Building partnerships and collaboration between housing providers and behavioral health practitioners

Hello, everyone. Welcome to the Recovery to Practice webinar. Our final webinar in this series of three that is exploring issues related to housing, homelessness, and at-risk housing for individuals who experience serious mental illness and other behavioral health conditions.

My name is Melody Riefer, and I work with Advocates for Human Potential. I am going to be your moderator today.

I want to give you a quick orientation to the webinar platform that you are looking at.

You should see a disclaimer slide on your screen right now. The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services, the Substance Abuse and Mental Health Services Administration, or the U.S. Department of Health and Human Services.

So you can find your way around the room. If you look to the bottom of your screen just below the slides, there is a pod that says Tech and Topic Questions. This is where we would like for you to type in any questions that you have about sound or image or any type of technical questions, but also where you are invited to pose your questions for the presenters. So any question that relates specifically to today's content should be typed into the Tech and Topic Questions pod.

There is a Chat pod to the left of the slides, right under the photographs of our presenters today. This is where you can chat with each other and with some of the staff from Advocates for Human Potential. We would love to hear where you are calling from, what type of work you do. You might want to do some networking. Or if you have any commentary to offer to the content. Also, please remember that you can get Continuing Education hours or a Certificate of Attendance if you click on the link at the end of the webinar. So in order to get this information, you are going to want to hang around for the whole webinar, and then click the link to give us a little bit of information about how you experienced the webinar, and if you want the Continuing Education hours, to complete a quiz.

I want to also point out to you that if you need captioning information, we do offer live captioning. And just above the participant Chat is a small box that says Captioning Information, and there is a web link there. If you grab that information and click on it or put it into your browser, a new window will open where you will be able to follow live captioning for this webinar.

I wanted to also mention, since we are wrapping up a series about housing, a partnership that we have with the SAMHSA SOAR Technical Assistance Center. SOAR addresses, specifically, resources available for people who receive Social Security income or Social Security disability income. You can access information about the technical assistance that is available by following the links that you see on this page. You can access these links after the webinar if you download the presentation. All of the information will be there for you. So don't worry about writing it down real quickly right now, just know that if you download the entire presentation, every link that you see during today's presentation will be available for you.

We have a couple of great experts who are going to wrap up our series on the impact of homelessness and housing instability on provider services today. Greg Shinn and Mike Brose are with the Mental Health Association Oklahoma, and both of these gentlemen are experts in the field of housing. And we are really lucky to have them be able to present to us on building partnerships and collaboration between housing providers and behavioral health practitioners. We know that not everybody on this call is a housing expert, nor do we think that this one webinar is going to make you an expert. But it will help you learn about where you can grab some expert information. And these two gentlemen are part of that bevy of resources.

So just before we begin our webinar today, I want to ask you a quick question. The screen is going to change and provide you an answer box to respond to, but think about what type of collaboration do you do with your local housing programs. And there are an array of options. Do you work on a case-by-case basis? Or are you the housing program in your area? Or do you not have any idea? Go ahead and

choose the answer that is most indicative of what is true for you. Going to give you all a little more of a chance to respond. What type of collaboration do you do with your local housing program?

Today's topic is going to focus on collaboration, and so we are just trying to get a feel for how you interact.

Okay. Thanks for letting us know. I see that it is almost neck and neck for agencies that work on a case-by-case basis and those who are the housing program. Someone else manages that type of work in some agencies. Others of you are not sure. Hopefully we will be able to help you define some terms and know where to look.

So, right now I want to introduce you to one of the smartest guys in housing and turn this over to Greg Shinn. Greg, thanks for being here. It's all yours.

(Inaudible.) Thank you for the really great introduction, Melody, and it is great to work with you again. We did work with Melody a long time ago in Oklahoma, so – so this is kind of a great reunion. And it's an honor to speak to everybody. I do see a lot of people logging in from all over the country and very diverse crowd that we are speaking with, and I really like that. So, please, don't hesitate to put your questions in there. We will try to get to as many as we can.

And I just want to start off by giving you a little bit of an overview. I don't know how many of you have been to Oklahoma before, but that is what the map in front of you is. It just shows about the density of the population in our state, and we have two really heavy metropolitan areas. That's Tulsa in the northeast and then Oklahoma City in the center of the state, if you look at the map there. And we are probably growing a little bit faster than the average state or the average counties in the country when we do projections for growth into the future.

So, then one of the things I want to show is who is the Mental Health Association Oklahoma? Well, we're an advocacy organization. We model advocacy, and we also model belief in recovery. We're all about recovery, and we try to promote opportunities for recovery in every single thing – every single way that we can including in our workforce.

So every year we do a voluntary staff survey, and you see the results of that survey, which was last done in 2016. And this was a partnership with the University of Oklahoma School of Social Work and the School of Organizational Dynamics, and we had two graduate students, Kate Quinton and Kara Brunk, and two professors, Rick Munoz and Brigitte Steinheider, and they conducted surveys and evaluated results of the report. And it was called Creating a Sense of Belonging at Mental Health Association Oklahoma.

And so we don't just talk about opportunities for recovery, we actively provide those employment opportunities. We walk it. We talk it. And we really say we are who we serve. And the serving reflects a sample size of over a hundred full and part-time staff. And we have done this staff now, I think, about seven years.

So we monitor this, and it has changed a little bit over time as we've grown. But it's very informative to us in how we direct our mission of our organization.

So when we start to talk about housing planning and community development and planning, we have grown over a long time. But we haven't just become bigger, we've become broader. Our reach has become broader as we have expanded, and it takes many partners to provide access across a metropolitan region or state. And it requires coordination and planning to form formal and informal partnerships or agreements for working together. Creating access to affordable housing in many neighborhoods for persons experiencing homelessness with disabilities. And then we want many options and we want to de-concentrate poverty. So there's ways that we do that, and that is why having different types of housing models, and primarily focusing on a scattered site model, which I will talk about a little bit. But you can't just have one county doing this, or one city, or one neighborhood, or just one organization. So in Oklahoma, obviously, it's not just the Mental Health Association that is working on

housing, planning, and community development, or access. It takes all types of partnerships. It takes – it takes your city and county government. It takes your faith community, faith-based providers. It takes nonprofit developers. It takes the shelters all participating. So it's a – it takes many, many partnerships to make this happen over time.

So when you take a look at how we have grown, this map represents the scattered-site model and the multiple locations that we have all across the Tulsa metropolitan area. For those of you that haven't been to Oklahoma, the river on the left side of that map is the Arkansas River which literally cuts right through the middle of downtown Tulsa, and the city is built on the river, and Tulsa County goes out in all directions around the river. And so this shows how we have – we're in more than 20 neighborhoods across the Tulsa metro. And each one of those locations we very intentionally planned to create access in that neighborhood because we want to provide affordable housing and supportive housing for people that have been homeless with disabilities in that neighborhood because that neighborhood has access to goods, and services, and jobs, and public transportation, and things like that. So this map represents 25 years of intentional community planning.

We do not show our Oklahoma City metro on this map. I'll build that one out sometime in the future, but right now this shows Tulsa, but we are in many locations in Oklahoma City as well. And we have just over 1,500 total units of multifamily housing.

And we are really built on a Housing First model. And for those of you that don't know about Housing First, I assume a lot of you do, but this was really a model that was pioneered by a colleague of mine, Dr. Sam Tsemberis. Working in New York City. I was running a homeless shelter for people with mental illnesses and he was running the mobile crisis team, the crisis psychiatric team. And he determined that people really just need the housing first, and the problem was – was that the model that was preexisting was built on everybody being ready to go into housing. And the housing providers that had all these preconditions so that it was really impossible for people to meet those preconditions, like having an income, being sober, being in – being in medical treatment and mental health treatment, and all these things that were just obstacles to housing.

So – so really the Housing First model says that housing is the first step to recovery. And so you want to provide the services, too. So it's not housing only, it's housing plus services, but housing is really the first step.

And so permanent supportive housing, which is also promoted by SAMHSA, is safe, decent, and affordable housing. We focus on the Housing First model of getting people into housing first. But then people have rights of tenancy under the state and local laws. And you have rights to privacy. You sign a lease. You have your own apartment. The property management can't just come in whenever they want to. How you operate it is very, very important.

And so fidelity to the Housing First and permanent supportive housing models have these different dimensions that you see on the screen there. And that includes choice of housing, which is what we try to offer with all those locations in all those different neighborhoods. And separation of housing and services, which I'm not going to get a lot into that, but you want to have property management separated from the service providers. The case management function is completely separate from who does the lease and all that. So. And then you have rights of tenancy and so forth. And you can download the permanent supportive housing toolkit, for free, from the SAMHSA store. If you have any questions about that, you might just type that into the Chat box, and the staff can help you get the link to how to download the permanent supportive housing toolkit. But it's everything in there from A to Z about how to do permanent supportive housing.

So, really, when we talk about partnerships in housing, they really are the foundation to building out the network. And you've got to have everybody at the table. So it takes a lot of planning work and intentional partnerships. So you need to have your continuum of care programs at the table. I'm sure a number of you participate in your local continuums of care. Those continuums of care, sometimes called the COCs, are structured a little bit differently in every community across the country. But every community does

have a COC. And if you don't know about your continuum of care, you can find out about your continuum of care, and you can look up your community on the HUD website. And you can find out who convenes your continuum of care.

Every community also has fair housing partnerships, apartment associations that govern or promote access to multifamily apartments and how to get into housing.

And then also you have tribal and public housing authorities, and state housing finance agencies, and also your Veterans Administration.

So fair housing is important because you want to know that you are not – that you have fair housing access and you are not discriminating against people with disabilities. And your staff need to be trained in how to create access and how you are not excluding anybody that might be disabled. And so, you want to get them trained on all those resources and find out, also, what your state housing finance agency and your VA does. Does your VA have, for instance, a grant and per diem program that gives access to disabled veterans that does Housing First.

So these are the kinds of things that you want to find out about in your community when you are planning your partnerships.

So, forming these partnerships creates access to affordable housing. And it's not just on the funding for development of affordable housing side, you also want to make sure you have got all your service providers at the table. So you want to look at who are your federally-qualified healthcare centers in your community. Those are called FQHCs. And you want to look at your community mental health centers, your substance abuse treatment providers, your state and private psychiatric hospitals, again the VA, and also your state department of mental health and substance abuse services. And your state department of mental health, that's what we call it here in Oklahoma. Sometimes the state department has a different name. But that's one of the partners that you want to have at the table, and they can fund you, and all of these partners can also be the referrals. They are not just your service provider partners, but they also are the referral network that you accept referrals from, and then they are the service providers that you want to be outreaching and telling them about access to your affordable housing.

So these, again, they are very intentional partnerships. One of the things that we do with our FQHC here in Tulsa, which is called Morton Health Services, is they have this free transportation network that has been funded by philanthropy here in Tulsa. And this transportation system is really amazing. It goes between the shelters. It goes between the permanent supportive housing locations. It goes between the health clinics. To the Social Security Administration. To the grocery store. And it does these big loops two or three times a day, and people can ride it for free. So that's an example of how we intentionally create a partnership that creates access to housing and services but that person doesn't really have anything to do with the housing development model.

So, again, when we are talking about the outreach teams and the referrals from the shelters, that's really important. And so, when we look at coordinated entry, which is now a focus from the Housing and Urban Development, it's really important that you have that – that priority list established and that you have formal ways to take referrals in and that people are prioritized. There's ways that – now vulnerability indexes are really big. There's different ones. The VI-SPDAT is a very common one that is out there right now that was developed by Ian Dejong out of Toronto. And so, these vulnerability indexes, they kind of rank and score people on their vulnerability, and it helps prioritize the referrals for the people that need the affordable housing.

And so you want to be able to house people as quickly as possible, and that is actually a requirement not by HUD. So any HUD-funded program must be participating in coordinated entry.

And you want to manage your relationships with multiple landlords and property management companies to streamline access. There's many types of case management models, and two that we use here in Oklahoma are the Pathways Case Management Program and also a program of assertive community

treatment. Assertive community treatment is a very common model, and I am sure that some of you are involved in ACT teams that are on the call now.

So these models are really intensive case management models. They emphasize small caseloads. And so that is important so that you have the right – the right intensity of service delivery for the needs of the people that you are trying to meet.

You also want to create access to medical services like HIV and HEP-C testing and other kinds of medical primary care, and Mike is going to focus on some of that later on and how we have done that.

Employment training in models like IPS, Individualized Placement and Support. And then providing economic opportunity for residents so that they can become self-sufficient. And that's where some of that SOAR training that Melody was talking about later on, so access to SSI, SSDI, and helping people get enrolled in benefits.

So – so I'm going to focus now on a couple of programs that we have run over the last eight years very quickly.

The first one is the Tulsa Housing and Recovery Program that was funded by SAMHSA. This was a five-year grant, and we had multiple partnerships and evidence-based practices including motivational interviewing, seeking safety, double trouble in recovery, and, of course, Housing First.

Over five years we achieved a 94% housing retention rate providing access to both single site and scattered site permanent supportive housing using intensive case management and harm reduction.

So over 12 months – over the five years – we had 151 total participants. And substance use was reduced by 72%. And that almost 70% of those people achieved sobriety for at least three months at a time. And we had 81% of those people maintained their gains over a long period of time.

We focused on connections to healthcare and peer support. And we had a nurse that did triage in primary healthcare health linkage.

And these are some of the services that we provided. Again, Morton, the FQHC, the VA, Social Security, and so forth.

So some of the outcomes were that we had 70, 72% reduce of substance abuse. Eighty percent reductions in trauma, but that also meant that some people did not have reductions in trauma, and some people did not stop using drugs or alcohol. They were still actively using substances, and they still had issues related to their mental illness. Yet 94% retained their housing, which is a really amazing outcome because that shows that a significant number of people can be in the Housing First program and not lose their housing or become homeless again even if they are not accepting treatment or participating in treatment.

So harm reduction is a really important model. It takes a lot of positive reinforcement and linked-in goals that are self-identified by the participant. And sometimes you need to be a benevolent landlord and help people change locations if that's what they are asking for or that is what's in their best interests.

The second one that I want to focus on, this is our statewide CABHI grant that was headed up by the Oklahoma Department of Mental Health and Substance Abuse Services. And the Project Director of this program was Suzanne Williams. I really want to give a shout out to her for this data. And this statewide CABHI grant, which is called the Cooperative Agreement to Benefit Homeless Individuals, was also funded by SAMHSA. And it was focusing on chronically-homeless individuals and homeless veterans.

And so we had two tiers to the funding. In the first tier we did Housing First, Pathways case management, Seeking Safety, and motivational interviewing again. And then in the second round of funding, which is called tier two, we did individualized placement and support, we got technical assistance from Dartmouth

University. We got Housing First technical assistance from Sam Tsemberis. We implemented SOAR. And we had really great outcomes.

And we served 93 people in Oklahoma City. The Homeless Alliance, Hope Community Services, Red Rock Behavioral Health, North Care, Catalyst was the substance abuse provider. And we got detox services from the Referral Center.

In Tulsa, we had the Community Service Council as the hub. Indian Nation Council of Governments was the contracting agency. We had mental health providers, family and children's and counseling recovery services, and substance abuse was through 12 &12. And you can see the sample sizes there.

Really good sample sizes. We had a broad array of demographics, but it was heavily male. Twenty-five percent Native American. And 82% were veterans. That was interesting. So we had, again, a 94% housing retention rate, which is totally amazing. And that really exceeds what you see among people with mental illnesses nationally, and that is a comparison provided by NAMI.

So – so one of the things that is really remarkable here was the 42% employment rate. And so one of the things that we learned by implementing all of these evidence-based practices is that Housing First works. And by giving participants the choice in the service delivery model and maintaining fidelity over time, we have shown over the last eight years with both these large programs a 94% housing retention rate. So I think there is no – there is no doubt that we can listen to our participants. We can learn from them. We can give them choice. We can try new approaches. And we don't want to limit the potential of people. So we want to work with them and not for them.

So I'm now going to hand this off to Mike Brose, and he is going to talk about another – another flexible model that we implemented here. So I'm going to go ahead, and unless Melody has something today, I'm just going to welcome Mike Brose, the Chief Empowerment Officer for the Mental Health Association.

Great. This is Mike Brose, and thank you, Greg, for that. This is a very important aspect to add on to the use of Housing First and all of our housing that we have done here at Mental Health Association Oklahoma.

So you can see there, on the screen, is, as Greg has mentioned, we have 28 sites in 25 different neighborhoods scattered across the community. And those pictures there that you see there on the slide kind of give you a little bit of an idea of the differences, the different types of housing that we have and operate and own here at Mental Health Association Oklahoma. You see there in the middle is a 76-unit apartment building. It was really our only new construction.

The one in the upper left, the Cedars Apartments, was one that was in total disrepair attached to a neighborhood that absolutely was abhorred by that particular property, and here four years ago it won the Tulsa Department Association Renovation of the Year Award, which we were very proud of.

And then you can see the other properties. So you can see we take a lot of pride in our properties. The lower center, Legacy Plaza, that you see there, the building – the high rise – on the left, which we are actually sitting in in temporary offices right now, will eventually be converted to affordable housing – fair market rate affordable housing, using Housing First fair market access in the community down the road. So we are in the early, early development phases of that.

But that kind of gives you an idea. Now, let me tell you a really brief little story as you view those housing. And we – and if you are in the housing business and you are on the webinar, one of the things that we do is we are very, very active taking people out and giving them tours, housing tours. Showing them what we are doing. And that has been one of our lessons learned is that when we have started to give people tours, and, by the way, it was a result of having to deal with some NIMB-Y issues. Many of the people on the webinar who are involved in housing are very familiar with Not In My Backyard issues, which is a big deal in affordable housing.

And so we began to take people out on housing tours. And really, it's very, very interesting. If you don't do that, and you are involved in housing, I would encourage you to really consider beginning to do that because what we have learned, and we have heard this over and over again from people in the community, is that we knew you were doing good things at Mental Health Association Oklahoma. We knew that you were providing housing for people who have been homeless, chronically homeless, ill-housed in different ways and issues. But we had no idea to the extent and the value to the community. And when we would do that, we would hear that line over and over again.

So our housing tours would become even more aggressive. We have had the leadership of the Chamber of Commerce. We have had our City Councilors, our Mayor. I have taken the Governor of Oklahoma on a housing tour. We have people from companies, corporations. People all over, across the community and state who have come out for housing tours. And, again, over and over again, we hear the message, we didn't really understand what you were doing.

So, yeah. So, one of the things is – I'm going to leave you – I'm going to go to the next slide, but I'm going to leave you with this little story that came out of one of our housing tours.

So we pulled up to one of our properties. It's called – it's not actually pictured here. It's called the Altamont Property. And out in front of the housing property was a fire truck with the lights flashing and an ambulance with the lights flashing.

So the people on the tour, I told them, hey, there's – we have these things happen sometimes. I have no idea what is going on. We're going to stick our head in. If they are in the middle of an emergency situation, we'll just move on to the next part of the tour.

Stuck my head in, found the individual who works for us, calm, collected, relaxed, smiling, interacting with one of our other residents. I asked our staff member, what's going on? Well, it turns out one of our residents in one of our apartment buildings, in one of our apartment units in that facility, had woke up, according to my staff member, woke up that morning with a severe backache. What did he do? He called 911. So this is where it was a jumping off point to our awareness that yes, you get people moved into Housing First, but you've got to also begin to find ways to address their integrated healthcare needs. Simple.

So, again, the point there is the lesson residents will teach us. And sometimes they teach us overtly, and sometimes it's more covert. Sometimes it's reading between the lines. But it's really important that we listen to the residents in our housing.

And so one of the things that they have taught us is that yes, I'm in my house. I'm really happy with it. I love it. I feel safe here. but – but the residents are still often without physical, mental, and – I want to add in, too, in terms of integrated healthcare – dental care. So we'll talk more about that as we move along here in the presentation.

So – and a lot of times it's because of lack of benefits, but one of the things we've learned, even if they do have benefits, oftentimes they don't necessarily begin to engage in, you know, accessing healthcare. And, you know, sometimes it's just as simple as lack of transportation. They don't want to go out and stand in the cold and wait for a bus.

Oftentimes we find, they taught us, that they are just afraid of large, institutional settings, buildings. They are intimidated. Sometimes that have a learning disability, illiteracy issues, and they – they have had access to healthcare in the past, and those have ended in failure. Those are intimidating. And so what do they do? Oftentimes our residents turn to 911 or emergency rooms. And I know many of you out there on the webinar have seen this and you are very, very familiar with it. And, again, our residents are teaching us these lessons.

So, again, Maslow was – Maslow was really right in terms of – one of the things we talked about, and, again, for those of you out there and as you educate people in your communities about what the – the incredible work you are doing, is that I'll use Maslow's need hierarchy as an illustration. And it's really

interesting because I found that no matter what people's educational backgrounds are, or what their – their histories are, whatever it may be, if you bring up Maslow's hierarchy of needs, and I have done this many, many times, yes, I know what that means. Well, I like to tell them, if you are homeless, on the street, guess what? You're not even on Maslow's need hierarchy.

So the first rung of that ladder is really Housing First. And then as you move up the hierarchy is – you begin – we begin to engage people. If you are practicing Housing First, you are bringing people in. They – under harm reduction, people who are still using substances sometimes, they are not engaged in good, quality healthcare and mental healthcare needs, dental issues. Those are still unmet so you begin to engage your resident in that. And then the residents will begin to let us know when they are ready. So that is a key question.

And, again, many thanks to Abraham Maslow, he was right.

So, you know, again, as I said earlier, don't expect a recently-housed resident to immediately engage in, and I use this, middle-class healthcare models. Many of you on this call, or this webinar, right now are really we – when I have a sore throat, I have a primary care doctor. I have a toothache, I see – I have regular six-month checkups. I have been blessed by great dental care all my life. I'm really thankful for that. And, you know, those are really healthcare models that many of our residents are either not familiar with, they have no history with those models, they don't really know how to access it. And then when they do, oftentimes they go here for one thing, for physical healthcare. They go over here for dental care. They go over here for different types of – and so it's – it looks very segregated.

What do we do? I jump in my car and I go where I need to go. And for many of our residents who do not have transportation, private automobiles or access to that, these can be very, very, you know, overwhelming. Why does it surprise us that they turn to 911 or emergency departments – and hospital emergency departments? They are adapting to what is presented and what is in front of them. So it should be no surprise to us at all that they do that.

So – so what we did. We told this – the story that I told you earlier, I told that story to one of – the President and one of the trustees of the William K. Warren Foundation here. And so out of that was born the Community Health and Wellness, is what it is called now. It is a collaboration of the William K. Warren Foundation and the Mental Health Association Oklahoma. Targeted towards our residents who have moved into our housing that are continuing to still access – call 911, show up in emergency rooms, to get their primary healthcare needs or their integrated healthcare needs met. And so this has become a huge issue.

Now we have added on a dental component, so the team – what's the team? Our physician assistant, and that's a really important piece because of physical – the physician assistant, the PA, sometimes the term in literature is used mid-level. I've kind of – my PA doesn't necessarily care for that term, but you see that in the literature. Why is that important? Because it's less expensive. And so we have an LPN that works with her. They're a team.

We also integrate with our case managers and case managers across the state – I mean across the community who integrate with that. Matter of fact, they are right now in their weekly community staff meeting as we speak right now. They are downstairs in this very building having and going through their cases and looking at where different patients, different residents if you will, where they are at with their integrated healthcare needs and what progress they are making.

Also we're using peer support specialists with that. In Oklahoma we call that Recovery Support Specialists. Those are people in recovery who, you know, that they have now become our employee. Greg mentioned that earlier, the number of people we employ who have actually lived homeless, lived without integrated healthcare needs being met. They are an integral part of that team.

They psychiatrist consultant. We have a psychiatrist, and we have a primary care physician who also consults. And also, again, remember your PA can prescribe. It's very, very important to remember that

she, in our case, Whitney Phillips, she is our PA, she can actually write scripts under supervision of our psychiatrist consultant and our primary care consultant.

So we take that care to that integrated model to their door. Again, we've talked about that they have a lot of transportation barriers. Many of our people do. Now, our admission criteria to the program is we administer the PHQ-9. A physical health questionnaire. Nine questions. Many of you are – measures depression.

We also measure a1C, blood sugars. And then hypertension scores, blood pressure. And now we have expanded that to include tooth and gum disease assessment.

Again, we are providing, with the model, we're taking it right to their door.

Now, again, our PA, our physician assistant, or the nurse, LPN, that works with her, many times they don't know these individuals. So we integrate with our case managers who have built a – in our housing, who have a relationship with them already. Many times they are introduced. There's an introduction, a very formal introduction is made. And we are basically then beginning the journey on an ongoing primary, psychiatric, healthcare, to-the-door service need for these individuals, and then begin to measure their impact.

Now keep in mind is we have individual – third-party outcome measurements provided by an outside consultant that is a part of the – the funding grant with the William K. Warren Foundation.

So, again, as Greg mentioned, I won't belabor it, development of partnerships. We cannot do it alone. Our integrated healthcare team, our community health and wellness, they can't do it alone. We have to partner with traditional office-clinic healthcare-based systems. We have to develop relationships. One of the real problems we've had is people who need very high-end specialty care. But we have to build – and they – it's interesting – those specialty care providers are very willing to partner with us as we develop those relationships with them.

So, outcome measurements. Again, as I mentioned, we use third-party independent evaluation. We – some of our data – and I want to, you know, one of the things we've learned, our lessons learned here, is some of the data sharing sources have had a – we have had a very difficult time accessing that. And we actually have made some progress on some of those areas since this – these slides were developed. I'm going to actually be able to add to you verbally. They won't be on the slides, but as we move through these, we're going to be able to show you those. And we're also getting information through our 911 providers now, which is beginning to show us some interesting data that is showing up on our impact.

So – so, here is our a1C, some of our outcomes. Again, right now, again the numbers are relatively small but the patterns are clear. We can see there on blood sugar enrollees is that you see the drop in terms of over time. And we have been able to see that. There has been a small spike. Some of that, those are timing issues. But over all we've been amazing to be able to bring that. We have people as high as a1C measurements of 15, 13 – all the way down, being able to bring them down to a very much more manageable level on their blood sugar, which is a huge difference for, you're talking about people at risk for amputations, all kinds of problems, heart disease, heart attack, stroke, through chronic high blood sugar levels, we've been able to bring those down.

Again, hypertension. Again you can see there we have been able to drop that. Our target goal, 140 over 90. We've been able to bring that down in our average enrollment. We're not satisfied with that, but we've been able to – of the 32 patients enrolled, 22 of them demonstrated hypertension. We have been able to, over time, been able to bring those down into more manageable levels.

Again, this is an interesting measurement. I have to write this out. It's known in the industry as the ASCVD, Atherosclerotic Cardiovascular Disease Risk Assessment. And this is a measurement over an estimated ten-year risk of cardiovascular disease, which includes stroke, heart attack, coronary death, based on age, smoking status, blood pressure, blood sugar, cholesterol levels. With our enrollees we've

been able to reduce that now at a level measured at 29%. That's very significant. We're very proud of that, and we're going to continue to work on those particular areas.

So, again, I want to add to it. Again, real quickly, slides that are not on here. With that, we've been able to, on our PHQ-9 baseline, remember I mentioned that, we've been able to reduce that. So, significant in the PHQ-9 score with our population has been reduced 43.75% in terms of their depression measurements over the time. That's not slide on there, but we have that data now.

Oh, excuse me, I'm going to back up there.

And then also we have been able to now finally get some information out of our Health Information Exchange. We have been able to reduce our ER visits pre-enrollment, post- - pre and post – measurement with our enrollees. ER visits have been reduced for the population by 66%. On patient stays, in our enrollees, we have seen a 30% drop over the course of the program. Now, we're just beginning to start in year three. We've been able to reduce inpatient stays 30%.

So, and with our dental care component, we have been able to – now, we're still in the middle of that. It started in year two. Twenty-six patients have been referred. Four patients have completed their treatment. I don't have a picture, but I saw one this morning of a before and after of one of our enrollees smiling with his bright new shiny gorgeous dentures, and he is ecstatic.

Eight patients are currently in the midst of having their dental care treatment go on with their tooth and gum disease. And 14 patients are currently waiting to be able to access that component of integrated healthcare, and so we are very proud of that.

So, that's the conclusion of my presentation, and we are now in the question and discussion comment phase.

Mike, Greg, thank you so much for your information. I kept thinking while both of you were talking about how we – historically we have struggled to show how or why housing matters so much, even though it seems like that would be an easy assumption to make. But the data that you all have classified and presented us with makes it possible to approach funders, and communities, and say, look, this stuff works. You know. And in doing so, we're not only saving dollars, we're saving lives. And so thank you so much for sharing this information.

We do have a number of questions that have come through, and I want to take care of a couple of – of kind of more brief questions first because it might frame some of your answers for the other questions.

Are your housing facilities, the ones that MHA Oklahoma manage, are those Medicaid or medical certified?

They're – they're not certified for any specific category of payment through Medicaid or Medicare or anything like that, or funded that way. But our goal is to have as many people as possible to obtain insurance so that the individual services that they are provided are reimbursable. And then many of our service providers that are partners with us, do the Medicaid billing, do the Medicare billing, or any – also other private insurance also if they can get that. Some of the other services, though, are – are funded through the SAMHSA grants. Obviously, when you looked at the T-HARP grant, that was a five-year grant where the service delivery model was funded by SAMHSA and then also when you saw H3OK, Suzanne Williams was the Project Director there at the Department of Mental Health, and that was funded through – the service delivery model there, including the partnerships, was funded through SAMHSA again. However, in both those cases, the clinical, mental health, and medical providers, also billed Medicaid at the same time.

Great.

This is Mike. I -

And so that's towards your principle of keeping services and housing separate as well, I'm assuming.

Yes.

And, you know, let me – this is Mike. I just want to add, is again, a lot of these people that we have, (a), we're not a Medicaid expansion state here in Oklahoma. So we have people who are not qualified at all for different reasons. But, again, we find over and over again, some of the individuals in our housing, they have Medicaid, they are dual certified Medicaid-Medicare, but they are not accessing that care. It's a very important point to keep in mind.

Sure. Sure. And what about Section 811? Is your funding under that program as well for people with disabilities?

No, we do not have any 811 or 202 HUD-funded projects. However, some of our community partners, including some of the big community mental health centers that we partner with here in Oklahoma, do have housing facilities that are funded by 811 or 202. All of our – all of our housing and the acquisition and rehabilitation projects that we have done here, multiple of them, or new construction, has been through a public-private partnership model using HUD funding, through the HOPE Investment Partnership program, through the city, through the county, through the state, through the new National Housing Trust Fund, through the national – through the state housing finance agency. And then what we do is we leverage millions and millions of dollars. You can imagine for all those units, we're talking approaching near $100 million of combined total public and private partnership investments to build out access to all that affordable housing across the state. Again, over 25 years.

But every time you go after public-sector funding, then you bring private equity into the deal. So – so the foundations, like the Warren Foundation that Mike talked about, we have many other foundations, they see us as an investment. Their return on investment is what Mike was talking about. Lower rates of homelessness. Lower emergency room visits. The decrease in the cost related to ending homelessness is – is really astounding.

Then on the other side of that you have economic development related to the infrastructure, building out, using the capital investments to develop the affordable housing, which creates jobs all across our community.

So – so the partnerships really pay back many times over, which is what drives our legislature, the federal government, to invest in us, state government to invest in us, the housing finance agency, the continuum of care, and so forth.

That – that makes a lot of sense. I'm wondering – we've had a couple of questions that are – are tied back into the information about why participants use emergency rooms or call 911. And I know you marked the decrease in that as one of the areas where you save so much money for the community. So can you speak to why you think people use those services a little more explicitly? And then how you are able to help them access services in a more cost-effective way?

Yeah. You know, again, I think some of it is just, you know, it's been a way of life. It's what you do when you are – have been on the streets for a long time. Or, you know, or it could be also there's times when we find family history. We find out – we have people, you know, Greg talked about the people we've hired, who were formerly homeless, who come to work for us. When they meet with our HR department, a lot of times we get feedback that the people – they have no idea what benefits even are. They have no exposure or history to that. So that's where that educational piece is so critically important.

And, again, to help people – to accompany them so they begin to access. You know, I think, again, through a middle-class lens of this world, we just think, oh, you don't do that, you do this. But I think with the people we serve, we have got to go slower. Slow down. Let them teach us and help us understand better where they are at with accessing that, and then begin to work with them and engage them in that process so they use a more traditional primary care setting, community mental healthcare setting, and not just rely on 911 emergency departments.

I think you are absolutely right, Mike. I have heard this spoken about in terms of being a cultural issue in terms of the culture of poverty, and that you don't know what you don't know.

You don't know. Exactly. Yeah.

And so if access to medical care was always through emergency rooms, you don't necessarily know that that is a more expensive way to access services.

So I appreciate your taking the time for answering that question.

Another question that we had, and you touched on – you both touched on this a little bit – but you mentioned the phrase a public-private partnership and different ways of funding. I'm wondering if you could – and this is a huge question, I know – but where did you – could you talk a little bit more about what that looks like or what that term means, and how you are able to leverage one for the other?

Yes, I think we can speak to that a little bit. But – so when I first came here, we were in the middle of a capital campaign in 2001, and that was a campaign to raise $5.25 million and try to end chronic homelessness. And we exceeded the goal, significantly actually, because when we started raising this private capital, we found out that then we were able to go after contracts, like, for instance, with the VA, that we never had before, because once we had the bricks and mortar, then we were eligible to apply, because we had site control, we were eligible to apply for contracts with service providers like the Department of Mental Health or the VA to provide services into the housing because we had site control over the units and we could guaranty access to the housing. And then the housing met life safety standards. Or housing quality standards for Section 8, and so forth. So then you start to build out a way where the public money leverages the private money, or the private money leverages the public money.

Then we did a second campaign that was for $30 million because we didn't end chronic homelessness the first time. Then we started attracting really big-time investment because once you start building it out and you realize you are not just providing access for people that are chronically homeless, you start preserving the affordable housing market that is at risk of being developed, and then working families can even lose their affordable housing.

So that's what I'm saying. The mission got broader, the reach got broader, as our funding and development model for both public-sector monies and private-sector monies, made more sense to the investors on both sides.

That's – that's – that's very helpful. You know, I think we could probably spend all afternoon for the next rest of the year talking about the – the interdependence of these funding streams, so I appreciate your summing that in a way that made it understandable.

I – I want to again thank you both for your information and sharing this with us. I – I don't want folks to miss out on something you both said a couple of different times. You said, over 25 years this is what we have achieved. And I think that's really important, that you can't grow a housing program that has the infrastructure and success that Mental Health Association Oklahoma has achieved over night. And you have learned lessons over and have really invested in – in – in improving things along the way so that you can reach the point where you go beyond the bed and have a – have someone who has bright, shiny, new dentures and can now have a steak.

So Greg and Mike, thank you so much for sharing your wisdom and just a small glimpse into the story that is the success of Mental Health Oklahoma.

I want to remind folks that these webinars are brought as an effort to focus on recovery in the practices across disciplines. And that the dimensions of recovery stand on this idea of homes being essential as well as health and community and purpose, and your work speaks to that.

I want to also mention that the PowerPoint slides and supporting documentation can be downloaded by clicking on the items that are in the Download Materials box. Click on it, and then it is going to say Upload the File, and it will upload it go your computer, and you will tell it where to go.

Recovery to Practice is an initiative that is funded by SAMHSA, and this is the marriage of multidisciplines looking at instilling recovery principles into the work we do.

We can't possibly answer every question or touch on every dynamic, and so we want to invite you to look at your continued learning on these topics, and so, as a part of the slides, we have resources available. You can click on the links after you download the slides, and it will take you to information about Housing First, addressing homelessness and mental health challenges, and assorted topics.

We have provided information in our quarterly newsletter on housing instability. I hope that you will take the time to look at the newsletter.

And we are already working on our new series that is going to kick off the year 2018. Our series is – is on recovery-oriented cognitive therapy. And this will be a series of four webinars taking place during four weeks in January and February. Note this slide and look for information about when you can register or sign up to receive notices about upcoming events so that we can keep you in the know.

Remember, if you want a Certificate of Attendance or if you need to earn a Continuing Education hour for attending this webinar, click this link and you will be taken to a new page that will allow you to fill out a short questionnaire about the webinar and then complete a quiz in order to get the Continuing Education hour.

We are very, very happy that you were able to join us today. This series on housing and homelessness has been incredible, full of detail. And Mike and Greg, I appreciate the fact that you have helped us wrap this up on a high note.

Thank you all for attending. I hope you have a great day. We will be talking with you in the new year.

Thanks so much. Bye.