ON THE GROUND FLOOR
HOUSING FIRST FREQUENT USERS OF HEALTH SYSTEMS INITIATIVE
COMMON CHALLENGES & PROMISING COMMUNITY PRACTICES

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INTRODUCTION

Many people who experience homelessness cannot readily access the health care they need because of housing instability. As a result, they make frequent, and often avoidable, use of emergency rooms and inpatient hospital treatment. This lack of access has been a major motivator for developing supportive housing initiatives that partner deeply with health centers to stabilize both aspects of vulnerable peoples' lives. Supportive housing has been shown to help tenants engage in preventative and ongoing health care so that they do not need to use crisis response services in order to address their health care needs.

ABOUT SUPPORTIVE HOUSING

Supportive housing combines affordable housing with supportive services that help people who face the most complex challenges live with stability, autonomy, and dignity. Supportive housing is a specific intervention designed for individuals and/or families who are homeless, at risk of being homeless or institutionalized, and experiencing multiple barriers to independent housing. These vulnerable individuals would likely not succeed in housing without access to critical support services and would not partake in services without a stable living environment.

- The housing in supportive housing is affordable, permanent, and independent. The services are comprehensive, flexible, tenant-driven, voluntary, and housing-based. Supportive housing embraces the "Housing First" approach.
- Housing First aims to quickly and successfully connect individuals and families experiencing homelessness to permanent housing without preconditions or barriers to entry, such as sobriety, treatment or service participation requirements.
- Health center and housing partnerships are key to delivering the comprehensive services in supportive housing.

For close to a decade now, communities have utilized supportive housing interventions to help break the cycle of homelessness and crisis among individuals with complex physical and behavioral health challenges who are the highest users of emergency rooms, jails, shelters, clinics and other costly crisis service systems. While community definitions of what constitute a high user vary, in general, high users are defined as individuals who have avoidable use of crisis systems, including hospitals, jails, and shelters. Communities use a data-driven approach, which includes looking across administrative system data systems and/or utilizing triage systems to determine system usage. Utilizing this frequent user approach, such as CSH's signature Frequent User of Systems Engagement (FUSE), communities are able to increase housing stability and reduce avoidable multiple crisis service use, which means more effective use of public funds.

In this brief, we document some of the common dynamics communities face when advancing supportive housing and health center partnerships that target homeless individuals who frequently use hospital and emergency departments for preventable reasons in four leading communities across the country: Los Angeles, CA (10th Decile Project); Camden, NJ (Camden Housing First Pilot); Orlando, FL (Housing the First 100); and Indianapolis, IN (Penn Place). In February 2016, CSH and the National Health Care for the Homeless Council (NHCHC) convened a virtual roundtable with these four communities. The virtual roundtable was designed to provide a place for participants to exchange ideas, effective strategies, best practices and useful resources. To have a diverse perspective, communities were chosen based on differing high-fidelity Housing First models, modes of partnership with health centers, length of implementation, and varying geography. To ensure that each community would benefit from the conversation, at least one provider or

partner from each community was interviewed prior to the roundtable to determine program goals, progress to date, challenges they have experienced, and what they wanted to gain from the experience. Topics for discussion were selected based on common themes between the communities and the major areas they wanted to discuss.

The Systems Trap

Communities across the country are spending billions on services for vulnerable individuals and families trapped in a continuous cycle of shelters, hospitals, jails, treatment programs and the streets. These individuals who frequently use these crisis systems for avoidable reasons often suffer from multiple and debilitating co-occurring chronic medical, social, behavioral health and long-term conditions that greatly contribute to their unmet health and other needs. Additionally, they experience many negative social determinants of health: poverty, homelessness or unstable housing, unemployment, and social isolation.[1] To address these challenges, communities have looked for evidence-based, innovative models that improve outcomes while containing public costs. Supportive housing and its tenancy support services is a key innovation that has been proven to advance these goals. While it can be challenging, coordinating care efforts across systems and including supportive housing in these efforts provides many opportunities to provide high quality, wrap around health care and tenancy support services.[2]

There is a strong body of evidence that demonstrates that Housing First programs that are targeted to frequent users provide a strong return on investment for communities. To examine the overall return on investment for supportive housing programs, communities are assessing overall system use prior to supportive housing and after supportive housing. Health centers can also look at their own return on investment for providing services to this population by examining increased use of preventive care and improved health outcomes.

Implementing Housing First Initiatives Takes A *Systems* Village… And Time

Housing First is an approach and framework for ending homelessness that is centered on the belief that everyone can achieve stability in housing directly out of homelessness and that stable housing is the foundational platform for pursuing other health and social services goals.[3] Created by Pathways to Housing founder, Dr. Sam Tsemberis, Housing First emerged as an alternative response to the traditional, linear approach communities have taken to address their homeless problems. In the traditional model, communities would require individuals experiencing homelessness to first participate in and graduate from temporary residential and treatment programs in order to gain access to permanent supportive housing[4]. The belief that individuals must become "housing ready" by overcoming personal challenges in order to access stable housing has been debunked many times over. In fact, the Pathways model has been remarkably successful in ending chronic homelessness: maintaining 85 – 90% retention rates even among individuals who have not succeeded in other programs. Housing First programs have held these high rates of housing retention among many subpopulations, including individuals who are chronically homeless, individuals with co-occurring mental health and substance abuse disorder, and individuals who cycle across multiple systems including jail, child welfare, and healthcare

[1] Housing is the Best Medicine: Supportive Housing and the Social Determinants of Health, CSH, June 2014 http://www.csh.org/resources/housing-is-the-best-medicine-supportive-housing-and-the-social-determinants-of-health/

[2] CSH explores the key opportunities and challenges to cross-sector coordination between health centers and housing providers in Health and Housing Partnerships: Overview of Opportunities and Challenges for Health Centers.

[3] U.S. Interagency Council on Homelessness. (2014) Implementing Housing First in Permanent Supportive Housing: A Fact Sheet from the U.S. Interagency Council on Homelessness with assistance from the Substance Abuse and Mental Health Services Administration. Retrieved from: https://www.usich.gov/resources/uploads/asset_library/Implementing_Housing_First_in_Permanent_Supportive_Housing.pdf

[4] United States Department of Housing and Urban Development. Housing First in Permanent Supportive Housing. Retrieved from: https://www.hudexchange.info/resources/documents/Housing-First-Permanent-Supportive-Housing-Brief.pdf

system. Not only is Housing First effective at keeping people housed and working toward recovery, it has also proven to be incredibly cost-effective.[5]

In a Housing First approach, services are provided using a harm-reduction approach, which does not require sobriety and participation in treatment services as preconditions for obtaining housing or requirements of ongoing tenancy. Many communities have taken to implementing Housing First initiatives at the realization that current mechanisms for tackling homelessness and overutilization of public systems are ineffective: in short they are not getting their money's worth.

Orlando, FL

"Housing the First 100" is in its first year of implementing their Housing First pilot. With strong community partnerships and support from the local hospital, this project has housed 43 individuals between August 2015 and February 2016. With a goal of housing 100 individuals in their first year, the health center works closely with the local HUD-supported CoC as well as cross-referencing the hospital frequent user data to identify, engage, and support individuals as they transition to and retain housing.

Camden, NJ

The Camden Housing First Pilot is working to house 50 homeless, high-utilizers of the healthcare system in a scattered-site model and connect them to appropriate health services. In February 2016, seven individuals have been housed and retained, an additional nine have secured a housing unit but have yet to move in, and a total of 20 have had their vouchers approved. The community is in the process of solidifying their community partnerships to expedite the housing and services process.

Indianapolis, IN

Penn Place is a single site Housing First program with onsite health services provided by Eskenazi Health and Midtown Mental Health. With significant time constraints imposed by the property, they managed to fill all units in a one-month timespan and have housed 42 individuals who were identified as chronically homeless frequent users of emergency rooms, ambulances, and police interactions. Through this process, they have developed supportive community partners that allowed for the successful implementation of a rapid move-in schedule, with the last residents moving in at the end of January 2016.

Los Angeles, CA

The most established program participating, the 10th Decile Project has been running for nearly a decade. Strong community collaboratives involving the hospital, homeless services provider, and health centers, and utilizing a specialized triage tool, have helped house 103 of the communities' highest cost, highest need, frequent users of emergency services.

While the concept of Housing First sounds easy, it relies on a heavy patchwork of systems coordination and integration and the intrinsic belief that people can and will address their challenges once basic needs like safety and shelter are met. Coordinating large systems like hospitals, corrections and parole, Department of Housing and Urban Development (HUD)-supported Continuums of Care (CoC), housing developers, heath centers, landlords, medical and behavioral

[5] Pathways National. Housing First Model. Retrieved from: https://pathwaystohousing.org/housing-first-model

service providers is no simple task. Building the connections to health center grantees and providers in the community is essential to breaking the cycle of expensive and unproductive care. From each of the four communities, clinicians, administrators, housing providers and other supportive service staff joined in the conversation. A total of 17 providers and representatives from the communities participated in the hour and a half long virtual event. Each of the four communities gave a brief overview of their program before moving into the discussion, which focused on **(1) Housing, (2) Staffing & Care Coordination, (3) Housing First & Community Partnerships, (4) Client Engagement & Fostering Community, and (5) Sustainability & Evaluation**. These topics were selected based on challenges and opportunities identified by the participating communities, which reflects those around the country as explored in CSH's National Cooperative Agreement publication summary of challenges and opportunities issued in September 2015, Health and Housing Partnerships: Overview of Opportunities and Challenges for Health Centers.

Housing First Challenges & Promising Practices

Topics	Challenges	Promising Practices Discussed
Housing	The lack of available interim housing.	Another community found that with a low vacancy rate, it could be 4-8 months before someone is in permanent housing. In the meantime, they were using hotels as a source of interim housing. While this can get expensive, they have developed partnerships with some hotels, providing greater flexibility to regularly check-in with clients. In other cases, individuals are placed in a shelter or a recuperative care program until they receive permanent housing. The recuperative care beds offer limited medical supervision, which is appropriate for individuals who are exiting hospitals. Funding for these beds comes from various sources including support from the county department of health services and hospital partnerships.
	Identifying and funding housing options, and the cost interim housing	To address the lack of available housing options, one community leveraged private and city funding to fill gaps. In addition to HUD-supported housing vouchers, a number of city housing vouchers provided support for individuals who may not meet the HUD definition of chronically homeless but were identified as high need. This was paired with county support, which created a 'barrier buster fund' to cover costs such as a security deposits and furniture. They also utilized Tenant-Based Rental Assistance funding that was managed by the county.
	Addressing the issue of prioritization for housing when those identified through hospital triage were not scoring high on housing assessments (e.g. VI-SPDAT).	One community created strong collaborations with local hospitals to help with the prioritization process. This involves monthly meetings where the hospital brings data on high utilizers and the care coordinator will use this information to engage clients at the hospitals for triage and intake into the program. The same community also noted that while they measure vulnerability using a triage tool, this tool does not often match up with the results of the Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT), the vulnerability assessment used by the local coordinated entry.
		A second community uses the VI-SPDAT for their regional coordinated entry process. Any outreach worker who encounters a person experiencing homelessness is to conduct the vulnerability assessment and any individual who scores a ten or above is placed on the coordinated entry registry. The community has also developed a side process for prioritizing consumers who have the same score by considering history of domestic violence, human trafficking, acute medical issues, veteran status, whether or not they are under 18, or if they are an LBGTQ youth. A key component of the partnership is that those who are prioritized are referred back to the health center for wrap around services.
		A third community also used the VI-SPDAT to assess for vulnerability, however they had a short timeframe to house consumers. Due to the quick turn-around, the decisions went through the housing committee, who prioritized those who needed Americans with Disabilities Act (ADA) compliant and accessible units first, then considered frequent user data from the local hospital and length of chronic homelessness.
	Finding appropriate housing placement for individuals needing higher levels of care, including ADA accessibility (e.g. nursing home or assisted living).	One community found that some high need individuals' needs were best met in a nursing home, especially considering the high cost of assisted living facilities and available Medicaid reimbursements. Some nursing homes will accept individuals with Medicaid before they have Medicare and will assist in the application process once they have transferred care to the facility. While another community has had difficulty finding nursing facilities

TOPICS	CHALLENGES	PROMISING PRACTICES DISCUSSED
		for individuals who have active substance use concerns, this community has had some success working with physicians to prescribe alcohol maintenance, which can be administered by nurses.
Staffing & Care Coordination	Concerns with staff capacity across the care team. Communities were interested in the staffing structure and licensure requirements as well as caseload ratios, particularly service staff needed for high-need formerly chronically homeless residents	In one community, they have instituted two core components of their staffing structure 1) the health center case manager works closely with the housing navigator and 2) the case manager has a low caseload of 12 to 15 per case manager. They also have case conferencing on each patient every seven days with the entire integrated care team, including the outreach specialist, housing specialist, lease up team, all the case managers, medical clinicians, nurse, housing locators, and mental health provider.
		Another community described the role of the support service and housing provider as the glue between various service systems. Their goal is to advocate for and support the consumer to design services in a more cohesive direction that best meets their needs.
		A third community found that by moving individuals into housing, they may no longer qualify for the homeless services, specifically health care and mental health services[6]. To ensure continuity of care, the health center agreed to provide these services for up to a year after housing, until the individual is ready to transition to a new care team. A warm handoff is ensured as providers with existing relationships introduce onsite staff to facilitate a natural transfer of care.

[6] HRSA has placed in the Service Area Competition (SAC) announcements since 2012 language addressing permanent supportive housing that in essence reads "Provide a plan that ensures the availability and accessibility of required primary and preventive health care services to people experiencing homelessness, defined as patients who lack housing, including residents of permanent supportive housing, transitional housing, or other housing programs that are targeted to homeless populations, in the service area."
In 2012, the National Health Care for the Homeless Council (NHCHC) issued a letter to Health Center program grantees serving individuals and families experiencing homelessness: http://www.nhchc.org/wp-content/uploads/2011/10/12-month-rule-Policy-Advisory-Sept-20122.pdf

The NHCHC letter references Senate Report 112-84, from the 112th Congress (2011-2012). On pages 37-38 of this report (https://www.congress.gov/112/crpt/srpt84/CRPT-112srpt84.pdf) states the Committee's language that informed the update to the SAC language: "Health Care for the Homeless [HCH].--HCH projects funded under section 330(h) of the PHS Act provide essential services to people experiencing homelessness, providing the access to comprehensive services and the continuity of care that are critical to establishing and maintaining housing and health stability. Permanent supportive housing is an important step in the process to permanent housing; however, the Committee believes that permanent supportive housing has important differences from truly permanent housing. Therefore the Committee believes that it is consistent with 330(h)(4) for HCH grantees to treat residents of permanent supportive housing or other housing programs that are targeted to homeless populations but do not limit tenant length of stay as persons who are homeless."

Topics	Challenges	Promising Practices Discussed
		The fourth community also works to ensure warm handoffs. Once individuals are identified for the Housing First program, their provider sees them through interim housing until they are connected to permanent housing where a separate care team oversees supportive housing. The care team, consisting of both health and housing providers, also utilizes bi-weekly case conferencing to review care plans and discuss individuals who are soon to be housed, in addition to regular, informal communication.
	Gaining clarity on staff roles including day-to-day expectations of case managers and more general role clarity between health and housing partners and what services to provide. This relates to the challenges regarding care coordination, specifically formalizing "warm" hand-offs across agencies.	One community is setting up a rotating monthly training schedule covering topics such as case management, motivational interviewing, and harm reduction. Another community has partnered with a local university to access online training modules that most program partners participated in.
		To encourage 'self-care' among providers, one community provides various team-building opportunities such as corporate 5Ks. They also host events in collaboration with clients, such as bowling nights for consumers, peer support specialists, and providers. They have found this to be helpful in building relationships and helping providers rekindle their passions.
		In addition to medical, mental health, and case management services, two communities offer payee services. One has 60-70 consumers on SSI who use this service. Using a harm reduction philosophy, the provider has set this up to balance money management and the ability to manage one's own finances.
		One community provider partners with community based adult service centers to offer recreational activities for residents to help get them actively involved in the community. Another community partners with local banks to help clients set up accounts and offer classes on budgeting and finance. They have also approached local utility companies to ease the burden of move-in costs, in addition to offering life skills classes through their academic partners.
Housing First & Building Key Community Partnerships	Obtaining buy-in to the Housing First approach from the community at-large (addressing concerns around NIMBY-ism), interested landlords, and other housing providers, especially in two of the communities where Housing First was a newer concept.	One community found that having their health center and other health care providers join in on their Housing First trainings, including the property manager, was helpful in getting the program up and running.
		Another community works with their local HUD-supported CoC to hold landlord summits for those who may be interested in learning about the opportunities that come with Housing First approach such as dedicated rent income and wrap around services. This funding is mixed with other local resources and private funds to put the pieces together for a damages fund, which helped reassure landlords.
		Another community has a team go out and meet with landlords to make sure the program has a good reputation. They try to balance advocating for the consumer with recognizing the business aspects of landlord concerns. By keeping communication open and honest, they have built up relationships in the community. Part of this includes being available to discuss landlord concerns, working to address issues, and keeping the landlord informed of progress.
	Building partnerships and working with partners. These challenges	Similarly, another community has found that open communication between the health center, housing provider, and hospital is key to building a strong partnership. By frequent communication, the providers can help hospitals

TOPICS	CHALLENGES	PROMISING PRACTICES DISCUSSED
	included communicating across organizations, communicating the target population, engaging health plans, and streamlining partnerships for care coordination.	understand the problem and how a housing provider can help address the issue. These relationships take time to build, but the time investment is essential to the ensuring understanding of the bigger picture.[7]
Client Engagement & Fostering Community	Outreach and engagement, both when in the interim stage of transitioning to permanent housing as well as keeping clients engaged once they are housed and connected to a care team.	One community found that the needs of individuals shift once they are in housing. Some consumers appear to have higher needs and may request services they had not previously required because they did not have access and they are experiencing loneliness after move-in. The underlying cause of these requests was a desire to have someone to spend time with while they were receiving these services. Recognizing this helped providers tailor their approach and in time, these individuals become more comfortable.
		In another community, the same team works with individuals from the time they are identified through housing and into the future. This helps build a solid relationship between the case worker and the consumer, opens the lines of communication. The pair works on monthly goals and makes time to sit and empathize with the consumer, which can help to identify the underlying need and a strategy to meet it.
	Fostering a sense of community among consumer both within a single-site housing model and scattered-site.	To combat feelings of loneliness, providers work to establish a sense of community for consumers. One community hosts a monthly lunch to bring consumers together, which helps connect those in scattered site housing. Another community has a single site model and is working to develop an activity calendar for their onsite community room, which will include everything from meals to bingo to monthly community meetings.
Sustainability & Evaluation	Communities expressed interest in examining reductions in avoidable hospitalizations	One community found an 85% reduction in inpatient costs and 67% reduction in ER costs, as well as a net cost avoidance of $34,306-$39-556 in healthcare costs, which takes into account the cost of the supportive housing program.
	Two communities were interested in the evaluation aspect of the program, how data is shared and who it is shared with, navigating challenges of self-reported data, and what performance and outcome metrics are being tracked and monitored.	A second community is tracking measures prescribed by their grant funding, including housing retention, with a goal of 85%, increased health outcomes for chronic conditions and other UDS clinical quality measures from move in date, reduced incarceration, and reduced emergency department utilization. They have partnerships with the two major hospital systems and are working on their frequent user list, which gives the provider access to the cost data on the hospitals' top 10% and top 50% of users. This community also decided to track medical outcomes from move-in up through the first year. Since they see a lot of individuals with chronic conditions, they are tracking hemoglobin A1c for consumers with diabetes and in individuals who are hypertensive they are tracking blood pressure. They are also tracking PHQ9 scores in collaboration with their behavioral health team.

[7] CSH has developed a **CSH Health and Housing Partnership Guide** to help communities understand both the value and strategies for developing strong health and housing partnerships.

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		One outcome from the first 70 individuals placed in housing is that 85.7% of 70 housed clients maintained or reduced hospitalizations.
		A third community has access to their local hospital claims data and statewide Medicaid data, which allows them the ability to evaluate health care costs, which has shown a reduction in hospital utilization and costs for high utilizers. They are looking into ways to gain access to statewide homeless service data through the HUD-supported Homeless Management Information System (HMIS) to track homelessness as well as jail data to see if there is a decrease across various systems.

DISCUSSION

As demonstrated from the virtual roundtable discussion, community-wide support and top-down buy-in from stakeholders across multiple disciplines are necessary to ensure health and supportive housing initiatives succeed. While approaches to these partnerships and Housing First model vary by size and scope, research has demonstrated that there are several program elements that serve as contributing factors to program success.[8] What follows are some community-wide recommendations that aid in supporting high fidelity health and supportive housing interventions:

- **Consistent and Clear Communication between the Health Center and Housing Provider.** For pilots with multiple service providers, roles and responsibilities for each of the partners must be clearly defined in writing and revisited regularly to support the overall success of the pilots to ensure continuity of care that is driven by a whole-person and tenant-centered care plan. There should be written descriptions of each partner's role, i.e. the project sponsor, housing and/or property manager, health care, and supportive services provider that are revisited at least annually. Weekly or bi-weekly case conferencing to update partners on hard to engage clients is essential, as is cross-training among agencies so each agency's program components and philosophies are well understood. Lastly, top-down agency buy-in on the partnership model must be continually reinforced, as well as opportunities for case management and engagement strategy trainings (harm reduction, motivational interviewing etc.).
- **Comprehensive Services that are Client-Driven.** Any successful Housing First program requires a client-driven and community-based service delivery approach based on harm reduction and includes comprehensive, flexible and voluntary housing and tenancy-based supports. Early planning with health centers and other health systems to identify the range of health services needed will both pinpoint where there are gaps, but also enable partners to build their capacity. Clients in a Housing First program must be provided choice in services and where they are delivered.
- **Prioritizing Most Vulnerable for Housing**. In order to effectively target limited resources for those in most need, communities across the country are implementing coordinated assessment and referral systems. Assessments to measure vulnerability, housing need, and preference should be done early and incorporated throughout the program to ensure care plans reflect the changing needs of clients. There are a variety of vulnerability assessment tools utilized by communities that differ based on a community's preferences and needs. Since some common vulnerability assessments may not emphasize health needs, communities could also consider health needs as a measure of vulnerability and create strategies to include this in the prioritization process. Communities seeking to implement Housing First should develop a streamlined system to match individuals experiencing homelessness to the most appropriate housing and services, and where individuals experiencing chronic homelessness and other high needs are prioritized for supportive housing interventions[9]. When creating these assessment and referral programs, ensure that key systems like hospitals, health centers, and corrections/parole have input and buy-in on the process.
- **Stream-lining the Process.** Agencies that administer housing voucher programs, such as public housing authorities, should make every effort to reduce barriers to housing for this targeted group. This means removing local exclusions for those with criminal justice backgrounds and active substance users[10] and accelerating processes like voucher approval and unit inspections for this targeted group. This commitment to

[8] U.S. Department of Housing and Urban Development. The Applicability of Housing First Models to Homeless Persons with Serious Mental Illness. 2008 Retrieved from: https://www.huduser.gov/portal/publications/hsgfirst.pdf

[9] United States Interagency Council on Homelessness. The Housing First Checklist: A Practical Tool for Assessing Housing First in Practice. July 2013 Retrieved from: https://www.usich.gov/resources/uploads/asset_library/Housing_First_Checklist_FINAL.pdf

[10] Federal law expressly prohibits Public Housing Authorities (PHAs) from providing housing assistance to those required to register as "sex offenders," and those convicted of manufacturing methamphetamine on public housing premises, however local PHAs have discretion to add exclusions.

offering permanent housing first to "hard-to-serve" individuals as quickly as possible, rather than requiring a period of stabilization, sobriety, or participation in treatment programs to demonstrate "housing readiness" is the core distinguishing feature of a Housing First program[11]. Health centers are able to continue to play an integral role on the care team after formerly homeless individuals are placed in PSH, as formerly homeless residents of PSH are eligible to receive Health Center services funded under Section 330(h) for an indefinite period.

- **Sufficient Supply of Accessible Affordable Housing**. A core component of Housing First is the ability to provide choice of unit type and where in the community individuals want to live. This means housing providers must make every effort to accommodate clients' wishes in where and with whom they want to live (e.g. spouse/significant other, reunification with children, pets, etc.). A sufficient supply of housing is key. Insufficient supply of physically-accessible housing causes delays in discharging individuals from inpatient settings and gaps in care provision. Lack of available housing may also lead to an over-reliance on buildings with friendlier landlords which may negatively impact efforts to encourage community integration; creating a stereotyping of buildings for those with special needs. For Housing First programs targeting high cost, medically-frail individuals, communities should work with local housing agencies and providers to prioritize units that are ADA-accessible for those with limited mobility.
- **Systems Coordination to Support Interim Housing Solutions.** Given the limited supply of available, adequate housing, one growing component in a Housing First initiative is the demand for safe, flexible interim housing options. Communities considering embarking on a Housing First program can plan and budget for interim housing and care in those settings to further the effectiveness of consumer recovery goals, ongoing service engagement and housing stability.
- **Adequate Financing for Supportive Housing Three-Legged Stool: Operating, Capital and Services**. While the Housing First approach is cost-effective when looking at the many costly public systems homeless individuals touch, this approach requires meaningful systems integration and the upfront capital to provide the services and housing. Diverse and robust funding streams are essential to maintaining a frequent user Housing First initiative. One of the potential benefits of building the partnerships among the health and housing sectors is the ability to access, coordinate, and target diverse streams of revenue. Adequate funding for comprehensive and flexible services, rent subsidies and funding for capital for new or to rehabilitated existing units are essential for any community planning to implement a Housing First program.

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[11] U.S. Department of Housing and Urban Development. The Applicability of Housing First Models to Homeless Persons with Serious Mental Illness. 2008 Retrieved from: https://www.huduser.gov/portal/publications/hsgfirst.pdf

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