Exhibit for Supportive Housing Provider Contract

Supportive Housing Service Standards for Providers

ALTSA Supportive Housing Mission: Our goal is to increase access to independent housing and stable tenancy, tailoring services to the individual's needs, preferences, and situation and building on a participant's strengths.

The service agency's work comes from the conviction that all people are people of dignity and worth, and all people have the ability to achieve the life they desire given the support and encouragement in achieving their chosen goals.

Summary of audited deliverables:

Quality of Service Documentation

1. Maintains participant confidentiality by using secure email.
2. Maintains participant's GOSH referral with their release of information in participant's file.
3. Completes Housing Assessment with participant.
4. Tracks and documents work with and on behalf of participant in participant's file.
5. Maintains supportive housing documents in the participant's file (e.g. credit checks, background checks, and lease).
6. Submits activity reports during pre- tenancy & transition period, and monthly notes once in tenancy.
7. Maintains reimbursement receipts in participant's file.
8. Maintains copies of permanent affordable or subsidized housing waitlist application information in participants file.
9. Completes a Crisis Plan with participant within 24 hours of community relocation (includes crisis hotline numbers) and maintains document in participant's file, updating as necessary.
10. Completes a goal and service plan with participant within 30 days of returning to community and maintains document in participant's file.
11. Reviews or updates goal and service plan with participant every 90 days once they are in the community, or as needed (minimum is 4x per year) and maintains document in participant's file.
12. Maintains documentation of 24/7 Coverage.
13. Files Quarterly Reports according to schedule.

Quality of Care

1. Accepts or denies referral within two business days.
2. Meets with participant within ten business days of referral.
3. Maintains minimum in-person contact per month of five hours (two and a half hours face to face).

4. Month one (or transition period) Maintains minimum contact of two home visits per week, totaling eight visits.
5. Months two and three period - Maintains minimum contact once per week with participant in the community during months two and three (or transition period) totaling 8 visits over two months.
6. Months four through seven- One home visit every other week, totaling eight visits over four months.
7. Months eight through twelve –one home visit per month, totaling five visits over five months.

System of Care

1. Connects with collateral partners within one week of referral.
2. Attends regularly scheduled staffing meetings.

Detail of expected deliverables and standards of service:

I. Overview on providing supportive housing services

A. **Eligibility -** The ALTSA Supportive Housing Program Manager (SHPM) will authorize supportive housing services. All participants must be:

1. Medicaid eligible;

2. Eligible to receive home and community based waiver or state plan services; and

3. Living in, or being diverted from admission to a state psychiatric hospital.

B. **Referrals -** Notify the SHPM and Home Community Services Case Manager in writing within two business days indicating whether your agency is accepting or declining the referral.

C. Upon **accepting** the referral, the provider will contact the participant within ten business days at the institution or program where the participant is living, and maintain documentation of contacts with participant and their supportive housing services.

1. The agency's participant file should contain a copy of the accepted referral, and other applicable documentation of the agency's ongoing work with the individual, including but not limited to:

a) DSHS Release of information with referral;

b) Housing assessment;

c) Background check and credit check;

d) Notes of in-person and other contacts with participant;

e) Crisis plan form and updates;

f) Goal and service planner form and updated forms;

g) Documentation of attendance at staffing meetings;

h) Monthly activity reports;

i) Permanent affordable or subsided housing waitlist application information;

j) Housing applications and leases;

k) Receipts for reimbursements for household items (please note that state funds may not be used to purchase televisions or to purchase other electronic devices used for entertainment purposes). Provider may include a copy of the authorization from case manager or ALTSA SHPM.

l) Other documentation as necessary

2. Maintain participant confidentiality by using secured email when communicating with DSHS Home Community Services.

D. **Obtaining housing** – The provider will conduct a housing search based on housing assessment, seek subsidies, and facilitate completion of any housing paperwork.

1. Complete a housing assessment with the individual to identify preferences, strengths and barriers.

2. Search for appropriate subsidies, complete and submit subsidy applications.

3. Conduct a housing search based on the assessment. Assist with eligibility determination and housing applications.

II. Standards of Supportive Housing services

A. **Housing Choice** - Choice is the foundation of permanent supportive housing.

1. Whenever possible, offer participants a choice of neighborhoods, apartments, and a say in their living environment to the extent that this is possible given housing market constraints.

2. Provide access to housing as quickly as possible with no requirements to demonstrate readiness.

3. Establish relationships with landlords offering a variety of housing options to maximize true choice.

4. Housing needs to be affordable, integrated into the community, and not require shared living spaces unless desired by the participant.

B. **No Program Contingencies of Tenancy** – Failure to engage staff in in-person visits does not lead to an exit from the program but requires staff to practice Assertive Engagement, outlined below in Exhibit Section II, P**.**

1. Continued tenancy is not linked to clinical, treatment, or service provisions.

C. **Standard Tenant Agreement** - Participants have a written agreement (e.g. lease, sub-lease) which specifies the rights and responsibilities per state and local law with no special provisions to maintain tenancy.

1. Provider should go over the lease and Landlord-Tenant law with participant to ensure participant understands their legal rights and responsibilities as a tenant.

2. Participant and agency should have a signed copy of the lease.

D. **Commitment to Re-House** - Provider assists participants who have lost their housing secure another apartment, without any housing readiness requirements. Staff should establish and maintain relationships with landlords to avoid legal evictions in favor of mutually agreed upon lease terminations, to the extent possible.

1. Decisions to rehouse participants are:

a) Individualized;

b) Participant-driven;

c) Not subject to any additional service requirements;

d) Not limited in number.

E. **Service Choice** - Support services are fully participant driven. Participant has the right to choose, modify, or refuse services and supports at any time. There is an expectation that staff are meeting with participants per the minimum frequency noted below in Exhibit Section III, **Contact with Participants**.

1. If a participant becomes disengaged, the onus is on the SH provider to utilize a variety of individualized assertive engagement strategies to re-engage the participant. The provider may not use disengagement as a time to step back services, and the responsibility to actively engage clients is the SH provider's function. SH providers must clearly communicate to the participant that the participant is in the driver's seat, and staff are there to support the participant in meeting their goals.

2. Failure to engage staff in in-person visits does not lead to tenancy loss or an exit from the program, it requires staff to practice **Assertive Engagement,** outlined below in Exhibit Section II, P.

F. **Support services** - Service provider must be able to provide a wide array of services as outlined in the contract (e.g. housing retention services, budgeting/finances, orientation to neighborhood and connection to activities of interest in neighborhood/area, linkage to mental health, chemical dependency, health & wellness services, job and/or education services, spiritual connections, etc.).

G. **Tenancy Support Services** - Provides ongoing support services to help participants obtain and maintain housing. The Supportive Housing services work begins as soon as the participant is admitted into the program with pre-tenancy and relationship building work, such as:

1. Discussions around housing/neighborhood wants and needs,

2. Housing search (including participant as much as possible),

3. Provider works with ALTSA SHPM around subsidy and apartment acquisition (where applicable) including Master Leasing opportunities,

4. Assists with utility setup and makes authorized purchases of furniture and

household items.

5. The provider assists with move-in and on-going tenancy support services including:

a) Working with participant to secure permanent housing,

b) Neighborhood orientation and connection to resources,

c) Landlord and neighbor relations,

d) Budgeting,

e) Shopping,

f) Facilitating requests related to property management services,

g) Understanding the rights and responsibilities of tenancy.

H. **Limits** - State funds cannot be used to purchase televisions or other electronic devices used for entertainment purposes.

I. **Social and Community Integration -** Program provides services to support social and community integration including, but not limited to:

1. Initial neighborhood orientation.

2. Facilitates access to and helps participants develop valued social roles and networks within and outside the program.

3. Helps participants develop social competencies to successfully negotiate social relationships.

4. Enhances citizenship and participation in social and political venues.

5. Works with participant to build a community of support outside of those in paid positions to provide support.

J. **Absence of Coercion -** Service provider does not use coercive activities such as leveraging housing or services to promote adherence to clinical provisions. Service provider respects boundaries of participant while maintaining an active enough presence to maintain housing stability.

K. **Services Continue Through Housing Loss or Institutional Stay** - Housing and support services are separate, so if a participant loses housing, they are not exited from the program and do not lose support services.

1. Agency continues to provide services to participant even if participants lose housing due to eviction, short-term institutional stay, etc., although service frequency may be reduced.

2. When a participant loses housing, staff should actively work with participant to find another apartment (preferably before their lease is terminated).

L. **Care Coordination during Stays in Institutions/Other Facilities -** Provider coordinates admission, treatment and discharge with other service providers when the participant experiences an institutional stay (e.g. hospital, skilled nursing facility, substance abuse treatment centers, etc.):

1. Program consults and coordinates with external providers on admissions as necessary.

2. Program consults with external providers regarding participant's treatment.

3. Program consults with collateral providers regarding discharge planning.

4. Program is aware of participant's discharge from facility.

M. **Person-Centered Planning** - Service provider conducts person-centered planning, including:

1. Development of service plan based on discussions driven by the participant's goals and preferences;

2. Conducting regularly scheduled treatment planning meetings; and

3. Practicing reflect strengths and resources identified in the assessment.

N. **Participant Self-Determination and Independence -** Provider increases participant's independence and self-determination by offering and honoring day-to-day choices as much as possible (e.g. there is a recognition of the varying needs and functioning levels of participants).

1. Provider's approach to services fully maximizes participant autonomy, self-efficacy and competence by consistently identifying and acknowledging participant's values, strengths and perspectives.

2. The provider offers options and support that allows the participant to make informed decisions.

O. **Harm Reduction Approach -** Service provider and staff actively utilize Harm Reduction, a perspective on treatment that includes a set of practical approaches to reduce the negative consequences of actions that incorporates a spectrum of strategies. Staff work with participants to reduce the risks associated with any harmful behaviors (safe injection, psychiatric symptoms, evictions, exploitation, etc.).

1. Utilizing a Harm Reduction approach, a provider has open and honest conversation with a participant about any consequences that could result from their actions. The provider should speak with the participant about ways to get their needs met that will reduce the risk of unwanted consequences.

2. The Harm Reduction approach is participant directed and driven with ultimate decisions being made by participant. The provider should speak with the participant about how they would like the provider to support their decisions.

<u>Example</u>: A participant is playing their music very loudly in the middle of the night. There have been several complaints by neighbors to property management which has resulted in a 10 Day Notice. The provider should speak

with the participant about their rights and responsibilities as a tenant and how playing music loudly in the middle of the night is in violation of their lease which could lead to the participant losing their apartment. The provider should have a conversation with the participant about why they are playing music loudly in the middle of the night and ways they can get their needs met without putting their housing in jeopardy (e.g. provider assists the individual budget for headphones). The participant can make an informed decision and let the provider know how they would like to be supported in their decision.

3. Provider able to demonstrate understanding of substance use including knowing how to assess, how to engage participant in conversations around use, and identifying goals around use (whether to minimize or reduce harm if continued use).

4. Participants are not required to abstain from alcohol and/or drugs. Participants are not required to undergo alcohol/drug or psychiatric treatment to continue to receive support services.

P. **Assertive Engagement** - Provider uses an array of techniques to engage participants who are difficult to engage (e.g. motivational interventions). In addition, the program has a thoughtful process for identifying the need for assertive engagement, measuring the effectiveness of those techniques, and modifying the approach where necessary.

1. Staff must be able to employ assertive engagement techniques, such as motivational interviewing, with the following skills and abilities:

a) Able to engage in relationship building work.

b) Able to gather, organize all information needed for a person-centered, strength based assessment.

c) Able to identify and discuss resources that most closely suit the person's goals, needs, and preferences.

d) Able to help people identify risk and consider mitigation strategies.

e) Able to help people identify potential problems with particular options and identify alternatives.

f) Able to facilitate agreement among all involved on course of action using tools and techniques such as motivational interviewing, problem resolution, including conflict resolution involving family members, and decision support making.

g) Able to generate a written plan based on the person's self-defined goals, strengths, values and preferences.

h) Able to communicate key aspects of the plan and the person-centered description to community partners.

i) Able to communicate in a manner that is understood by others using accessible formats, language, adaptive tools, and when appropriate, involve other individuals when special language, cultural or other issues require additional attention.

j) Able to work with people to revise and make modifications to their plans over time.

Q. **Caseload Ratio** - To maintain housing for people with complex needs, services and supports must be readily available. Permanent Supportive Housing is designed to improve housing stability for people with significant functional impairments. Housing is often jeopardized if a participant does not have the intensity and flexibility of supports and services a low caseload ratio allows.

1. **Optimum caseload size** is fifteen people per Full Time Equivalent (FTE).

2. Caseload size can increase to twenty people per FTE as long as the Supportive Housing Provider is ensuring access to person-centered, flexible and intensive services.

R. **24-Hour Coverage** - Provider ensures all participants have a working phone upon move-in and the participant knows how to use the phone. Providers are expected to provide after-hours and weekend access to support.

1. For best practice, the program has a formalized 24-hour on-call service operating under a rotating coverage system in which one staff person acts as the 'on-call' in one week intervals. The team can explain the purpose of the after-hours line and work with participants to establish boundaries as appropriate per the individual.

2. If a provider utilizes an established service for 24-hour coverage, the provider should be checking in with those operating the coverage on a daily basis. An example would be a provider using their agency's 24-hour mobile crisis team as an option for their Supportive Housing participants to call after hours. The Supportive Housing staff should check in with the mobile crisis team daily, including weekends, and follow up with participants as needed.

3. If a 24-hour on-call coverage system is not currently feasible, at a minimal providers should have a call in number for participants, landlords and other system of care members to be able to leave a voicemail during off-hours. It is the expectation that the voicemail is checked at least daily, including weekends.

III. Expectations on Contact with Participants

A. **Pre-Tenancy -** A Supportive Housing Provider should confirm acceptance of a referral within two business days of receiving the referral.

1. Upon accepting a referral, the Supportive Housing Provider's assigned staff member should meet with the participant in person within ten business days to establish rapport and fill out a housing needs assessment.

2. As frequently as possible, the initial meeting should be scheduled at a date, time and location most convenient for the participant.

B. **Background Checks** - Within ten business days the Supportive Housing Provider should pull a background report to identify potential housing barriers. Coupled with the housing needs assessment, the provider can start to work with the participant to

overcome any barriers to renting and identify housing resources the participant's needs.

C. **Collateral Contacts** - While working to schedule an in-person meeting with the participant, within one week of accepting a referral the provider should connect with collateral contacts.

1. Collateral contacts can assist the Supportive Housing case worker better understand what services and resources the participant currently has access to and areas where the participant will need assistance from the Supportive Housing Provider.

2. Collateral contacts may also have the best contact information for the participant. Dependent on the participant, it might be best to coordinate the first in-person meeting with a collateral contact.

3. Frequent, in-person meetings and communication with the participant and collateral contacts are key during the pre-tenancy phase of Supportive Housing.

D. **Move-in -** To ensure the participant has everything they need upon move-in, the provider must:

1. Assist in securing essential transition items: furniture, household items, groceries, etc. (this can be done in advance of a move-in without the participant if the participant agrees).

2. Crisis Plan Form Completion **–** The crisis plan must be filled out with the participant either just before move-in or on the day of move-in. Staff should ensure the Crisis Plan lists local emergency numbers, including 24/7 crisis hotline numbers, and educate participants on situations in which they should utilize these resources.

3. The service provider must conduct the first home visit within 24-hours of move-in.

4. Friday move-ins should be kept to a minimum.

5. If a move-in does take place on a Friday, the service provider must check-in with participant within 24-hours of move-in, which may take place via phone or in person.

6. The service provider should check in with the Home and Community Services case manager within 48-hours of the move-in.

E. **Personal Care Intake Meeting** - The service provider should be present for the initial meeting to set up personal caregiving services.

1. Typically, this initial meeting entails a supervisor from the personal care agency, of the participant's choice, coming to the participant's home to conduct the assessment, and to discuss a personal care service schedule. The supervisor uses this information to assign a personal caregiver.

2. ALTSA also asks the service provider to attend the first (or first few) visits with the assigned personal caregiver.

F. **Goals and service plan completion and updates** – The provider will complete an assessment of the participant's goals to return to community living and to maintain community living, including areas to focus (e.g. goals on housing, financial, health, etc.) to identify preferences, strengths and barriers. The goal and service plans will focus the Provider's work, and the monthly activity reports summarize the work completed to meet the participant's goals.

1. Complete a goal and service planning assessment document with the individual within 30 days of the participants' return to the community to identify service plans, preferences, strengths and barriers.

2. After living in the community, continue to review the goal and service planning assessment document as needed or every 90 days with the individual to validate service plans, make updates, and continue to identify participant's ongoing goals, preferences, strengths and barriers.

G. **Home visits** - The following is the ***minimum*** number of home visits that must take place within the first year. In addition to home visits, the service provider should have contact with the participant via phone, email, and through third parties. *ALTSA strongly encourages numerous home visits each week for <u>at least</u> the first month in housing, and during requested and approved 'transition periods'.*

1. Month one (or during requested and approved '*transition period'*)	Two home visits per week, totaling eight visits.
2. Months two and three	One home visit per week, totaling eight visits over two months.
3. Months four through seven	One home visit every other week, totaling eight visits over four months.
4. Months eight through twelve	One home visit per month, totaling five visits over five months.
5. Minimum number of home visits per year	29 visits, with minimum in-person contact per month of five hours (two and a half hours face to face)

H. **Agreed Upon Visit Dates** - The specifics of the home visit schedule should be worked out between participant and staff.

1. If participant requires more frequent home visits to maintain tenancy, it is in both provider's and participant's best interests to accommodate this.

2. If a crisis, event or '*transition period*' arises staff would need to increase frequency of home visits.

3. A home visit should involve staff being present inside the participant's apartment, but does not need to take place solely in the home. Staff may go for coffee with participant, to the grocery store, library, for a walk in the participant's

neighborhood, etc.

I. **Staff Supervision -** To ensure quality service provision, best practices suggest that direct service staff should receive regular, formal supervision.

1. **Staff education -** including ongoing education on the principles of Housing First, Harm Reduction, Assertive Engagement, Motivational Interviewing, Trauma Informed Care, Positive Engagement, etc.

2. It is also best practice for providers to have **Team Meetings** in which staff meet weekly to plan and review services for participants.

J. **Participant Representation –** Whenever possible, it is best practice to have participants represented in program operations and be provided with regular opportunities to provide input. Avenues for participant input may be through committees, as peer advocates, or on governing bodies (e.g. Board of Directors).

K. **Transportation -** The provider may transport or assist participants in arranging transportation to any appointments (medical, dental, mental health, financial, legal or other) and accompany participant to appointments as needed.

1. During the transition period, as a participant is getting used to living in their own apartment and out of an institutional, residential or emergency system setting, the service provider is encouraged to transport the participant as they work on familiarizing and orienting the participant to their community and other transportation systems the participant can access.

2. The transportation might include trips to social activities, the library, grocery store, thrift store, etc.

L. **Coordinate System of Care*** - A "**system of care**" is a strengths-based, culturally relevant, participatory framework for working with individuals with complex needs. A system of care approach utilizes inter-agency collaboration, individualized programming and community-based service provision.

1. The provider acts as the point person for the participant and drives collaboration across system and provider.

2. The provider engages and facilitates ongoing communication and collaboration with various providers working with the participants (e.g. community mental health case manager, chemical dependency professional, employment specialist, emergency and crisis providers, medical doctor, personal caregiver, AAA case manager, guardian, family, etc.).

3. The provider advocates for participant access to community resources and services.

4. The provider consults and collaborates with community providers to ensure continuity of care.

IV. <u>Reports, Monitoring, Quality Standards and Deliverables.</u> The Contractor is

expected to:

A. **Maintain participant and collateral contacts**, and timely completion of supportive housing deliverables as outlined in 'Service Standards for Providers'.

B. **Participate in scheduled training**, fidelity, and peer review processes as specified by the DSHS ALTSA.

C. **Submit a monthly report** on the form provided by DSHS within 15 days of the end of each month detailing individuals served.

D. **Provide progress reports** which shall include demographic and service information to demonstrate performance outcomes as specified by ALTSA. Quarterly reports are due to ALTSA as detailed in the below schedule.

Reporting Period	Quarterly Report Due
January-March	May 15th
April-June	August 15th
July-September	November 15th
October-December	February 15th

Edition dates:	Notes of updates:
1. 2017	Implementation edition
2. April, 2019	Updated with outline numbering, and quick references on audited deliverables.
3. February, 2019	Log of editions established. Corrections include: • Quick list of deliverables is now single list that matches wording in the Contact with Participants section. • Typo correction on section reference for Contact with Participants, • Typo correction on section reference for Assertive Engagement, • Deadline on initial contact with participant (ten business days), • Deadline on contact with collateral contacts (one week), • Minimum in-person contact per month added to table of participant contacts.