to her history of unsafe behavior, and as a result, Jane remains in the hospital until an appropriate home care setting with adequate behavioral support can be located.

Overview of Environmental Scan & SWOT Analysis

Considering the needs of individuals discussed above, the environmental scan of integrated health and housing services highlight barriers and outlines potential solutions aimed at improving our system's ability to meet the needs of people who use those services. While the focus of this work was centered on individuals who are unstably housed or homeless and have complex service needs, the best practices discussed here can be applied broadly and scaled appropriately.

To arrive at recommendations, our process involved a literature review of nearly 100 documents and studies, more than 100 stakeholder interviews, 50 people with lived experience (PWLE) interviews, research of promising models and best practices, bimonthly state advisory workgroup guidance and review, four community stakeholder workgroup review and validation meetings, and two PWLE focus groups. People with lived experience were compensated for their time and feedback, and other stakeholders were engaged related to their work. In our one-hour interviews we explored the following topics using open-ended questions with all who agreed to participate:

- Accessibility and barriers to access (working well/not working well) related to housing services, health services, and top 3 barriers;
- Recommendations for improving the housing and health systems;
- Services necessary to support successful transitions;
- Services necessary to advance recovery goals; and
- Other recommendations or comments.

All interviews were documented to track responses, respondents, years and background of experience, programs, roles, counties served, and themes discussed. The responses from the stakeholder and PWLE interviews were then grouped, coded, and sorted to track for themes. These themes are summarized below in the form of a SWOT (Strengths, Weaknesses, Opportunities, Threats):

Strengths

- **Existing Programs:** There is an increasing focus on scaling existing models for integrated housing and health services and programs. The strongest programs include the characteristics outlined in the *Solutions Rubric* detailed later in this report, as well as skilled leaders who have either built or partnered to establish their programs. These models can be funded, expanded, or scaled.
- **Integrated Services:** Some communities have managed to integrate healthcare and housing services, fostering collaboration between sectors. Specialized case management and access to capital funding and housing vouchers are key components of integrated access. Stakeholders expressed that the Veterans Administration (VA) programs and the Canadian housing first programs have been successful because they are single payor systems.
- **Ability to have "Add-on" Support:** State agencies have been thoughtful about how to align the various components of funding to support successful programs. A few mentioned include Home and Community Services (HCS) (in-home care, environmental modifications, residential settings with health supports for eligible individuals) and Governor's Opportunity for Supportive Housing (GOSH) (housing case management and rental assistance, in addition to in-home care). The Department of Commerce Community Behavioral Health Rental Assistance Program (CBRA) (rental assistance) program was also noted. These are established programs and offer a foundation to serve people with complex service needs.

- **Supportive Leadership:** Governmental backing from the governor and legislators is driving reforms in housing and healthcare. Equally important is local government and leadership that supports and addresses community concern, funding gaps, and regulatory barriers.
- **Community Partnerships:** These partnerships bridge service gaps, create opportunities to address community challenges, promote access to services, and support reaching underserved areas. Community partnerships are especially important in supporting access to health services in housing settings and for rural communities with limited resources.
- **Workforce Initiatives**: Efforts are underway to address healthcare and human services workforce shortages through training and compensation improvements.[16]

Weaknesses

- **System Fragmentation:** Housing and health services are fragmented with high demand, complex eligibility criteria (often the result of federal policy), and significant regional variation, making access challenging. While HCS has packaged housing and health programs through streamlined eligibility, HCA and MCOs are working toward creating a similar structure for behavioral health and continue to address barriers to integrated care.
- **Lack of Funding:** Innovative programs are written into state policy, such as the Homeless Outreach Stabilization Program, but are not utilized because they are not funded.
- **Coordinated Assessments:** There is a lack of standardization in assessment among health and housing providers, eligibility, and program criteria. This lack of standardization leads to inconsistent assessments, poor information sharing, and ultimately complications in housing retention and continuity.
- **Discharge Planning and Transitions of Care:** Discharge planning is challenged by gatekeepers, absence of community resources (settings and services), system fragmentation, knowledge of community resources, and absence of payment for case management and care coordination. This impacts access to health and housing supports and services.
- **Case Management and Care Coordination:** Case management services are often not available to provide discharge planning, engagement and navigation to facilitate access to health services. This is further complicated by limited availability of clinical case management services, where staff have training to support individuals with complex service needs. These needs may vary by populations, and when this service is provided as a best practice, case managers have limited oversight or authority over the plan. (Case management and care coordination definitions are addressed in more detail in the *Case Management Gap Analysis* below.)
- **Health Services Access and Quality:** Short-term, limited integrated services, long waitlists, provider shortages, and difficulties in maintaining eligibility disrupt and/or delay consistent care. There is generally a lack of accessible preventive crisis services.
- **Housing Access and Quality:** General lack of availability of units and lack of rental assistance, compounded by increasing cost of living and an onerous application process, makes housing virtually inaccessible to people with complex health needs without appropriate funding, housing navigation assistance, and service access. While programs like Foundational Community Supports (FCS) are able to provide case management, care coordination, and some flexible funding, the

[16] *Wage Equity for Non-Profit Human Services Workers: A study of work and pay in Seattle and King County*, University of Washington School of Social Work, February 2023.

availability of units and health services remains a barrier. Furthermore, an absence of quality standards and oversight of fidelity within PSH creates inconsistencies in services upon which residents depend to maintain their housing.

- **Transportation:** Inadequate and unreliable transportation, particularly in rural areas, further restricts access to services. Medicaid only reimburses providers for transportation when a client is present. Driving to/from client contact is not reimbursable and creates significant funding challenges for agencies to deliver services within the community.

Opportunities

- **Expand Integrated Service Programs:** Creating a standard for what services, at a minimum, are provided within permanent supportive housing (PSH) and scaling up successful models, such as PSH and integrated health services, would improve continuity of care. This includes extending programs, like the Foundational Community Supports (FCS) and GOSH, as well as expanding wraparound services, such as behavioral health and medical care in housing settings.
- **Enhance Coordination and Collaboration:** Model programs noted throughout the report demonstrate that strengthening partnerships between housing providers, healthcare systems, and case managers is essential for creating a seamless service experience. Standardizing assessments and improving information sharing across sectors would increase the likelihood that individuals receive the right services at the right time.
- **Improving Case Management:** Enhancing case management services by defining clear roles, increasing accountability, and providing adequate resources for follow-up would improve the coordination of care. Increasing rates and improving reimbursement models for case management would also incentivize and support better service delivery and collaboration between health providers and case managers, especially in crisis situations and discharge planning.
- **Workforce Development:** Increasing investment in workforce training and retention, particularly in specialized areas like behavioral health, geriatric care, and services for individuals with intellectual or developmental disabilities (ID/DD), is key to addressing workforce shortages that lead to service gaps. Initiatives to improve compensation and career development opportunities would help mitigate burnout, reduce employee turnover and improve the ability to provide stable, consistent care.
- **Increasing Flexibility in Funding:** Creating more flexible funding structures would allow programs to better address individual and local needs. This includes sustainable funding models that support long-term housing and healthcare solutions, particularly for those with complex service needs who require intensive, ongoing care.
- **Address Transportation Gaps:** Expanding Medicaid transportation contracts and providing additional funding for transportation services, particularly in rural areas, would increase access to both healthcare and housing services for vulnerable populations.

Threats

- **Fragmented Systems:** The lack of coordination between health and housing systems creates barriers to housing stability. Differing eligibility requirements, service definitions, and information sharing practices hinder access to consistent care. Fragmented service delivery often leads to gaps in care, particularly during transitions between housing or healthcare settings.
- **Limited Access to Integrated Services:** Integrated services, combining housing and health interventions, are scarce. Short-term programs and lack of permanent supportive housing (PSH)

options reduce the continuity of care. Many individuals face challenges in maintaining eligibility for healthcare services, which is essential for long-term recovery and stability.

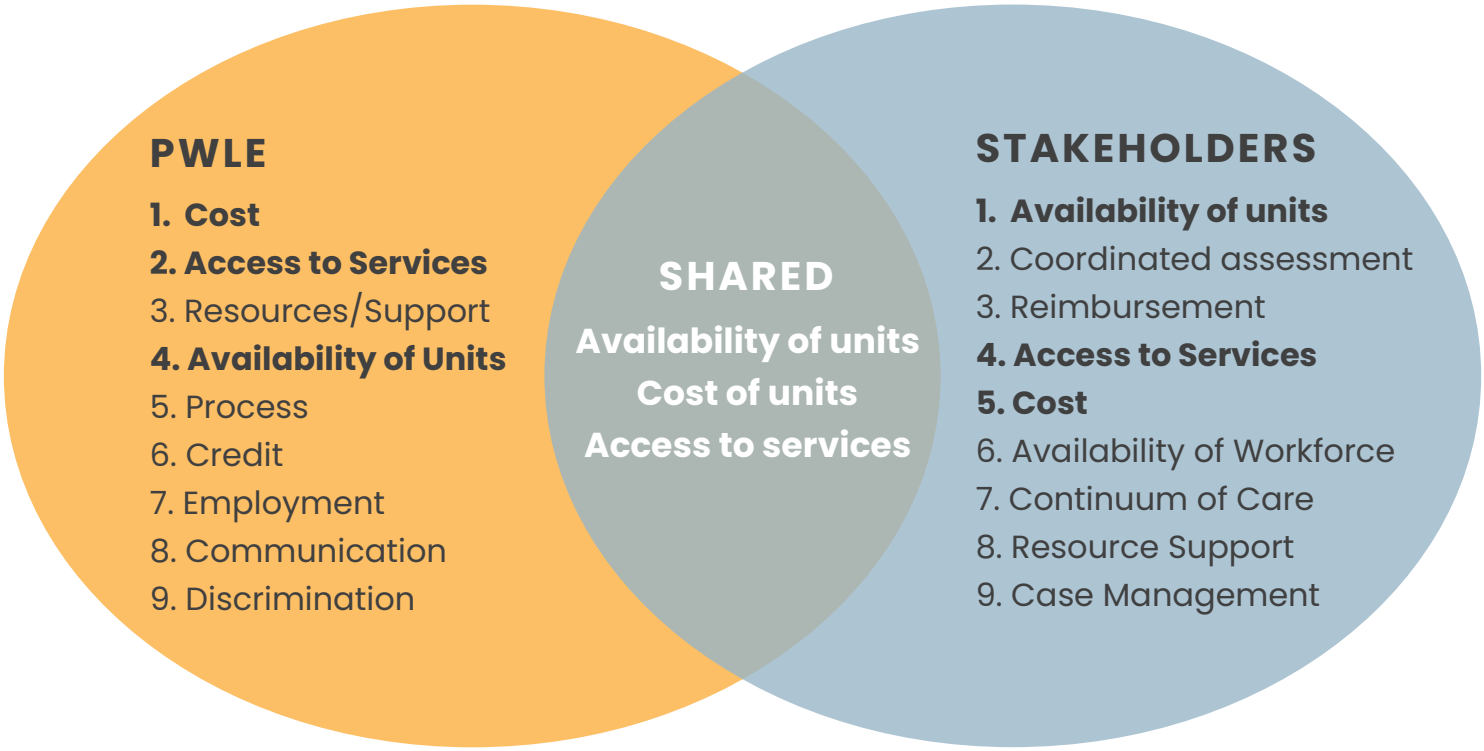
- **Inconsistent Assessments and Case Management:** The absence of standardized assessment tools across housing and healthcare providers complicates the process of identifying and addressing individuals' needs. Case management services are often inadequate, with limited resources, accountability, and inconsistent follow-up, leading to poor outcomes in managing health and housing crises.
- **Workforce and Training Shortages:** Staffing shortages, particularly in specialized roles such as behavioral health and geriatric care, make it difficult to provide the necessary level of support. Burnout among staff, combined with a lack of specialized training, reduces the capacity of services to address the complex needs of the population.
- **Housing Choice:** Persons with lived experience reported that there is often limited choice in the environment that best supports their recovery. Individuals and organizations mutually expressed concern for the volume of substance use and its impact on personnel, workforce, and community safety.
- **Funding Constraints:** Current funding models are often inflexible and short-term, leaving programs under-resourced. This limits the ability to expand services and meet the growing demand for integrated health and housing solutions, particularly for high-risk populations.
- **Transportation Barriers:** Access to transportation, especially in rural areas, is a major challenge. Unreliable or unavailable transportation limits the ability of individuals to reach healthcare appointments or housing services, compounding their vulnerability.
- **Cost of Living:** Rising living costs, pressures in the housing and real estate market, and the scarcity of affordable housing undermine access.
- **Rural Infrastructure:** The lack of medical and housing infrastructure in rural areas limits both health and housing services options, exacerbating service disparities.

At the conclusion of creating the themes and summaries of the SWOT, these themes were coded and cross-walked with the *Solutions Rubric* to allow for the SWOT components to be investigated against key characteristics of best practices and critical success factors, and later the framework for recommendations. The team also quantified survey responses on the top three barriers to consider recommendations in relation to common challenges.

Top Three Barriers

The diagram below illustrates the top three perceived barriers to accessing and maintaining housing in the community for people with complex service needs. To arrive at this summary, answers provided by all respondents were compiled, segmented and compared for both stakeholders and PWLE. Each time an item was mentioned, it was counted; the list includes barriers mentioned ten or more times. Combining the totals revealed the shared top three barriers. The shared items were referenced 38 times or more across 150 interviews. The shared barriers are highlighted in the following illustration.

Figure 2: Diagram of Top Barriers to Accessing and Maintaining Housing



Other themes identified by PWLE were related to their personal situation, including culture and language, family status and child support, motivation, safety, and transportation. When reviewing findings during the focus group, PWLE reinforced that the absence of a safety net and access to services and resources means people will continue to go into crisis. They further emphasized the importance of life skills and independent living skills training to support growth and health stability for those exiting homelessness. Lastly, they stressed the importance of peers in building trust toward receiving services, especially given prior negative experiences and variations in staff attitudes and training.

The main themes for PWLE varied slightly from system stakeholders beyond the top three. The stakeholders were similarly concerned with safety net, resources, and cost, with the variation that these concerns centered on reimbursement and workforce challenges impacting their ability to deliver services and offer resources and support. They referenced workforce and funding barriers contributing to challenges in best-practice service delivery, ability to be person-centered, ability to provide in-home care, and ability to meet needs of individuals in the community.

Appendix C contains an unabridged overview of the system gap analysis.

Solutions Rubric for Complex Service Needs

Methodology for Rubric

As mentioned above, the study sought to understand the key characteristics of organizations that were successful in supporting people with complex service needs in order to create a "Solutions Rubric for Complex Service Needs" with which to evaluate the current system and recommendations.

To arrive at the characteristics of the key attributes on the rubric, the team considered the literature review and promising models and pilots in a landscape assessment. (Case studies illustrating some of the key characteristics are described in the next section, *Promising Model Case Studies*.) During the interview process, which included national experts, the team further explored recent innovations and approaches to people with complex service needs. The rubric was then used to measure program components and system variables that were cited as reasons for success. The gap analysis and related solutions reflect and consider these components.

The *Solutions Rubric for Complex Service Needs* has two sections:

1. Key Characteristics of Organizations which are aspects of program services and settings that address the needs of its client and residents outlined in *Table 1*.
2. Critical Success Factors are aspects of the system typically beyond an organization's direct control that are necessary to ensure successful service delivery outlined in *Table 2*.

Key Characteristics of Organizations

Table 1: Key Characteristics of Organizations Successful in Supporting Complex Service Needs

Key Characteristic of Organizations	Rationale
Coordinated Assessment	Entry to a setting comes with coordinated assessment and compilation of key information of medical, behavioral, physical and social needs in order to ensure adequate and appropriate support is available.
Transition Settings and Services	Discharging to shelters or settings without support services can lead to crisis or disrupt the linkage to appropriate care in the community.
Ongoing Case Management	Ongoing care coordination and case management to ensure continuity and adjustments to services as needs resolve or arise. The level of case management is flexible based on needs. Respite settings are available.
Access to Health Services (Clinical, Mental Health, SUD)	Ideally services are on-site or easily accessible through telehealth, mobile health, transportation or case management support. Partnerships with providers fill gaps in services needed on site. Support for scattered site service provision, particularly SUD treatment services, eldercare, and transportation.
Rental Assistance	Long-term rental assistance to ensure housing security and reduce the trauma of transitions.
Specific Population Add-On Support	Ability to provide support in the setting specific to unique needs, i.e. peer counselors, hospice care, physical accessibility of apartment, translation services, childcare. Other add-on programs might include: • Community Protection Program • Specialized contract with BH support • Supported Living Services • LTSS with Medicaid Exceptional Supports • Specialized dementia care • Foster and kinship supports

Critical Success Factors

Table 2: Critical Success Factors in Supporting Complex Service Needs

Critical Success Factors within System	Rationale
System Capacity	Enough units, beds, providers or program space is available to meet the need.
Location, Community Connection & Culture	Ability to stay near their existing community and care providers, helping reduce the trauma of transitions. Fit of community and culture to the residents (i.e. age-appropriate setting, I/DD inclusion) and gathering spaces to underpin resident's commitment to setting.
Staffing & Training	Fully staffed with professionals trained in service needs.
Transportation	Convenient and timely means of accessing services, education and employment.
Flexible Funding for Resident Needs	Ability to support unique needs that arise during transitions, i.e. deposit/move-in assistance, furniture, clothing, registration fees.
Risk Management & Insurance	Safeguards for property owners and operators to cover risks associated with behaviors of residents (i.e. contamination from drug use, criminal activities, harassment and assault of staff and between residents).

Promising Model Case Studies

A key aspect of the environmental scan was evaluating promising models and active pilots both in Washington state and across the country to determine what aspects of these programs should be represented in our recommendations. While over 30 housing models and approaches were studied, the following six case studies illustrate how the key characteristics and critical success factors of the *Solutions Rubric for Complex Service Needs* function in practice.

Case Study #1	**SUD: Eastlake, Washington – DESC 1811** ***Population Served*:** Formerly adults experiencing homelessness with chronic alcohol use disorders
Purpose	Built upon the Housing First philosophy, 1811 Eastlake offers supportive housing and on-site healthcare services to the residents while allowing voluntary treatment for substance use. The staff at DESC 1811 provide consistent and ongoing access to supportive services necessary for the residents to succeed and stabilize. Supportive services range from State-licensed mental health and substance use disorder treatment, nutritional services, in-house case management, and group focused activities.
Measure of Success	DESC 1811 Eastlake's approach has seen a documented reduction in publicly funded services ranging from medical services, incarceration, and rehabilitation facilities, saving the taxpayers millions of dollars.
Funding	Federal, State, County, and City funding; private funding through grants and donations; Medicaid-funded health services.
Solutions Rubric Alignment	- Coordinated Assessment - Ongoing Case Management - Access to Health Services – on-site and partnerships - Rental Assistance – HUD Section 8 - Staffing and Training

Case Study #2	**Respite: Montefiore, New York – Housing at Risk Program** ***Population Served*:** Homeless and housing-insecure patients (NYC/Bronx)
Purpose	The Housing at Risk program is designed to provide health and housing assistance to homeless people with complex needs. Montefiore staff work to connect the discharging patient with resources for housing through partnerships with local housing providers and respite facilities. After housing placement, the Montefiore case management staff continue to work with the person on their healthcare needs while providing guidance to retain the housing by assisting in gaining access to legal counsel, obtaining essential records, and applying for benefits.
Measure of Success	Since adopting the program, Montefiore has seen a documented decrease in repetitive emergency room visits and shorter hospital stays resulting in improved patient outcomes, an increase in staff morale, and overall reduction in costs to the hospital and the greater community.
Funding	State funding; insurance
Solutions Rubric Alignment	- Coordinated Assessment - Transition settings and services - Ongoing case management - Access to Health Services – partnerships - Community Partnerships - Flexible Funding for Resident Needs

Case Study #3	**IDD/DD: Multi-State – Dungarvin** ***Population Served*:** People with Intellectual and Developmental Disabilities
Purpose	Dungarvin is a national organization committed to providing housing and healthcare support tailored to each person's needs and goals in a variety of settings. The staff at Dungarvin support their clients with a range of services including vocational, case management, supported sobriety, and social enrichment programs. Dungarvin does not operate large facilities, but provides further support by offering in-home assistance, host home collaboration, and residential services to meet the needs of each program participant.
Measure of Success	Founded in 1976, Dungarvin has grown from a single facility in Minnesota to providing services to over 5,000 individuals with intellectual and developmental disabilities in more than 1,100 locations across 15 states.
Funding	Medicaid Home and Community-Based Waiver; private pay
Solutions Rubric Alignment	- Ongoing Case Management - Access to health services – on-site - Specific Population Add-On: - Physical accessibility of apartment - Supported living services - LTSS with Medicaid Exceptional Supports - Foster and kinship support - Location; Ability to stay near existing community and care providers - Staffing and Training - Transportation - Community and Cultural - Community Partnerships - Scattered Site Service Support

Case Study #4	**Youth: King County, Washington – Friends of Youth** ***Population Served*:** Youth at-risk or experiencing homelessness including those aging out of the foster care system
Purpose	Offering a community of support, Friends of Youth seeks to improve the outcomes for the individuals and families they serve. Through partnerships, Friends of Youth has developed a network of providers offering housing navigation resources including shelters, transitional housing, and permanent housing opportunities. To further their mission and philosophy of care, Friends of Youth provide their clients with on-going case management counseling, vocational training support, and financial/legal assistance.
Measure of Success	Serving the Eastside of King County for 70 years, Friends of Youth measures its success by the youth and family they support each day. In 2023, Friends of Youth was able to provide help to 1,439 youth and families through their housing and healthcare services.
Funding	Federal, State, County, and local; grants/donations

Solutions Rubric Alignment	- Transition Settings and Services
	- Ongoing Case Management
	- Access to Health Services – partnerships
	- Specific Population Add-on:
	  - Peer Counselors
	  - Supported Living Services
	  - Foster and Kinship Support
	  - Legal Advocacy
	- Location
	- Staffing and Training
	- Flexible Funding for Resident Needs
	- Community Partnerships
	- Scattered Site Service Support

Case Study #5	**Elderly & Veterans: Virginia – Bay Aging** ***Population Served*:** Persons aged 62 and older with a federal preference provided to Veterans and persons experiencing homelessness
Purpose	Specializing in housing for people 62 years of age and older, Bay Aging has sought to provide stability to their residents by offering affordable housing with a multitude of services. With 10 communities funded through the HUD Section 202 program, Bay Aging has recognized the growing number of people over the age of 50 at-risk or experiencing homelessness. By providing housing that offers affordable rent, healthcare services, case management/care coordinator support, transportation assistance, and social interaction opportunities, Bay Aging is promoting housing stability to their resident population.
Measure of Success	With HUD approval and partnership, Bay Aging became the first age- and income-restricted provider to offer Veterans a preference for housing. As a result, in 2015, Virginia made significant in-roads to end veteran homelessness. Additionally, with HUD approval, in 2018, Bay Aging was the first provider to offer a HUD homeless preference under Section 202 housing for elderly adults. In 2021 and 2022, Bay Aging has been recognized for its achievements in housing innovation.
Funding	HUD Section 202 with Project Rental Assistance Contract (PRAC); State; private sector
Solutions Rubric Alignment	- Ongoing Case Management - Access to Health Services – partnerships - Rental Assistance - Specific Population Add-On: - Physical accessibility of apartment - Translation - Legal advocacy - Location - Staffing and Training - Transportation - Flexible Funding for Resident Needs - Move-in deposit assistance - Emergency housing choice vouchers - Community Partnerships

Case Study #6	**Respite: Seattle/King County, WA – Edward Thomas House Medical Respite** ***Population Served*:** Homeless and housing insecure patients
Purpose	Harborview's Edward Thomas House Medical Respite is a voluntary, short-term medical respite facility for those with acute health concerns. The medical team at Edward Thomas House work collaboratively with the individual to assess the person's current and long-term medical and behavioral health needs as well as future housing options. Upon stabilization, primary care and housing referrals are provided, as well as connections to public funding assistance.
Measure of Success	Edward Thomas House was named after a formerly homeless person who was a frequent visitor to Harborview who found stability in a respite facility after being referred by his medical doctor. This referral led to his ability to find stable housing, never returning to a shelter. Harborview has found that time under respite care has reduced costs as well as shorter in-patient stays.
Funding	State and local funding; insurance
Solutions Rubric Alignment	- Coordinated Assessment - Transition Settings and Services - Access to Health Services - partnerships - Staffing and Training - Community Partnerships

A complete list of the housing models analyzed for this report can be found in *Appendix D*.

Current Health & Housing Solutions Gap Analysis

The final component of the study's gap analysis reviewed the current health and housing solutions offered in Washington State against the *Solutions Rubric for Complex Service Needs,* developed in the Environmental Scan phase of the project.

Health & Housing Programs Gap Analysis

Due to the variety of ways health and housing needs are addressed, the analysis was divided into five categories of program types. As reflected in *Table 3* below, these program types varied from housing only solutions to fully integrated health and housing programs to collective care facilities to services with housing support and finally to providing services only.

Appendix B contains the complete analysis against the key characteristics of the *Solutions Rubric*, including availability of transition services, coordinated assessments, ongoing case management, access to services, rental assistance and specific population add-ons. Length of stay and other specific barriers to the programs were also detailed. Each solution was evaluated based on the extent to which it could support people with complex service needs.

Other than solutions that benefit from a single payor and tight service coordination, such as Veterans Affairs Supportive Housing (VASH), there is no current solution that adequately addresses all the key characteristics. However, combinations of existing services and settings could come close with adequate investment in capacity and cross-sector coordination.

Table 3 provides an overview of these programs. When a solution comes close to meeting the requirements of people with complex service needs, that item has been bolded below.

Table 3: Current Solutions Gap Analysis for Complex Service Needs

Promising Solutions Indicated in **bold**

Solution Category	Programs
1. Housing Only *Only housing is provided in all circumstances.*	• Affordable Housing with State & Federal Rental Assistance • Rapid Rehousing • Community Behavioral Health Rental Assistance (CBRA)[17]
2. Housing & Services *Usually housing is combined with services, but not always.*	• **Governor's Opportunity for Supportive Housing (GOSH)** • **Supported Living Program with Enhanced Rate Complex Needs Pilot** • Recovery Residences & Oxford Houses • Medical Respite • Transitional Housing • Shelters • **Permanent Supportive Housing (PSH) - Single Site** • **Permanent Supportive Housing (PSH) - Scattered Site** • Veterans Affairs Supportive Housing (VASH) • Tribal Housing & Health Services
3. Collective Care Facilities *Housing and services are provided together.*	• **Adult Family Home (AFH) with Intensive Behavioral Support Supervision (IBSS)** • Adult Family Home (AFH) • **Assisted Living Facility (ALF)** • Skilled Nursing Facility (SNF) • Enhanced Service Facility (ESF) • Residential Habilitation Center (RHC) • **Intensive Behavioral Health Treatment Facility (IBHTF)** • Mental Health Residential Treatment Services (Inpatient) • Substance Use Disorder Residential Treatment Services (Inpatient)
4. Services with Housing Support *Services may provide support for housing, including rental assistance.*	• **Housing and Recovery through Peer Services (HARPS)** • **Forensic HARPS (FHARPS)** • **Foundational Community Supports (FCS)** • Civil Transitions Program • Young Adult Housing Program (YAHP) • Independent Youth Housing Program (IYHP)
5. Services Only *On-site services that may provide support in access to housing.*	• In-Home Care • Community Choice Guides (CCG) • **Community Residential Services (including Supported Living and State-Operated Living Alternatives)** • **Program of Assertive Community Treatment (PACT)** • **Projects for Assistance in Transition from Homelessness (PATH)** • Youth and Young Adult Housing Response Team (YYAHRT)

[17] While CBRA is rental assistance only, enrollees also have access to outpatient services.

Case Management & Care Coordination

An overwhelming majority of stakeholder interviews and PWLE feedback described the essential and transformative role of personal relationships in ensuring successful transition to housing, recovery, access to services and long-term stabilization. However, the current system of case management and care coordination is highly fragmented and under capacity.

Defining Roles

The scope of services offered by case managers and care coordinators varies greatly. For the purposes of this study, we view case management as personalized one-on-one assessment, planning, education, advocacy, resource coordination, crisis resolution and sometimes clinical support. Care coordination is also personalized but is typically limited to coordination of any health and human services, as well as connection to community-based resources.

Care coordinators are often not clinicians and therefore may need specialized training to address individuals with complex service needs. Community health workers (CHWs), peer navigators and recovery coaches often perform care coordination and other community navigation functions. Because they may have community connections and/or personal experience, these care coordinators develop close, trusting relationships with the individuals they serve and the community-based organizations. While care coordinators require training on community resources and processes, case managers also require specialized clinical competencies, including crisis intervention, discharge planning and other counseling skills.

Table 4 provides a brief overview of the current landscape of case management and care coordination and illustrates the limitations of the current system.

Table 4: Case Management Gap Analysis for Complex Service Needs

Program	Level of Care	Limitations	Eligibility
Program of Assertive Community Treatment (PACT)	Daily, Intensive Support	• Strict eligibility and medical necessity criteria • Only two (out of 22 teams statewide) having housing coupled to the program • Workforce challenges impact census, scaling, and team-based model • Not available in all regions	High acuity, severe and persistent mental illness
Wraparound with Intensive Services (WISe)	Daily to Weekly, Intensive Support	• Strict eligibility and medical necessity criteria • Must be systems-involved	Limited to people under age 21
New Journeys	Daily to Weekly, Intensive Support	• Must have a diagnosis of psychotic disorder	Ages 15-40

Program	Level of Care	• Limitations	Eligibility
Intensive Response Teams (IRT)	Weekly	• Mental health care support within ALTSA residential settings only • Very limited capacity	Discharging or diverting from state hospitals or long-term hospitalization
Intensive Case Management (ICM)	Weekly, Intensive Support	• Co-occurring SUD & Mental Health • Capacity & funding • Eligibility and complexity-based	Pilot project with Co-occurring conditions
Health Home Program	Health Action Plan, Monthly Visits	• Have at least one chronic condition and are at-risk for another • Have a PRISM Predictive Score of at least 1.5 • Meet Medicaid eligibility	Apple Health clients of all ages, including Medicaid/Medicare dual eligible clients
FCS Case Manager	Weekly	• Setting-specific • For higher risk individuals and limited to the waiver	Complex needs with medical necessity and specific risk criteria
On-site Facility Case Manager	Weekly or Monthly Check Ins	• Not available for transitions between settings • Availability limited	Resident in setting
DDA Case Resource Managers	Weekly or Monthly Check Ins	• Large caseloads • Availability limited	DDA client
ALTSA Case Manager	Weekly or Monthly Check Ins	• Specific to ALTSA services • Large caseloads	ALTSA client
Youth Engagement Team (YET)	Outreach-based	• Specific to youth • Large caseloads	Ages 12-17
Recovery Navigator	Outreach-based	• Setting-specific • Narrow systems expertise	Resident in setting
Community Health Worker	Outreach-based	• Geographic limitations • Less specialized behavioral health knowledge	Resident in geographic region
Medicaid MCO Case Manager	Complexity-based	• Varies by MCO • Large caseloads	Specific MCO enrollee & complexity criteria
Care Navigator	As needed	• Setting-specific • Narrow behavioral health expertise	Client or resident of setting only

In summary, often case management is assigned based on a person's enrollment in a specific program. When an individual changes programs, residential settings or providers, their case manager may not follow the individual. This shift can hamper the ability for residents to form long-term, trusting relationships. In addition, system capacity, eligibility and levels of care are not appropriate to meet complex service needs. Furthermore, high workforce turnover and secondary trauma experienced by the staff working in case management may strain those programs that service those individuals with complex needs.

People with Lived Experience described the essential and transformative role of personal relationships in ensuring successful transition to housing, recovery, access to services and long-term stabilization.

Recommendations

Recommendations to address the gaps in serving people with complex care needs were developed in response to the specific areas identified in the *Solutions Rubric for Complex Service Needs.*

The recommendations were then refined by leveraging existing studies and initiatives such as Ruckelshaus' *Pathways to Housing Security in Washington* (2023), Washington Department of Commerce *Five-Year Homeless Housing Strategic Plan* (2024), *Washington Complex Discharge Task Force and Pilot: Interim Recommendations* (2024) and *Behavioral Health Housing Action Plan* (BHHAP) facilitated by the Washington Low Income Housing Alliance (2022). To illustrate alignment, we cross-walked this project's recommendations with these major reports and initiatives (see *Appendix E*).

The study's recommendations were also shared and discussed with the State Agency Advisory Group, the Stakeholder Workgroup, and in focus groups of People with Lived Experience (PWLE). Both stakeholders and PWLE emphasized the financial barriers and supported recommendations to address those. While providers emphasized the need for system coordination, assessment, supportive services, and individual choice, PWLE emphasized the need for life skills to learn to live as part of a community and better oneself, as well as the financial, employment, and health resources to support being able to do so.

Finally, in presenting these recommendations, this study acknowledges the interdependence of the gaps in services with wider social and economic challenges, such as:

- Cost of Living and Affordability
- Housing and Real Estate Market Pressures
- Insurance Market Pressures
- General Human Services & Healthcare Workforce Scarcity
- Challenges of Rural Infrastructure
- Causes and Impacts of Poverty
- Impact on Health Care Providers of Integrated Managed Care

While these issues are not directly addressed by the study, this context is important to consider when understanding the effectiveness of solutions.

Finally, recommendations align with the continuum that a person experiences with systems of care, transitions to care and access to care:

These groupings condense the categories in the *Solutions Rubric for Complex Service Needs.*

1. Systems of Care Recommendations

Capacity & Funding

1.1. Conduct a Community Needs and Capacity Inventory Assessment including a county-by-county quantitative analysis to consider population health needs, capacity of programs and funding availability. Include utilization of outpatient behavioral health services, ALTSA and health services required for people with complex service needs. Veteran and Tribal populations should be segmented specifically given their unique payer system.

1.2. Expand capacity, eligibility, and awareness of programs with successful outcomes, focusing on regional gaps:

- Expand PACT team availability statewide
- Expand FCS program, including eligibility criteria for young adults (including technical assistance for providers)
- Expand FCS Transition Assistance Program (TAP), including Medicaid waiver renewal that includes reimbursement for transition costs, which may include short-term rental payments and current FCS TAP costs
- Expand GOSH program
- Remove time limits on HARPS bridge subsidies from transition settings and services
- Expand pool of professionals available for supported decision-making and limited guardianship to address discharge delay due to decision-making barriers
- Provide outreach and education on Medicaid enrollment for those eligible
- Provide outreach and education on aging and disability services and supports
- Provide public education around aging and disability services, what is or is not covered, including how Medicaid spend-down impacts eligibility
- Increase funding for state-administered long-term rental voucher programs for BH populations

1.3. Ensure the competitive application process for PSH sites incorporates an assessment of plans for sustainability, quality, partnerships, and commitment to population-based needs. Successful bidders should be offered technical guidance, supported through funding, and be required to engage with state quality initiatives.

1.4. Establish a quality initiative aimed at improving PSH provider ability to implement and sustain fidelity standards, including the opportunity to learn about models of care, funding (including leveraging Medicaid benefits), and partnerships to support and develop programs beyond limited case management and 24/7 support. This collaboration could support the state and providers in identifying and scaling up models for provision of services in site-based and scattered-site PSH. Consider methods for staff oversight, ongoing supervision and drop-in site reviews.

1.5. Allocate more funds to be used for operations, maintenance, and services to preserve the current stock of subsidized and affordable housing.

Coordinated Assessment

1.6. Develop and utilize tools that support alignment between organizations working to support individuals with complex service needs. Collaboration to include DSHS, Commerce, HCA, and Department of Health (DoH). Evaluate usage across the state and include tools for:

- Referrals
- Resource coordination
- Data sharing (HMIS, ProviderOne, MCOs, CARE, Medicare)
- Inventory channels
- Outcome tracking

1.7. Create a coordinated entry pathway system that cultivates operational connections among entities working on outreach, entry into the homelessness response system, placement in housing, case management into support services, and management of longer-term housing stability. Ensure attention is given to infrastructure and local engagement to address community needs, stakeholder concerns, and local barriers.

Risk Management & Workforce

1.8. Expedite onboarding and training for caregivers, peers, Community Health Workers (CHWs), and provide meaningful wages. Increase funding for CHW capacity given absence of fund sources for this role and align with workforce capacity building initiatives.

1.9. Improve working conditions, training, wages and supports for the frontline workers who directly provide homeless services and housing assistance. This includes ensuring pay parity and benefits for peers, caregivers, and community health workers and should follow recommendations of the Commerce's workforce report, as well as HCA's Milliman cost study.

1.10. Establish universal core competencies in culturally responsive, anti-racist, and trauma-informed practices for providers, administrators, and leaders across sectors, and regularly provide the training needed to put those competencies into practice. Consider increasing availability of interpreter, translation and other communications tools (i.e. ASL).

1.11. Support legislation or agency rule changes to reduce barriers to housing, including criminal history, evictions, credit score, and other income-related barriers and partner with legal services organizations to conduct regular training on landlord-tenant rights and disability rights. These efforts could include public education campaigns and state outreach and assistance to communities in need of support due to local barriers.

1.12. Study specific collaboration and risk mitigation requirements of landlords who are challenged by crime, violence and contamination in units.

2. Transitions to Care Recommendations

Transition Services

2.1. Strengthen housing connection upon discharge from inpatient settings and strengthen connection to services within the homeless and housing systems:

- Define the **role, types and functions of case management** and who provides housing and service-related care coordination during transitions. Streamline and eliminate duplication in roles.
- Consider requiring **specific discharge planning processes** (i.e. meetings) unless a client specifically opts out.
- Create a **transition plan that includes appropriate respite models** based in the community for people exiting institutions while searching for permanent housing.
- Support **step-down transition settings** and support services to support rehabilitation and community reintegration (i.e., medical respite, IBHTF).

Coupled with Transition & Home-Like Settings

2.2. Invest in capacity of supervised and supportive home-like settings (i.e. PSH with supportive services, Adult Residential Facilities, Assisted Living with Population Specific Add-ons, Enhanced Service Facilities, IDD Set-Aside Units with Supported Living). These home-like settings could be specialized or include add-on services including:

- Behavioral health supports and interventions for ID/DD and BH
- Youth and family support to address legal and child welfare dynamics
- Programs that provide life skills & independent living training (i.e. budgeting, shopping, housekeeping), community integration support, nutritional support, in-home care, medical support services, memory care, and accessibility
- In-home care services and supports for aging, disabled, and those in need of palliative care (including accessibility modifications in housing)

2.3. Extend Complex Discharge Pilot through June 2027 with a workgroup to evaluate and recommend Medicaid funding mechanisms to be operationalized.

3. Access to Care Recommendations

Access to Services & Case Management

3.1. Address network gaps with reimbursement for strategies that promote access to care including funding for health systems and CBOs to hire peers, navigators, and community health workers, as well as flexible care settings, such as walk-in clinics, mobile services, street medicine, PSH-based services, Medications for Opioid Use Disorder (MOUD) telehealth, BH-ASO crisis supports, and medical respite to prevent destabilization and promote recovery.

3.2. Update current tiered payment rates for Supported Living/Community Residential Living and establish add-on payments to support community living. Increase is needed for direct support providers; other coordinating staff needed to help with community inclusion; medical, financial, and advocacy support; and necessary administrative and other operating costs, including transportation.

3.3. Expand Medicaid contract for transportation and emergency services transport, particularly in rural areas.

3.4. Ensure reimbursement for ongoing case management for development and implementation of all complex service plans. Evolve current case management and care navigation efforts into a cross-sector navigation system that responds to the specific needs of individuals and households and follows them longitudinally as those needs evolve.

- Outline the MCO role in case management (with ratios), define levels of transition support and facilitate connection of case management to assessment of health, housing, community-based services, and Coordinated Entry (CE).
- Reduce barriers to access of case management services by offering them to participants by default with an option to opt out.
- Engage entry points to discuss screening and placement. Ensure a deliberate process with suitable time without disruption until linked.
- Consider a model of comprehensive enhanced bundled payments to support CHW growth and role in continuum of care.

In Conclusion

Over the course of this project, the team noted excellent work happening throughout the state, ranging from established services to promising pilots. Other studies have recommended many of the same solutions, which have been cross-walked in *Appendix E* below.

Above all, one of the most important areas of investment is in the workforce, assuring adequate compensation, appropriate training, and safe working conditions. Without this, no program, no matter how well designed, will succeed.

With additional resources and improved coordination of services, the components are in place to significantly reduce the risk of housing instability among individuals with complex service needs.

Appendices

Appendix A: List of Stakeholder Organizations

The following is a list of organizations consulted in the stakeholder engagement research. An asterisk (*) after an organization name indicates participation in the Stakeholder Workgroup.

State Agency Representation

Department of Children, Youth and Families
- Housing & Homeless Prevention Program*
- Youth & Young Adult Housing Response

Department of Commerce
- Apple Health & Homes*
- Office of Supportive Housing
- Continuum of Care*

Department of Social and Human Services
- Aging and Long-Term Support Administration (ALTSA)*
- Behavioral Health Administration
- Developmental Disabilities Administration
- Economic Services Administration
- Facilities, Finance and Analytics Administration/Research and Data Analysis*
- Home and Community Services (HCS)
- Office of Indian Policy
- Service Experience Team (SET)*

Health Care Authority
- Children's Long-Term Inpatient Program (CLIP)
- Division of Behavioral Health and Recovery (DBHR)*
- Foundational Community Supports (FCS)*
- Medical Director
- Medical Respite Program
- Office Community Voices and Empowerment
- Tribal Affairs

State Associations & Foundations

Association of Washington Housing Authorities
Bree Collaborative/Foundation for Health Care Quality
Community Health Network of WA*
Kuni Foundation
Permanent Supportive Housing Coalition*
The Rural Collaborative
Washington Alliance for Quality Recovery Residences (WAQRR)
Washington Low Income Housing Alliance (WLIHA)
Washington State Housing Finance Commission
Washington State Hospital Association (WSHA)*

Behavioral Health - Administrative Service Organizations (BH-ASOs)

King County Department of Community and Human Services, Behavioral Health and Recovery Division*
Greater Columbia
Great Rivers
Carelon Behavioral Health (Pierce, North Central & Southwest)*
North Sound
Salish
Spokane
Thurston-Mason

Managed Care Organizations

Community Health Plan of Washington
Coordinated Care
Molina*
United Healthcare
Wellpoint

National Models & Researchers

Addictions, Drug & Alcohol Institute at the University of Washington
Benioff Homelessness & Housing Initiative at University of California, San Francisco
The Bridge NY
Center for Urban Community Services (CUCS)
HaRT3S
Pathways to Housing
Pathways to Housing DC
School of Social Policy & Practice at the University of Pennsylvania

Healthcare Providers & Caregiving Agencies

Associated Ministries
Catholic Community Services of Western Washington*
Catholic Healthcare Collaboration*
Coastal Community Action Program (CAP)
Columbia River Mental Health
Community Transitions
Compass
Comprehensive
Destination Hope and Recovery
First Choice Home Care
Full Life Care
Heritage NW Consulting
Jefferson Healthcare*
MultiCare Health System
Navos
Northwest Regional Council
Pioneer Human Services

Sea Mar*
Seattle Aging and Disability Services
Life Therapeutic Works
Volunteers for America
Yakima Neighborhood Health Services*

Housing
Bayside Housing and Services
Catholic Charities of Eastern Washington (CCEW)
Catholic Housing Services
Compass Housing Alliance
DESC*
Housing Hope
Imagine Housing
Interfaith Works*
Mercy Housing
Olympia Community Action Program (OlyCAP)*
Plymouth Housing
City of Seattle Office of Housing
Snohomish County Housing Authority*
Vancouver Housing Authority

People With Lived Experience (PWLE)
The Arc of King County*
The Bridge Coalition
Catholic Community Services of Western Washington*
HCA Peer Pathways Annual Workforce Development Conference
National Alliance on Mental Illness (NAMI) Washington*
Open Doors for MultiCultural Families
Peer WA*
Weld Seattle*

Appendix B: Gap Analysis of Current Solutions for Complex Service Needs

The following charts detail the complete gap analysis of current solutions for complex service needs mapped against the six key characteristics of successful organizations identified in the *Solutions Rubric for Complex Needs* developed earlier in this report. They are divided into five primary categories:

1. **Housing Only:** only housing is provided in all circumstances.
2. **Housing & Services:** usually housing is combined with services, but not always.
3. **Collective Care Facilities:** housing and services are provided together.
4. **Services with Housing Support:** services may provide support for housing, including rental assistance.
5. **Services Only:** on-site services that may provide support in access to housing.

Table B1: Housing Only Solutions

Program	Point Agency	Barriers	Length	Transition Settings & Services	Coordinated Assessments	Case Mgmt	Access to Services	Rental Assistance	Specific Population Add-ons
Affordable Housing with State & Federal Rental Assistance	Commerce	- Affordability/subsidy (especially for 0-30% AMI) - Availability - Criminal and rental history - Not always accessible - Not enough set asides in multifamily sites for I/DD	Not time-limited	No	No	No	No	Some and not time-limited	No
Rapid Rehousing	Commerce	- Program awareness - Supported access	Not time-limited	No	No	No	No	Yes, but time-limited	No
Community BH Rental Assistance (CBRA)	Commerce	- Limited capacity - Implementation methods and priority populations differ across the state depending on subcontractor	Not time-limited	No	No	No	No	Yes	No

Table B2: Housing & Services Solutions

Program	Point Agency	Barriers	Length	Transition Settings & Services	Coordinated Assessments	Case Mgmt	Access to Services	Rental Assistance	Specific Population Add-ons
Governor's Opportunity for Supportive Housing (GOSH)	DSHS - ALTSA	- Housing availability - Supported step down - Services availability and not all services are available to add on to settings (i.e. dementia care)	Not time-limited	Yes	Yes	Yes	Some	Yes	Some
Supported Living Program with Enhanced Rate Complex Needs Pilot	DSHS - DDA	- Limited availability - Siting challenges	Not time-limited	No	Yes	Yes	Yes	No	Some
Recovery Residences & Oxford Houses	HCA	- No substance use allowed - No clinical services or challenges with access - Discharge planning is challenging - Coordinated entry and priority status - NIMBY	2-5 years	Yes	No	No	No	Some	No

Program	Point Agency	Barriers	Length	Transition Settings & Services	Coordinated Assessments	Case Mgmt	Access to Services	Rental Assistance	Specific Population Add-ons
Medical Respite	Commerce	- Limited availability - Reimbursement models still under development	Up to 30 days	Yes	No	Some	Some	No	Some
Transitional Housing	Commerce	- Affects CE priority - Limited services - Limited funding	24 months	Yes	No	Some	Some	No	Some
Shelters	Commerce	- Very limited services - Challenges in engagement within a transient setting - Funding	30 days	No	No	No	Some	No	No
Permanent Supportive Housing (PSH) - Single Site	Commerce	- Transition supports are absent - CE may not match with appropriate services - Limited case management - Many levels and interpretations of PSH (fidelity) - Harm reduction setting can create risks for other residents, staff & landlords - Partnerships are	Not time-limited	No	No	Some	Some	Some	Some

Program	Point Agency	Barriers	Length	Transition Settings & Services	Coordinated Assessments	Case Mgmt	Access to Services	Rental Assistance	Specific Population Add-ons
		challenging if not both a housing and service provider							
Permanent Supportive Housing (PSH) - Scattered Site	Commerce	- Support for landlords and risk management - Supported services or in-home services are hard to coordinate	Not time-limited	No	No	Some	Some	Some	Some
Veterans Affairs Supportive Housing (VASH)	DVA	- Limited to Veterans - Losing access to vouchers due to housing stock or landlord willingness to take voucher	Not time-limited	Yes	Yes	Yes	Yes	Yes	Some
Tribal Housing & Health Services	Office of Indian Affairs	- Limited to Tribal communities	Not time-limited	Some	No	Some	Some	Some	Some

Table B3: Collective Care Facilities Solutions

Program	Point Agency	Barriers	Length	Transition Settings & Services	Coordinated Assessments	Case Mgmt	Access to Services	Rental Assistance	Specific Population Add-ons
Adult Family Home (AFH) with Intensive Behavioral Support Supervision (IBSS)	DSHS - DDA	- Limited beds - Start up and ability to comply with regulations - Workforce and training of staff - Rates	Not time-limited	Some	No	Some	Some	Some	Some
Adult Family Home (AFH)	DSHS - ALTSA - DDA	- Limited beds - Challenges of getting services on site - Workforce and training of staff - Rates	Not time-limited	No	No	Some	Some	Some	Some
Assisted Living Facility (ALF)	DSHS - ALTSA - DDA	- Limited beds - Challenges with higher levels of medical, mental health & social needs - Rates	Not time-limited	No	Some	No	Some	Some	Some
Skilled Nursing Facility (SNF)	DSHS	- Lack of substance use disorders - Lack of training on behavioral health/behaviors	Not time-limited	Yes	Yes	Some	Yes	No	No

Program	Point Agency	Barriers	Length	Transition Settings & Services	Coordinated Assessments	Case Mgmt	Access to Services	Rental Assistance	Specific Population Add-ons
		- Requires medical necessity							
Enhanced Services Facility (ESF)	DSHS - ALTSA	- Limited beds - Siting challenges - Rates	Not time-limited	Yes	Yes	Yes	Yes	No	No
Residential Habilitation Center (RHC)	DSHS - DDA	- Limited availability	Temporary	Yes	Yes	Yes	Some	No	No
Intensive Behavioral Health Treatment Facility (IBHTF)	HCA	- Individuals with recent violent behaviors can be a challenge for the community -Voluntary - Must be adherent to treatment	Average length of stay 12 months	Yes	Yes	Yes	Yes	No	No
Mental Health Residential Treatment Services (Inpatient)	HCA	- Challenges with placement at discharge - Coordination across all providers - Managed care and length of stay	30-90 days	Yes	Yes	Yes	Yes	No	No

Program	Point Agency	Barriers	Length	Transition Settings & Services	Coordinated Assessments	Case Mgmt	Access to Services	Rental Assistance	Specific Population Add-ons
Substance Use Disorder Residential Treatment Services (Inpatient)	HCA	- Access to services - Criminal/legal involvement and impact on housing - Length of stay and discharge planning into housing	14-28 days	Yes	Yes	Yes	Yes	No	No

Table B4: Services with Housing Supports Solutions

Program	Point Agency	Barriers	Length	Transition Settings & Services	Coordinated Assessments	Case Mmgt	Access to Services	Rental Assistance	Specific Population Add-ons
Housing and Recovery through Peer Services (HARPS)	HCA	- Short-term subsidy - Subsidy amounts - Limited capacity	3 months	Some	No	No	No	No	Yes
Forensic Housing and Recovery through Peer Services (FHARPS)	HCA	- Short-term subsidy - Subsidy amounts - Limited capacity - Must be ordered into OP competency restoration program -Must be referred by a peer	3 months	Some	No	No	No	No	No
Foundational Community Supports (FCS)	HCA	- Limited capacity - Trained workforce availability	6 months with renewal	Yes	No	Yes	Some	Yes	No
Civil Transitions Program	DSHS -DDA -ALTSA	- Only for those not competent to stand trial and not restorable due to diagnosis of dementia, traumatic brain injury or IDD	6 months	Some	Some	Some	Some	Yes	Some

Program	Point Agency	Barriers	Length	Transition Settings & Services	Coordinated Assessments	Case Mmgt	Access to Services	Rental Assistance	Specific Population Add-ons
Community BH Rental Assistance (CBRA)	Commerce	- Limited capacity - Implementation methods and priority populations differ across the state depending on subcontractor	Not time-limited	No	No	No	No	Yes	No
Young Adult Housing Program (YAHP)	Commerce	- Age-limited (18-24) - Limited service collaboration	Until youth ages out	Yes	Yes	Yes	Some	Yes	Some
Independent Youth Housing Program (IYHP)	Commerce	- Age-limited (18-24) for dependents of the state - Limited service collaboration	Until youth ages out	Yes	Yes	Yes	Some	Yes	Some

Table B5: Services Only Solutions

Program	Point Agency	Barriers	Length	Transition Settings & Services	Coordinated Assessments	Case Mgmt	Access to Services	Rental Assistance	Specific Population Add-ons
In-Home Care	DSHS - ALTSA	- Finding, onboarding, and paying caregivers - Caregiver hours - Person-caregiver match - Need housing or shelter to access this service - Knowledge of these services - Hours are determined by standardized levels of need which may not be adequate in all cases	Not time-limited	No	Yes	Yes	Some	Some	No
Community Choice Guides (CCG)	DSHS - ALTSA	- Lack of funding - Transitional support that doesn't continue	Limited	Some	No	Some	Some	No	No
Community Residential Services (including Supported Living and State-Operated Living Alternatives)	DSHS -DDA	- Limited Capacity - Population-specific - Need housing secured separately - Dependent on availability of appropriate housing unit	Not time-limited	Some	Some	Some	Some	Some	Some

Program	Point Agency	Barriers	Length	Transition Settings & Services	Coordinated Assessments	Case Mgmt	Access to Services	Rental Assistance	Specific Population Add-ons
Program of Assertive Community Treatment (PACT)	HCA	-Limited capacity	Annual review	Yes	Yes	Yes	Yes	No	No
Projects for Assistance in Transition from Homelessness (PATH)	HCA	-Limited to individuals experiencing Serious Mental Illness (SMI) or Co-Occurring Disorders and is experiencing or at risk of homelessness - Requires state cash or in-kind match for Federal funds	Not time-limited	Yes	Yes	Yes	Yes	No	No
Youth and Young Adult Housing Response Team (YYAHRT)	HCA	- Age-limited (until age 24) - Requires housing availability - Child welfare considerations - Rental history and legal authority to sign leases	Until youth ages out	Yes	Yes	Yes	Yes	No	No

Appendix C: Unabridged System Gap Analysis

The following chart contains an unabridged overview of the challenges and weaknesses, as well as the strengths and opportunities in the current system of care for people with complex service needs. These gaps were mapped against the areas identified in the *Solutions Rubric for Complex Needs* detailed earlier in this report.

Table C1: Unabridged System Gap Analysis

Systems Capacity	
Challenges and Weaknesses	**Strengths and Opportunities**
• Supply and demand (scarcity and capacity of housing and services) • Workforce (staffing, training) • Affordability and rising cost of living • High level of crisis • Fragmentation • Complex eligibility • Regional variation & politics • Variable standards • Limited ability to add-on support or move through system settings • Population specific barriers (Youth, DDA, Forensic, Behavioral, Aging) • Community concern & stigma	• Many effective programs exist - HCS, GOSH, CBRA, HARPS, FCS, PACT, IBHTF, etc. • Long-term care programs • Low-barrier entry programs • Prioritization of highest need • Supportive government • Streamlined eligibility • Office of Apple Health and Homes • Blended funding for health and housing programs or partnerships
Coordinated Assessment	
Challenges and Weaknesses	**Strengths and Opportunities**
• Variable assessment • No standard definition of services • Coordinated entry variation and competition • Differing priorities (health system, housing, community) • Information sharing barriers • Homeless definitions	• Integrated setting with comprehensive services • Centralized access • Cross-system collaboration • Presumptive eligibility

Transition Settings and Services	
Challenges and Weaknesses	**Strengths and Opportunities**
• Long waitlists and fragmented systems • Inability to accommodate disruptions in housing • Full range of services are not available (population specific barriers) • Full range of settings are not available • Court orders, mandates, medical necessity impact timelines • Crisis response and adaptive response not readily available within community settings	• Specialty case management and supportive services • Best practice discharge planning (see BREE, complex CM, discharge planners toolkit) • Mobile and outreach programs (HCA pilot) • Care coordination, navigation, transition support (GOSH, FCS) • Recovery Housing
Ongoing Case Management	
Challenges and Weaknesses	**Strengths and Opportunities**
• Level, specialty and duration of case management is variable or may not meet needs • No designated accountable party • There is no reimbursement • Resource knowledge and access (process, paperwork, system alignment) • Only offered in specific circumstances	• Certified Community Behavioral Health Clinics (CCBHCs) • Relationships and collaboration • Peer support for outreach and engagement • BH-ASO community engagement coordinators • Health Care Coordinators
Access to Health Services	
Challenges and Weaknesses	**Strengths and Opportunities**
• Access to health services and especially integrated services • Limited networks with limited workforce • Short-term nature of programs and absence of continuity disrupts health goals • Prioritization and re-prioritization of resources or programs (one-time, grants) • Access to health services impacts access to housing and vice versa (must go together) • Services not geared (level, type) to population being housed	• Mobile medical units, medical respite, telehealth • Complex discharge planning • On-site crisis support • Support services designed to meet needs or residents in public housing settings • Formal partnerships when services are not on site • Program for All-Inclusive Care for the Elderly (PACE) • Drop-in centers staffed with services and resources

• Severity and stigma can result in exclusion • Maintaining eligibility for critical services • Partnerships to support access when not able to deliver in house	• Community-Based Organization (CBO) funding support • Housing and health connection - prioritization of health-based needs • Reimbursement of flexible care settings • Programs integrating services on-site or through partnership
Rental Assistance	
Challenges and Weaknesses	**Strengths and Opportunities**
• Constrained capacity • Time-limited • Scarcity of units • Cannot be used in desired locations • Landlords unfamiliar with programs or will not take housing participants • Rental assistance commitment is needed from funders to develop affordable housing but cannot get commitment until development is completed.	• Voucher amounts up to par with market rates • Rental assistance should be continuous • Support to landlords to adopt voucher as payment • State housing voucher programs
Specific Add-On Population Supports	
Challenges and Weaknesses	**Strengths and Opportunities**
• Notable gaps for ID/DD, Medical Complexity, Geriatric, SUD • Limited or no behavioral health support in medical settings • Limited or no medical support in behavioral health settings • Specialty programs do not include housing and housing does not include specialty care • Living support adjustments	• Service add-ons to follow the person (rather than requiring a change in setting) • A variety of add-on supports exist and have been shown to be successful (hospice care, translation, childcare, specialized dementia care, foster and kinship supports, LTSS with Medicaid Exception Supports, Support Living Services) • Diversity, equity, inclusion efforts
Transportation	
Challenges and Weaknesses	**Strengths and Opportunities**
• Barrier to navigating resources, accessing care, and employment • Not enough and providers are closing	• Transportation tied to settings facilitates connection to services and employment • Accessibility lessens frustration and improves engagement and recovery

Staffing and Training	
Challenges and Weaknesses	**Strengths and Opportunities**
• Reimbursement • Capabilities • Burnout • Specialized training • Scattered sites have limited access to mobile teams • Project-based sites may not have the right team members for need/intensity • In-home caregiver recruitment, training, payment • Payment for skilled work outside of hospital and jail settings • Workforce trauma and wellness	• State initiatives recognize gaps in healthcare providers and make investment to train and compensate adequately • Intelligent, competent, values-driven state workers motivated to create a future state in coordination and community
Flexible Funding	
Challenges and Weaknesses	**Strengths and Opportunities**
• Sustainability (one time funding and grants) • Cost of real estate • Majority of financial resources allocated to new developments vs. support to existing communities • Capital needs assessment of existing properties • Insurance • Immature reimbursement models, including Medicaid process, limit funding access to providers • Private and commercial market vs Medicaid and Medicare (especially for aging) • Limited Operations, Maintenance and Service program (OMS) funds • Reimbursement (medical vs recovery support) • Health-Related Social Needs (HRSNs) funding support	• Use federal funding to leverage state and local funds • Counties are filling gaps in funding • Medicaid waiver programs (FCS, pre-release Medicaid, HRSN) • Ensure state programs allow for flexibility based on local needs and capacity • PSH OMS funds • Some PSH providers are leveraging Medicaid • Payment adjustments and benefit packages to address complex needs

Location, Community Connection, and Culture	
Challenges and Weaknesses	**Strengths and Opportunities**
• Isolation • Stigma • Cultural responsiveness • Language • Security • Zoning • Transportation • Proximity • Community concerns	• Purpose built and staffed settings • Integrated health and housing partnerships • Community space
Risk Management	
Challenges and Weaknesses	**Strengths and Opportunities**
• Differing viewpoints on harm reduction approaches • Tenant behavior impact on landlords and community (challenges when not staffed well/absence of services) • Provider qualifications for PSH • Insurance • Access to health services, crisis services, and case management	• Master leasing • Commerce mitigation funds • Collaboration between landlords, case managers, peers, service providers and persons receiving services to support placement and transition

Appendix D: Landscape Assessment of Promising Models & Pilots

The following chart details the complete list of promising models and pilots studied in the landscape assessment of the environmental scan.

Table D1: List of Promising Models and Pilots Studied

Name	Eligibility and Population Focuses	Funding Sources	Philosophy of Care: What do they offer?	Services
Model 1: Bay Aging, Area Agency on Aging (AAA) Urbanna, Virgina	• Aging adults • Chronic medical conditions	• HUD Section 202 • Housing w/PRAC	• Supportive services • On-site care coordinators • HUD Housing preference to Veterans and seniors	• Housing crisis hotline • Financial assistance • Emergency housing services • Housing navigation • Supportive services • HMIS tracking
Model 2: Rain City Housing - Vancouver, BC	• Indigenous homeless persons • LGBTQIA+ groups	• N/A	• Observe and place a focus on substance use in housing programs	• Peer witnessing services • Overdose prevention sites (on-site drug use allowed) • 2SLGBTQIA+ • Housing first
Model 3: Medical Respite - National Taking to Integrated Permanent Supportive Housing to Scale - Louisiana	• Mental illness • Substance use disorders • Development disabilities • Chronic health conditions • Elderly • Young adults	• HUD Section 811 Project Rental Assistance • Medicaid • CBG • PSH advocates • Low-income Housing Tax Credits	• Offer PSH with individualized services on a local scale	• PSH housing units and services • Referral and service coordinators with a housing first model
Model 4: Working Together to Empower Community Inclusion - USA	• People leaving institutionalized settings: psychiatric facilities, jails, and healthcare facilities	• HUD funds • State funds • Grants • CBG funding • LIHTC funds • HOME funds	• Build partnerships and communities • Transitions to housing for those with mental health needs	• Home health care • Determination of individual needs • Employment services

Model 5: Medical Respite - National Montefiore Health System - Bronx, NY	• Those seeking medical treatment	• State funding • Insurance companies	• Develop an early understanding of socioeconomic conditions/health and their connection to housing stability	• Alert system for housing-insecure at emergency rooms • Housing at Risk program • Maintaining housing services • Affordable housing units
Model 6: Medical Respite - National Medical Respite Pilot Program - MA	• People who are exiting medical facilities with no housing options • Not in need of 24/7 housing	• Healy Driscoll Administration	• Offer homeless people a safe place to recuperate from hospital visits and learn about their health conditions	• 40 beds of temporary housing and clinical supports while people receive assistance in finding long-term housing
Model 7: Medical Respite - National Medical Respite Care: Too Healthy for the Hospital, Too Sick for the Streets - Washington DC	• People who are exiting medical facilities with no housing options • Not in need of 24/7 housing	• Private insurance covers those on - Medicaid (seeking Sect. 1125 Waivers) • Hospitals • Philanthropies • State and Local governments	• Offer homeless people a safe place to recuperate and learn about their health conditions	• N/A
Model 8: Youth - Local Youth Homelessness Prevention - WA	• Homeless youth • Young adults • Between ages 12-24	• Grants (including • Balmer Group) • State	• InReach program at Volunteers of America (Spokane) • Supportive housing • Employment • Education • Family reunification	• Mobile case management • Services to youth 12-24 experiencing homelessness in Spokane

Model 9: IDD/DD - National Opportunity Village Organization - Las Vegas, NV	• Adults with disabilities	• Fundraising • Philanthropy	• Supportive environment where residents can thrive	• Inclusive housing • 24-hour on-site security • Support services • Resident leadership roles
Model 10: IDD/DD - National Housing Choices - Santa Clara, CA	• Persons with IDD/DD	• State funding • Local funding	• Enhance the lives of people with developmental disabilities by creating and supporting quality affordable housing opportunities	• Assist clients in finding affordable housing within their network of properties • Resident coordinator and on-going support • Emergency rental assistance
Model 11: Medical Respite - Local Edward Thomas House - Seattle, WA	• People that are too sick to return to shelters, but do not need hospital level care • Must be referred by a medical provider and have acute medical problems	• Harborview Medical Center • Owned by King County, but managed by the University of Washington	• Harm reduction philosophy to work together with the patient to resolve medical problems	• N/A
Model 12: Medical Respite - Local Peninsula Community Health Services of Kitsap, Mason, and rural Pierce County	• People that are too sick to return to shelters, but do not need hospital level care	• Capital funding from state, county, and local government • Foundations • Partner agencies	• Provide medical respite/community solutions to housing • Food insecurity • Dental support	• Patients receive 24/7 support up to 30 days • Staff help organize exit for patients to transfer into stable environments
Model 13: Medical Respite - Local Yakima Neighborhood Health Services - Yakima, WA	• Chronically homeless people with medical needs	• Leveraged federal programs	• Provide medical respite/housing for those not sick enough for the hospital but not well enough for shelters/streets	• Housing and medical services to reduce strain on medical services • Mobile clinic vans to provide medical services • Housing for respite care in the Yakima area

Model 14: Medical Respite - Local Permanent Options for Recovery-Centered Housing (PORCH) - Pierce, Chelan/Douglas Counties (WA)	• Adults with a history of mental illness and housing instability or homelessness	• Federal funding over a 5-year period to DSHS	• Increase housing stability and encourage living through supportive services	• Permanent Support Housing services • Life skills • Employment/vocation support • Treatment • Housing retention
Model 15: Veterans - National US Vets, USA	• Homeless Veterans	• Grants • Contract revenue • Private contributions	• Prevent and end veteran homelessness • Empower vets through housing • Comprehensive services • Advocacy	• Housing (12 locations, 6 states) • Mental health/wellness • Workforce development • Individualized support
Model 16: Veterans - Local Renton Veterans Center - Renton, WA	• Homeless Veterans earning below 60% AMI	• Federal, state, and local funding	• Housing and support services for homeless veterans including those with families	• 59 units of permanent housing • Veteran specific services • Case management and support
Model 17: Youth - National Youth in Transition - The Annie Casey Foundation	• Youth aging out of the foster care system	• Annie E. Casey Foundation	• Foster a sense of commitment among all those concerned with the welfare of children, and invest in partners to improve the lives of children	• Grant funding for child welfare/foster care • Community change and development • Employment • Education • Training
Model 18: Youth - Local The Mockingbird Society - Seattle, WA	• Youth at risk of experiencing homelessness upon aging out of foster care	• N/A	• Transform the foster care system and end youth homelessness	• Youth programs • Public policy advocacy
Model 19: Youth -Local Friends of Youth - East King County, WA	• Youth at risk or experiencing homelessness upon aging out of foster care	• State and local funds • Donations • Community volunteers • Local and national businesses	• Serving youth and young families facing homelessness, foster care, and behavioral health challenges	• Shelter • Supportive housing • Transitional housing • Rehousing and rapid rehousing • Emergency shelter for persons 18-24

				• Case management, counseling, life skills, financial and legal assistance
Model 20: City-Funded Program - Local Janian Medical Care from Center for Urban Community Services - New York, NY	• Persons with a history of homelessness who have comorbid health conditions	• New York City local city tax	• Integrated health and housing program, with medical outreach to permanent supportive housing sites.	• Housing • Psychiatry • Primary care • Outreach and engagement support • Case management • Counseling • Peer support • Employment support
Model 21: The Emerging Crisis of Aged Homelessness - Los Angeles, Boston, NYC	• Homeless seniors (55+)	• Medicaid • Medicare • SSI • SOAR	• Match intervention intensity to client needs • Increasing age is associated with higher service use	• N/A
Model 22: IDD/DD National - Dungarvin - Across 15 states	• People with developmental disabilities	• Medicaid Home and Community-Based Waiver • Private pay • Grants • Fundraising • Partnerships with local and national non-profits (VOA)	• Supports the philosophy of supported living and self-determination • Enhance an individual's independence and maximize their quality of life	• Housing • Day services • Supported foster care • Children's services • Respite care • Host homes • Support for people with traumatic brain injuries
Model 23: IDD/DD Local - Ambitions - WA	• People with IDD/DD	• N/A	• Dedicated to assisting people with IDD/DD achieve lifelong ambitions and dreams	• Supported living services, some in shared living situations • One-on-one support up to 24 hours per day
Model 24: IDD/DD Local - Hope Human Services - Lacy, WA	• Adults and youths with IDD/DD	• Services contracted through DDA and certified by Residential Care Services • Each person pays for own rent, food utilities, and living expenses	• Creating exceptional life experiences for the supported individual, person-centered planning, community-based activities	• Supported living for both adults and youth for 2-3 people in a shared environment • Habilitative services to include home, health, financial, and medical management • Must be referred by Regional DDA Resource Management Team

Model 25: IDD/DD Local - Alpha Supported Living Services - King, Snohomish, and Spokane counties, WA	• People with IDD/DD	• Grants • Philanthropy • Clients pay their own rent and living expenses	• All services provided are person-centered goal setting involving the client, guardians/family, staff	• Supported living communities where people can live alone or up to 4 housemates • Personalized behavioral, social, and mental health supports • Community Inclusion Services
Model 26: Homeless Local - DESC - 1811 Eastlake - 75-units, - Seattle, WA	• Housing for adults experiencing homeless with chronic alcohol use disorders • Housing of those who were previously the heaviest users of publicly funded crisis services	• Grant from Robert Wood Foundation funded for an initial 3 years of operation	• Community where no person is abandoned, ignored, or experiences homelessness, help people with SUD and services BH through comprehensive treatment, services, and housing	• 75 units of housing • 24/7 support staff/in-house case management • Nutritional services • Medical monitoring • Voluntary SUD services on site • On-site ARNP as primary care provider • Group focused on meaningful activities
Model 27: Youth Local - LIHI - Marian West Apartment - Marion, WA	• Homeless young adults experiencing homelessness (18-24)	• Low-income Housing Tax Credits (Building) • YouthCare (services) • University Food Bank • Fundraising • Philanthropy	• Provide a safe place for the residents to live and thrive	• 20 units of affordable housing • Services provided by YouthCare
Model 28: Homeless Local - Central City Concern - Portland, OR	• Persons and families experiencing homelessness; concerns with SUD and BH, • Special focus is on BIPOC communities	• Donations/grants • Revenue from Social Enterprise Business employing graduates of their programs • Local and State funding	• Caring, innovative services that address the whole person	• Housing • Employment training • Assistance in seeking work opportunities • Mentoring program
Behavioral Model 29: Behavioral Health Admin Services (BH-ASO) Carelon Supportive	• Persons diverted from criminal prosecution to BH treatment services • Those who need housing upon discharge from	• HCA • Clark County Community Services	• Hybrid program that identifies and addresses a specific health crisis and promote a healthier community	• Crisis Services for high utilizers of services • Prioritize those without housing • Provides necessary support to stabilize the individuals into

Housing Program - WA	crisis stabilization services			housing to reduce recidivism • Temporary stays • Housing barrier removal assistance • Move-in costs/landlord incentives • Rental Assistance • Essential needs • Case management
Model 30: Georgia State Housing Voucher Program	• People with severe and persistent mental illness	• State-funded	• Permanent supportive housing program that individuals obtain safe and affordable housing that supports	• Housing vouchers • Bridge Funding to help facilitate their transition and help with move-in expenses • Project for Assistance in Transition from Homelessness (PATH) • Street outreach • Case management
Model 31: Substance Abuse and Mental Health Services Administration - Rockville, MD	• People experiencing homelessness with SUD and special needs (Veterans, LGBTQ, people of color)	• Federal, state and local funding • Private insurance	• Recovery is about the individual's choices, engaging members of underserved groups	• Recovery Housing (abstinence-based) • Housing First

Appendix E: Recommendations Cross-walked with Existing Initiatives

The following table crosswalks this report's recommendations with existing studies and initiatives, including:

- Pathways to Housing Security in Washington sponsored by The William D. Ruckelshaus Center (2023)
- Washington Complex Discharge Task Force and Pilot: Interim Recommendations (2024)
- Behavioral Health Housing Action Plan (BHHAP) facilitated by the Washington Low Income Housing Alliance (2022)
- Washington Department of Commerce Five-Year Homeless Housing Strategic Plan (2024)

A number after the initiative in the table below ties to a specific recommendation made in that study.

Table E1: Cross-Walk of Recommendations with Existing Initiatives

Type	Theme	Condensed Recommendation	Related initiatives
System of Care	Capacity	**1.1. Conduct a Community Needs and Capacity Inventory Assessment** including a county-by-county quantitative analysis to consider population health needs, capacity of programs and funding availability. Include utilization of outpatient behavioral health services, ALTSA and health services required for people with complex service needs. Veteran and Tribal populations should be segmented specifically given their unique payer system.	BHHAP (1, 6, 7) Ruckelshaus Report (6) Homeless Plan (1.4)
System of Care	Capacity	**1.2. Expand capacity, eligibility, and awareness** of programs with successful outcomes, focusing on regional gaps: • Expand PACT team availability statewide • Expand FCS program, including eligibility criteria for young adults (including technical assistance for providers) • Expand FCS Transition Assistance Program (TAP), including Medicaid waiver renewal that includes reimbursement for transition costs, which may include short-term rental payments and current FCS TAP costs • Expand GOSH program • Remove time limits on HARPS bridge subsidies from transition settings and services • Expand pool of professionals available for supported decision-making and limited guardianship to address discharge delay due to decision-making barriers	BHHAP (1, 2, 3) Complex Discharge (2, 3, 4) Ruckelshaus Report (4, 6) Homeless Plan (3.4, 5.4, 5.6) DSHS ALTSA 2025-27 Budget Request for Investment in Rental Subsidies (Program 050; Policy Level - 7D - Housing Supports) Initiatives to expand Medicaid coverage including pre-release enrollment of corrections populations and advocacy of coverage by Tribal groups.

Type	Theme	Condensed Recommendation	Related initiatives
		• Provide outreach and education on Medicaid enrollment for those eligible • Provide outreach and education on aging and disability services and supports • Provide public education around aging and disability services, what is or is not covered, including how Medicaid spend-down impacts eligibility • Increase funding for state-administered long-term rental voucher programs for BH populations	
System of Care	Capacity	**1.3. Ensure the competitive application process for PSH sites incorporates an assessment of plans for sustainability, quality, partnerships, and commitment** to population-based needs. Successful bidders should be offered technical guidance, supported through funding, and be required to engage with state quality initiatives.	BHHAP (1, 2, 3) Homeless Plan (1.3.3)
System of Care	Capacity	**1.4. Establish a quality initiative aimed at improving PSH provider ability to implement and sustain fidelity standards**, including the opportunity to learn about models of care, funding (including leveraging Medicaid benefits), and partnerships to support and develop programs beyond limited case management and 24/7 support. This collaboration could support the state and providers in identifying and scaling up models for provision of services in site-based and scattered-site PSH. Consider methods for staff oversight, ongoing supervision and drop-in site reviews.	Ruckelshaus Report (4) Homeless Plan (1.3.3, 2.2.3.) Commerce PSH Toolkit HUD PSH Accelerator Program
System of Care	Capacity	**1.5. Allocate more funds to be used for operations, maintenance, and services** to preserve the current stock of subsidized and affordable housing.	Ruckelshaus Report (5) Homeless Plan (2.1)

Type	Theme	Condensed Recommendation	Related initiatives
System of Care	Coordinated Assessment	**1.6. Develop and utilize tools that support alignment between organizations** working to support individuals with complex service needs. Collaboration to include DSHS, Commerce, HCA and Department of Health (DoH). Evaluate usage across the state and include tools for: • Referrals • Resource coordination • Data sharing (HMIS, ProviderOne, MCOs, CARE, Medicare) • Inventory channels • Outcome tracking	Complex Discharge (3) BHHAP (1, 2, 3, 4, 6, 7) Ruckelshaus Report (9) Homeless Plan (3.1)
System of Care	Coordinated Assessment	**1.7. Create a coordinated entry pathway system** that cultivates operational connections among entities working on outreach, entry into the homelessness response system, placement in housing, case management into support services, and management of longer-term housing stability. Ensure attention is given to infrastructure and local engagement to address community needs, stakeholder concerns, and local barriers.	BHHAP (3, 7) Ruckelshaus Report (9, 11) Homeless Plan (4.1)
System of Care	Staffing and Training	**1.8. Expedite onboarding and training for caregivers, peers, Community Health Workers (CHWs), and provide meaningful wages.** Increase funding for CHW capacity given absence of fund sources for this role and align with workforce capacity building initiatives.	BHHAP (5) Ruckelshaus Report (16) Homeless Plan (2.5) Initiative for new Behavioral Health Service Specialist (BHSS) may address workforce gaps and expedite onboarding.
System of Care	Staffing and Training	**1.9. Improve working conditions, training, wages and supports for the frontline workers** who directly provide homeless services and housing assistance. This includes ensuring pay parity and benefits for peers, caregivers, and community health workers and should follow recommendations of the Commerce's workforce report, as well as HCA's Milliman cost study.	BHHAP (5) Ruckelshaus Report (15)

Type	Theme	Condensed Recommendation	Related initiatives
System of Care	Staffing and Training	**1.10. Establish universal core competencies** in culturally responsive, anti-racist, and trauma-informed practices for providers, administrators, and leaders across sectors, and regularly provide the training needed to put those competencies into practice. Consider increasing the availability of interpreter, translation and other communications tools (i.e. ASL).	Ruckelshaus Report (16)
Systems of Care	Risk Management	**1.11. Support legislation or agency rule changes to reduce barriers to housing**, including criminal history, evictions, credit score, and other income-related barriers and partner with legal services organizations to conduct regular training on landlord-tenant rights and disability rights. These efforts could include public education campaigns and state outreach and assistance to communities in need of support due to local barriers.	BHHAP (1) An example of a successful initiative is the Eviction Resolution Pilot Program which provided legal aid to tenants.
Systems of Care	Risk Management	**1.12. Study specific collaboration and risk mitigation requirements of landlords** who are challenged by crime, violence and contamination in units.	Office of the Insurance Commissioner Workgroup
Transitions of Care	Transition Services	**2.1. Strengthen housing connection upon discharge** from inpatient settings and strengthen connection to services within the homeless and housing systems: • Define the **role, types and functions of case management** and who provides housing and service-related care coordination during transitions. Streamline and eliminate duplication in roles. • Consider requiring **specific discharge planning processes** (i.e. meetings) unless a client specifically opts out. • Create a **transition plan that includes appropriate respite models** based in the community for people exiting institutions while searching for permanent housing. • Support **step-down transition settings** and support services to support rehabilitation and community reintegration (i.e., medical respite, IBHTF).	Complex Discharge (2, 4) BHHAP (2, 3, 5) Ruckelshaus Report (4)

Type	Theme	Condensed Recommendation	Related initiatives
Transitions of Care	Transition Settings	**2.2. Invest in capacity of supervised and supportive home-like settings** (i.e. PSH with supportive services, Adult Residential Facilities, Assisted Living with Population Specific Add-ons, Enhanced Service Facilities, Supported Living, IDD Set-Aside Units). These home-like settings could be specialized or include add-on services including: • Behavioral health supports and interventions for ID/DD and BH • Youth and family support to address legal and child welfare dynamics • Programs that provide life skills & independent living training (i.e. budgeting, shopping, housekeeping), community integration support, nutritional support, in-home care, medical support services, memory care, and accessibility • In-home care services and supports for aging, disabled, and those in need of palliative care (including accessibility modifications in housing)	Complex Discharge (4) BHHAP (1, 2, 3, 5) Ruckelshaus Report (4) Homeless Plan (5.1, 5.2, 5.6) RCW 71.24.145: Homeless outreach stabilization transition program exists but has not been funded.
Transitions of Care	Transition Settings	**2.3. Extend Complex Discharge Pilot** through June 2027 with a workgroup to evaluate and recommend Medicaid funding mechanisms to be operationalized.	Complex Discharge (1, 2)
Access to Care	Access to Services	**3.1. Address network gaps with reimbursement for strategies that promote access to care** including funding for CBOs, peers, navigators, and community health workers, as well as flexible care settings, such as walk-in clinics, mobile services, street medicine, PSH-based services, Medications for Opioid Use Disorder (MOUD) telehealth, BH-ASO crisis supports, and medical respite to prevent destabilization and promote recovery.	Complex Discharge (2, 4) BHHAP (2, 3, 5, 6, 7) Ruckelshaus Report (9, 11, 12) Homeless Plan (2.1)
Access to Care	Access to Services	**3.2. Update current tiered payment rates for Supported Living/Community Residential Living and establish add-on payments to support community living.** An increase is needed for direct support providers; other coordinating staff needed to help with community inclusion; medical, financial, and advocacy support; and necessary administrative and other operating costs, including	BHHAP (5)

Type	Theme	Condensed Recommendation	Related initiatives
		transportation.	
Access to Care	Access to Services	**3.3. Expand Medicaid contract for transportation** and emergency services transport, particularly in rural areas.	BHHAP (5)
Access to Care	Case Management	**3.4. Ensure reimbursement for ongoing case management** for development and implementation of all complex service plans. Evolve current case management and care navigation efforts into a cross-sector navigation system that responds to the specific needs of individuals and households and follows them longitudinally as those needs evolve. ● Outline the MCO role in case management (with ratios), define levels of transition support and facilitate connection of case management to assessment of health, housing, community-based services, and Coordinated Entry (CE). ● Reduce barriers to access of case management services by offering them to participants by default with an option to opt out. ● Engage entry points to discuss screening and placement. Ensure a deliberate process with suitable time without disruption until linked. ● Consider a model of comprehensive enhanced bundled payments to support CHW growth and role in continuum of care.	Complex Discharge (2, 4) BHHAP (2, 3, 5, 7) Ruckelshaus Report (9, 11)

A number of other related initiatives and studies were also consulted as recommendations were developed:

Reports and Studies:

- Momentum for Change: Ending the Nonprofit Starvation Cycle from The Bridgespan Group and (2019) and cited by Campaign for 20%
- Housing Needs for Individuals with Intellectual and Developmental Disabilities in Washington State from DSHS DDA (2022)
- Bree Collaborative Complex Patient Discharge Report and Guidelines
- 2022 Behavioral Health Workforce Assessment from the Washington Workforce Training & Education Coordinating Board (2022)
- Wage Equity for Non-Profit Human Services Workers from University of Washington School of Social Work (2023)
- Second Washington Tribal Opioid and Fentanyl Summit Report (July 2024)
- WA State Permanent Supportive Housing Perceptions and Community Health Survey (2024) from University of Washington Addictions, Drug & Alcohol Institute

Legislative Initiatives and Workgroups:

- Governor's and Tribal Leaders Social Services Council (GTLSSC) including the Homelessness and Poverty Workgroup
- Washington State Office of Insurance Commissioner Housing Trust Fund Insurance Market Study Workgroup (current)
- HB 1905 (2022) – created the Youth and Young Adult Housing Response Team (Rapid Response Team) coordinated by DCYF but involving multiple state agencies (including DSHS) to triage and provide housing supports to youth at risk of homelessness upon exiting a systems of care.
- HB 1580 (2023) – created the Rapid Care Team within the Governor's Office (with heavy HCA involvement) responsible for supporting and identifying housing services and living arrangements for youth (under 18) who are staying in a hospital without medical necessity because they are unable to return to the care of a parent or guardian.
- HB 1929 (2023) - created a post-inpatient housing program for young adults to provide supportive transitional housing with behavioral health support focused on securing long-term housing for young adults exiting inpatient behavioral health treatment.
- SSB 5189 (2023) - created the new Behavioral Health Support Specialist (BHSS) profession. The BHSS credential, which requires a bachelor's degree and a training program, will allow credential-holders to provide low-level behavioral health services under the supervision of another provider. DoH will be collaborating with the University of Washington and other interested parties to establish standards, rules, and other requirements for the profession. The BHSS credential is expected to be available by January 1, 2025.

Principle Allies

CONTACT

Principle Allies
Issaquah, Washington

www.principleallies.com
(206) 450-6190