Wisconsin Public Psychiatry Network Teleconference (WPPNT)

- This teleconference is brought to you by the Wisconsin Department of Health Services (DHS), Division of Care and Treatment Services, Bureau of Prevention Treatment and Recovery and the University of Wisconsin-Madison, Department of Psychiatry.

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WPPNT Reminders

How to join the Zoom webinar

- **Online:** https://dhswi.zoomgov.com/j/1606358142
- **Phone:** 669-254-5252
- Enter the Webinar ID: 160 635 8142#.
  - Press # again to join. (There is no participant ID)

Reminders for participants

- Join online or by phone by 11 a.m. Central and wait for the host to start the webinar. Your camera and audio/microphone are disabled.
- Download or view the presentation materials. The evaluation survey opens at 11:59 a.m. the day of the presentation.
- Ask questions to the presenter(s) in the Zoom Q&A window. Each presenter will decide when to address questions. People who join by phone cannot ask questions.
- Use Zoom chat to communicate with the WPPNT coordinator or to share information related to the presentation.

- Participate live or view the recording to earn continuing education hours (CEHs). Complete the evaluation survey within two weeks of the live presentation and confirmation of your CEH will be returned by email.
- A link to the video recording of the presentation is posted within four business days of the presentation.
- Presentation materials, evaluations, and video recordings are on the WPPNT webpage: https://www.dhs.wisconsin.gov/wppnt/2022.htm.

Housing Insecurity: What to do When Individuals Experience Homelessness

IMPACT

Changing Lives. For Good.

Outreach

COMMUNITY HEALTH CENTERS

What is a CoC?

- Continuum of Care are the consortium of homeless service providers in a give county or region
- CoCs are mandated to work together by HUD and to work toward collective outcomes in reducing homelessness, reducing the length of homelessness, and increasing positive outcomes in housing
- The Milwaukee CoC chose IMPACT as its provider of Coordinated Entry

- List of CoCs in Wisconsin:

https://www.hud.gov/states/wisconsin/working/cpd/coccontacts

How is Homelessness Defined?

- Category 1 – "Literally Homeless"
  - (1) Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:
    - (i) Has a primary nighttime residence that is a public or private **place not meant for human habitation**;
    - (ii) Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate **shelters**, transitional housing, and hotels and **motels paid for by charitable organizations or by federal, state and local government programs**); or
    - (iii) Is exiting an institution where (s)he has resided for *90 days or less* and who resided in an **emergency shelter** or place not meant for human habitation immediately before entering that institution

      *This includes documented jail, hospital, and treatment stays (e.g., Crisis Resource Center, inpatient AODA treatment) of <90 days and the individual is homeless before and after their institution stay.

Source: www.hudexchange.info

AODA treatment options
Shelter vs. AODA inpatient treatment programs

An example in Milwaukee:

- AODA treatment programs that include temporary housing (but are not Medicaid or insurance driven): Guest House AODA program, Milwaukee Rescue Mission (MRM) New Journey Program (up to 12 months), Salvation Army's Adult Rehabilitation Centers (up to 12 months).
  - These programs are still considered treatment under the HUD category 1 homeless definition.

- We also work to promote connections to outpatient services, insurance driven inpatient services (through major hospital systems), detox programs, and peer support, such as Alcoholics Anonymous, Narcotics Anonymous, and Smart Recovery programs.
- Please reference your local CoC for guidance on reporting on homelessness for individuals and families you serve.

How is Homelessness Defined Continued?

- Category 2 – “Imminent Risk of Homelessness”
  - (2) Individual or family who will imminently lose their primary nighttime residence, provided that:
    - (i) Residence will be lost within 14 days of the date of application for homeless assistance;
    - (ii) No subsequent residence has been identified; and
    - (iii) The individual or family lacks the resources or support networks needed to obtain other permanent housing

Source: www.hudexchange.info

How is Homelessness Defined Continued?

- Category 3 – "Homeless Under Other Federal Statutes"
  - (3) **Unaccompanied youth under 25 years of age**, or families with Category 3 children and youth, who do not otherwise qualify as homeless under this definition, but who:
    - (i) Are defined as homeless under the other listed federal statutes;
    - (ii) Have not had a lease, ownership interest, or occupancy agreement in permanent housing during the 60 days prior to the homeless assistance application;
    - (iii) Have experienced persistent instability as measured by two moves or more during in the preceding 60 days; and
    - (iv) Can be expected to continue in such status for an extended period of time due to special needs or barriers
  - In Milwaukee, Pathfinders and Walkers Point serve transition-aged youth. Look to your own CoC to see what agencies or funding opportunities are available for youth in your area.

Source: www.hudexchange.info

How is Homelessness Defined Continued?

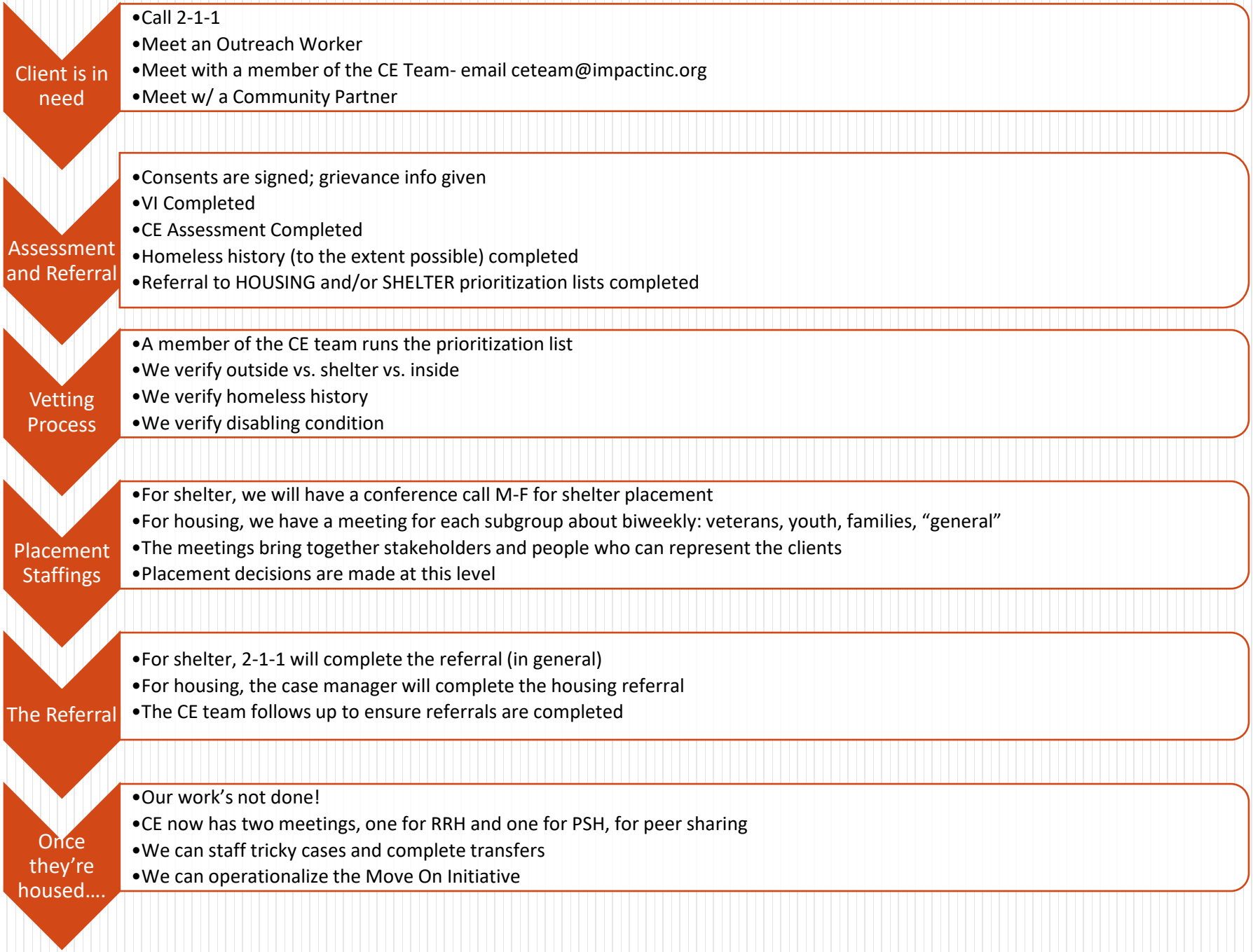
- Category 4 – “Fleeing/Attempting to Flee DV”
  - (4) Any individual or family who:
    - (i) Is fleeing, or is attempting to flee, domestic violence;
    - (ii) Has no other residence; and
    - (iii) Lacks the resources or support networks to obtain other permanent housing

- Milwaukee CoC - IMPACT 211 protocol
  - Due to funding constraints, all DV shelter options must be contacted for shelter placement first before using Coordinated Entry.
    - This includes: Sojourner, Milwaukee Women’s Center, Waukesha Women’s Center, and Advocates of Ozaukee.

Source: www.hudexchange.info

What is Coordinated Entry?

- HUD mandate for identifying, assessing, and prioritizing referrals to services for those who are homeless
  - The need is far greater than the resources
  - Sometimes what is thought to be needed is not the best resource
- Functions as the day-to-day logistics of the Milwaukee Continuum of Care
- Informs systems change
- Look to your local CoC for questions and support:
  - Balance of State CoC: https://www.wiboscoc.org/ce2022.html
  - Dane County CoC: https://www.danecountyhomeless.org/coordinated-entry
  - Milwaukee CoC: http://milwaukeecoc.org/coordinated-entry/
  - Racine County CoC: https://racinecoc.org/


Client is in need
•Call 2-1-1
•Meet an Outreach Worker
•Meet with a member of the CE Team- email ceteam@impactinc.org
•Meet w/ a Community Partner
Assessment and Referral
•Consents are signed; grievance info given
•VI Completed
•CE Assessment Completed
•Homeless history (to the extent possible) completed
•Referral to HOUSING and/or SHELTER prioritization lists completed
Vetting Process
•A member of the CE team runs the prioritization list
•We verify outside vs. shelter vs. inside
•We verify homeless history
•We verify disabling condition
Placement Staffings
•For shelter, we will have a conference call M-F for shelter placement
•For housing, we have a meeting for each subgroup about biweekly: veterans, youth, families, “general”
•The meetings bring together stakeholders and people who can represent the clients
•Placement decisions are made at this level
The Referral
•For shelter, 2-1-1 will complete the referral (in general)
•For housing, the case manager will complete the housing referral
•The CE team follows up to ensure referrals are completed
Once they’re housed….
•Our work’s not done!
•CE now has two meetings, one for RRH and one for PSH, for peer sharing
•We can staff tricky cases and complete transfers
•We can operationalize the Move On Initiative

Housing Best Practices

- Housing First
  - https://www.youtube.com/watch?v=pwdq2VWavtc (3:47) -- "Housing First: Principle Into Practice - Animated Overview"
- Rapid re-housing (RRH)
- Permanent supportive housing (PSH) as seen in Milwaukee County:
  - Verifying chronic homeless status (at least 12 months homelessness in one episode or 4 or more episodes)
  - Disability status determination by a qualified medical or mental health professional (licensed medical physicians, psychiatrist, psychologist, APNP, PA, LCSW, or LPC). *See presentation attachment.
- Motivational Interviewing
- Harm Reduction

What is Rapid Rehousing?

- Rapid re-housing provides short-term rental assistance and services.
- Goals are to help individuals:
  - Obtain housing quickly (within 30 days)
  - Increase self- sufficiency and stay housed.
    - Income
    - Benefits
    - Communication
    - Mental health services
    - Primary care
- The resources and services provided are tailored to the needs of the individuals.
  - Location of housing
  - Long-term affordability
  - In home resources
  - Child services
- It is offered without preconditions (Housing First).

Source: https://www.hudexchange.info/resource/3891/rapid-re-housing-brief/

Coordinated Entry and the Bigger Picture

- Family Initiative
- Chronic Initiative
- Youth services
- Veterans Initiative
- Healthcare partnerships

Homeless Prevention

- Origins and context
- Targeted population: category 2 homelessness
- Service looks like
  - Assistance with the housing search
  - Advocacy with landlords
  - Guidance and plan making

Projects for Assistance in Transition from Homelessness (PATH)—a statewide SAMHSA grant program

- Case managers and outreach workers help individuals, couples, and families experiencing homelessness achieve self-identified goals that will lead to stable housing.
- PATH team members connect persons experiencing homelessness with long-term community supports, including:
  - Public benefits (FoodShare, health insurance—Medicaid and market place insurance, SSI/SSDI application assistance)
  - Emergency shelter, transitional housing, and permanent supportive housing in collaboration with partners through the Continuum of Care (CoC)
  - Obtaining free food and clothing
  - Mental health treatment & role of PATH clinician in screening for program qualification (or referring to local mental health providers)

PATH Program Goals & Criteria

- The **program goal** is to help people experiencing homelessness eliminate barriers that keep them from successful long term housing by making connections to income, housing, and supportive services.
- Program participants must be currently homeless adults (category 1 - living on the street or staying at an emergency shelter) or be at imminent risk of becoming homeless (category 2 - losing housing within 14 days or less of the referral) and be living in Milwaukee County. Qualifying participants must also live with severe and persistent mental illness or co-occurring disorders.
- PATH team members are available on a one-time basis or over an extended period of time and can even provide short-term case management for qualifying individuals.
- At Outreach Community Health Centers, our PATH team works closely with Coordinated Entry to provide services to Milwaukee County residents.
- Statewide PATH contact is Chelsey Foster Myhre, chelsey.myhrefoster@dhs.wisconsin.gov

How You Can Help

- Advocate for homeless housing funding within your agency, including staff specific for finding housing and funding designated for rent and security deposits.
- Join your local CoC email listserv
  - Balance of State CoC: https://www.wiboscoc.org/ce2022.html
  - Dane County CoC: https://www.danecountyhomeless.org/coordinated-entry
  - Milwaukee CoC: http://milwaukeecoc.org/coordinated-entry/
  - Racine County CoC: https://racinecoc.org/
- If interested in Milwaukee IMPACT 2-1-1 referral partnership, please email Erika at eolson@impactinc.org

Q&A

Presenters contact info:

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- Erika Olson, eolson@impactinc.org

Milwaukee City & County
Continuum of Care
Coordinated Entry

MEDICAL STATEMENT
CERTIFICATION OF DISABILITY

(To be completed by a licensed medical physician, psychiatrist, psychologist, a.p.n.p., p.a., lcsw or lpc)

Applicant's Name _____ Social Security No. _____

Address _____

Authorization to Release Medical Information: _____
Signature of Applicant/Participant Date

The above named person is applying for participation, or is a current participant, in the Milwaukee City/County Continuum of Care. The person is seeking a permanent housing program for individuals who have a disability, primarily severe mental illness, chronic substance abuse and/or HIV/AIDS or related diseases. To determine the applicant's/participant's eligibility, this Program must verify the disability as defined by the U.S. Department of Housing and Urban Development (HUD). HUD regulations define disability as follows:

1. Inability to engage in any substantial, gainful activity by reason of any medically determinable physical or mental impairment:
- (a) which has lasted or can be expected to last for a continuous period not less than 12 months or more; or
- (b) which can be expected to result in death; or
- (c) in the case of an individual who attained the age of 55, and is blind and unable by reason of such blindness to engage in substantial, gainful activity requiring skills or ability comparable to those of any gainful activity in which he/she has previously engaged with some regularity and over a substantial period of time; or

2. The individual has a developmental disability, which is a severe chronic disability that:
- (a) is attributable to a mental or physical impairment or combination of mental and physical impairments;
- (b) is manifested before the person attains age 22;
- (c) is likely to continue indefinitely;
- (d) results in substantial functional limitation in three (3) or more of the following areas of major life activity:
  - (1) self-care,
  - (2) receptive and responsive language,
  - (3) learning,
  - (4) mobility,
  - (5) self-direction,
  - (6) capacity for independent living,
  - (7) economic self-sufficiency; and
- (e) reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated;

3. A person who has a physical, mental, or emotional impairment which:
- (a) is expected to be of long-continued and indefinite duration;
- (b) substantially impedes his/her ability to live independently; and
- (c) is of such a nature that such ability could be improved by more suitable housing conditions.

CERTIFICATION OF DISABILITY

Based on the definition listed above, the applicant/participant:
- ☐ does not meet
- ☐ meets the disability criteria under (____1 or ____ 2) and ____ 3 above

List the Disability: _____

Licensed Medical Physician, Psychiatrist, Psychologist, A.P.N.P., P.A., LCSW or LPC:

_____ _____
Signature Date

_____ _____
Print Name Business Telephone Number

_____
Address

Applicant's Name: _____

MEDICAL STATEMENT
DISABILITY DOCUMENTATION

(To be completed by a licensed medical physician, psychiatrist, psychologist, a.p.n.p., p.a., lcsw or lpc)

To determine the applicant's/participant's eligibility and/or level of subsidy, documentation of disability is required.

For applicants who receive SSI and/or SSDI, a Benefit Verification Letter from the Social Security Administration will meet this requirement. A request for a Benefit Verification Letter can be submitted at the following site: www.socialsecurity.gov/beve

For applicants who do not received SSI and/or SSDI, HUD regulations require a written statement documenting the disability. The written statement must be signed by a licensed medical physician and include the following:

1. Identification of the physical, mental or emotional impairment

2. Explain why the disability is expected to be of long-continued or indefinite duration

3. Describe how it impedes the individual's ability to live independently and

4. Explain how the individual's ability to live independently could be improved by living in more suitable housing conditions.