
A plan of the Frequent Users System Engagement (FUSE) Collaborative to provide stable housing and community services for 200 Maine persons who are homeless or at risk of homelessness and are the most frequent consumers of high-cost services. In response to LD 475, a resolve of the 130th Maine Legislature.

A FUSE Collaborative report and plan to the Joint Standing Committee on Health and Human Services

January 1, 2022

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Purpose

The 130th Maine Legislature established the **Frequent Users System Engagement (FUSE) Collaborative** (L.D. 475) tasked with the following:

“That the collaborative shall develop a plan to provide stable housing and community services to 200 persons who are homeless or at risk of homelessness who are the most frequent consumers of high-cost services, such as psychiatric hospitals, emergency shelters, emergency rooms, police, jails and prisons.”

Target Population

The target FUSE population is defined as follows:

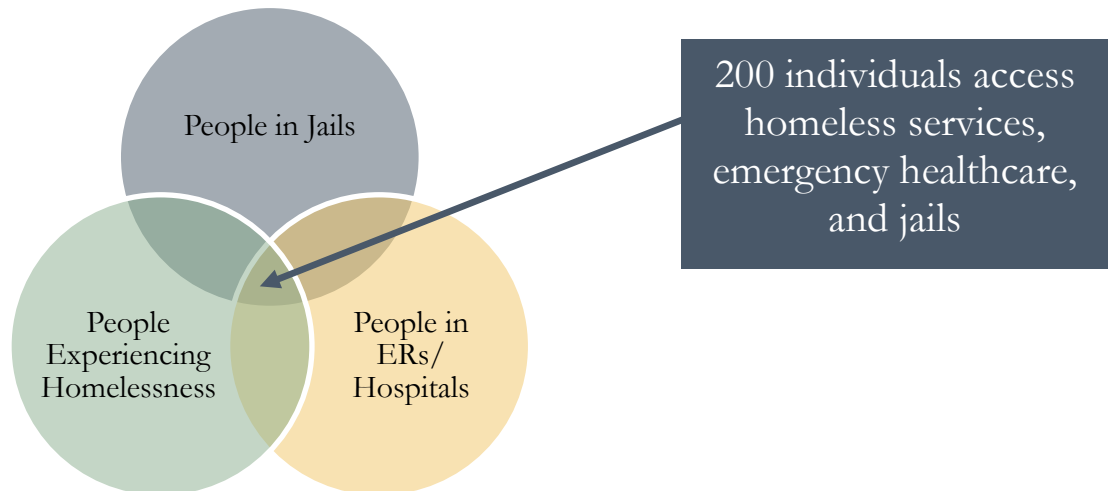
Individuals must be identified as having long-term homelessness as defined as having resided in a place not meant for human habitation, a temporary outdoor shelter, an emergency shelter, homeless shelter, or a setting of institutional care or incarceration for a minimum total of 180 days out of the last 365 days. Stays in a setting of institutional care or incarceration may not account for more than 90 of the member’s total homeless days in any one 365-day period; AND have two chronic conditions or one chronic condition with a qualifying risk factor of having a second chronic condition.

Background

Description of Frequent Users System Engagement (FUSE) Approach

The Frequent Users Systems Engagement (FUSE) systems planning model was developed by Corporation for Supportive Housing (CSH). The model combines data driven population targeting, multi-stakeholder engagement, and targeted supportive housing for the frequent users of emergency services.

The target population for FUSE includes those individuals who meet criteria for frequent utilization of crisis systems, including homelessness, low income, behavioral health concerns, chronic physical health conditions and frequent emergency room and/or hospitalizations. This population often has frequent interaction with law enforcement as well. The diagram below indicates the intersection of homeless services, emergency healthcare, and jails where we would find the population of individuals frequently accessing all three – estimated at about 200 individuals in Maine.



The FUSE approach has worked in nearly 40 other communities across the country that target this population for supportive housing. FUSE data suggests that:

- 30% of our resources are being spent on 1% of our homeless population because they remain homeless
- We can safely predict that cost per person served will be a fraction of the resources now spent on individuals in the FUSE population
- This population does not do well when unhoused and tends to do better when housed
- The intervention that works best for them is Permanent Supportive Housing (PSH), providing sufficient supports for housing stability and improvements in overall health
- Once this population is housed, shelters, jails and emergency rooms will not be crowded with the same people and law enforcement and EMS personnel will be able to focus on the general public rather than the same small group of people

FUSE Outcomes in Other States:

Connecticut Statewide FUSE program:

- \$7,800 annual cost reduction;
- 92% supportive housing retention rate; and
- Significant decreases in overnight hospitalizations (68%) and ER visits (62%).
- 73% reduction in jail stays after 1 year; and
- A near total decrease in emergency shelter usage (99%) for the first 120 people housed through the initiative.

Minnesota – Hennepin County FUSE program:

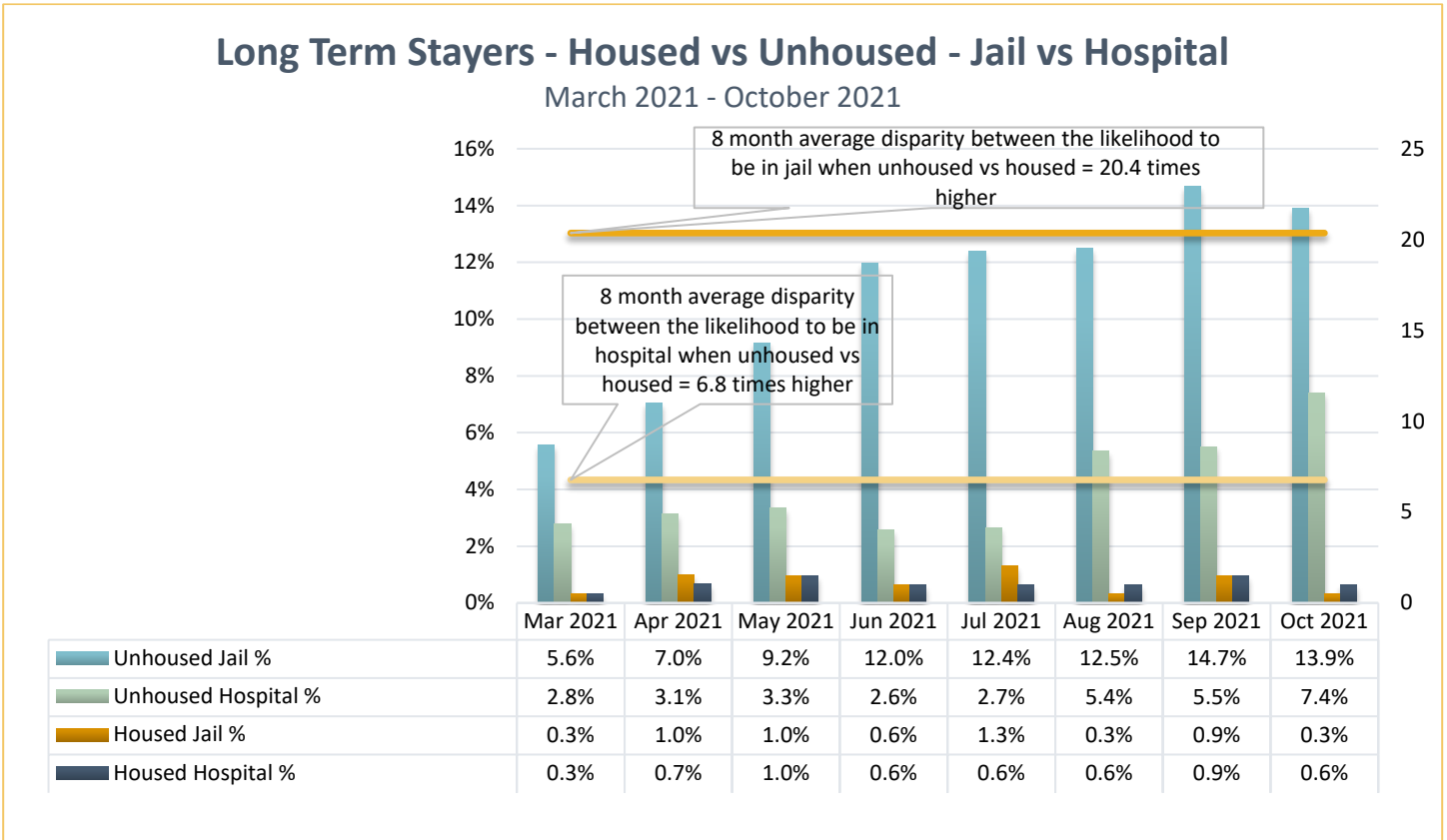
- \$13,000 in annual cost savings for Hennepin County per person;
- 60% fewer arrests (with 45% having had 1 or no arrests);
- 700 fewer nights in jail (39% reduction);
- 1,704 fewer shelter nights (39% reduction);
- 85% remained housed after 6 months;
- 90% avoided returning to shelter; and
- 80% avoided returning to jail.

Michigan – Washtenaw County FUSE program:

- 81% housing retention rate;
- 87% enrolled in Primary Care;
- 46% zero ER utilization;
- 56% zero inpatient hospital stays.

What Has Worked in Maine to Date

Since April 2015 Portland’s Emergency Shelter Assessment Committee has focused on a by name list effort to house and keep housed the longest stayers in homelessness (Long Term Stayers – LTS) in the city. Eighteen organizations have been working together on this and as of November 2021 the group has housed 355 individuals, with a success rate of 90.3% in remaining stably housed.



This chart shows that over an eight-month period in Cumberland County individuals who remained unhoused were over 20 times more likely to be in jail and almost 7 times more likely to be hospitalized than their peers who found stable housing.

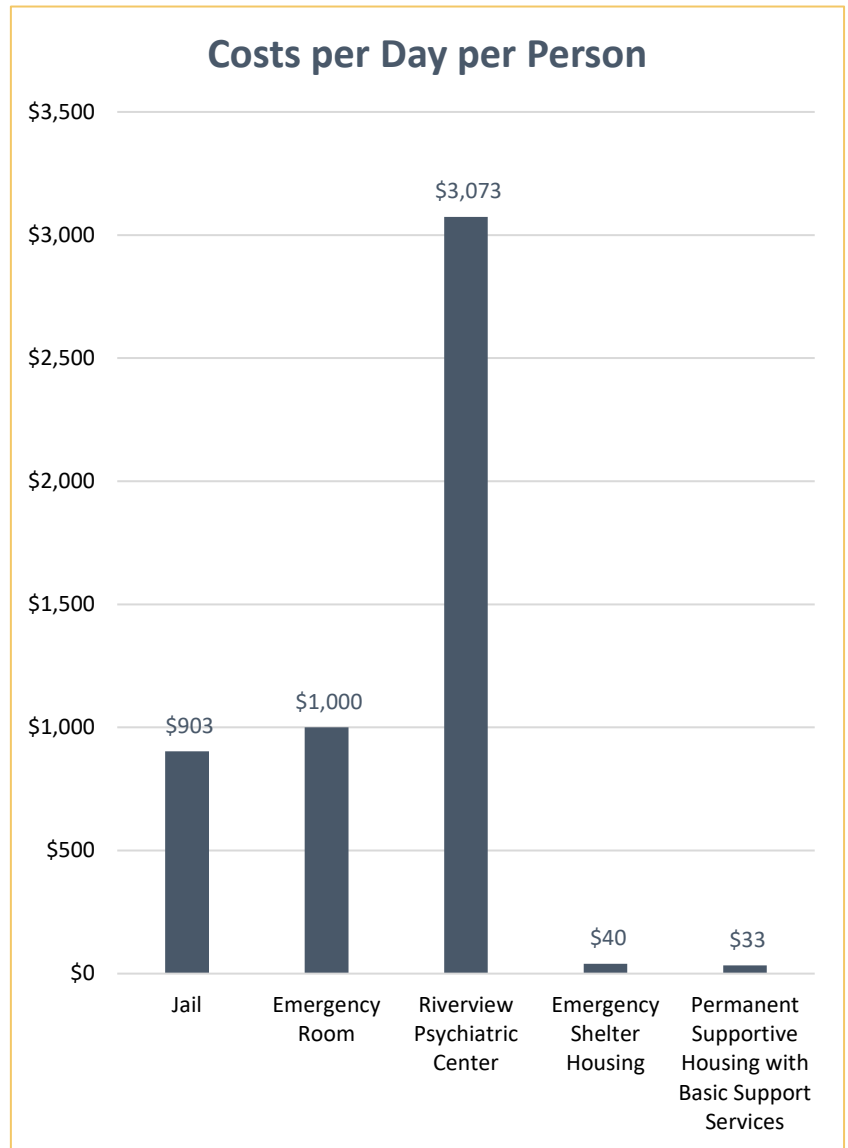
Potential Cost Savings in Maine

Today in Maine it costs:

- \$903 per day to have an individual in jail
- \$1,000 per person per day to have an individual in an emergency room, not accounting for emergency transportation or potential hospitalization following such visits
- \$3,073 per person per day to have an individual at Riverview Psychiatric Center
- \$40 per person per day to keep an individual at the least expensive emergency shelter (Oxford Street in Portland), not accounting for food and other homeless services

It currently costs:

- \$9,756 to house an individual for an entire year in Maine (\$813/month for a one-bedroom apartment in Maine; in Portland \$1,100/month, according to the National Low Income Housing Coalition’s “Out of Reach 2020” housing cost study).
- And approximately \$2,400 per year for support services (\$60,000 salary and benefits divided by a caseload of 25)



For a total cost of \$12,156 per year per individual (\$15,600 in Portland) to provide Permanent Supportive Housing with basic support services. This is a mere **\$33** per day or \$43 per day in the Portland-area housing market.

Maine Challenges and Opportunities

Challenges

- **Housing Supply:** There is a significant lack of available permanent supportive housing units for this population, along with inconsistency in the availability of rental subsidies
- **Barriers to Housing:** It is difficult to find housing that this population can't be rejected from or kicked out of. Most face barriers to obtaining housing, including:
 - a record of evictions
 - poor credit histories
 - stigma and discrimination toward both the population and rental assistance such as Housing Choice Vouchers or Shelter Plus Care
 - no appeal process for private landlords denying housing
 - a lack of intensive case managers that can work with landlords to support individuals in housing.
- **Service/Treatment Funding:** Individuals struggling with long-term homelessness often require a high level of care to address their physical and mental health needs. While there are programs that can provide ongoing services for people with complex needs, all of these programs are voluntary and based on client choice. This creates challenges for housing providers when an individual becomes housed and decides they no longer need formal services. Current services do not uniformly allow for assertive engagement efforts required to help people stay engaged in treatment (see sect. 17 Assertive Community Treatment regs “outreach through a closed door” as a positive example).
- **Support Funding:** There is no funding mechanism to provide ongoing support for individuals choosing not to engage in formal behavioral health services.
- **Barriers to Engagement:** Individuals belonging to this population tend to experience symptoms of mental illness often resulting in isolation, paranoia and distrust.
 - Lack of a successful strategy for engagement in general
 - Lack of successful strategy for continuity of engagement from pre to post tenancy
 - Constant crises are an impediment to long term service implementation
 - This population tends to disappear, either due to being unsheltered or lost in another system, interfering with long term service plans

Opportunities

- **Collaboration:** there are partners from multiple systems working to find solutions for this population. These include the two key components of MaineHousing and Office of Behavioral Health working together to find pathways to permanent supportive housing.
- **Established Permanent Supportive Housing (PSH) Program:** MaineHousing has an annual funding source for PSH through the federal Housing Trust Fund.
- **HOME ARP:** The American Rescue Plan provided approximately \$20 million to Maine to address homelessness, including the creation of new housing units which could include permanent supportive housing units.

- **MaineCare Homeless Health Home Program:** A new MaineCare service is in the approval process which will target this population for both pre and post tenancy support.
- **Long Term Stayers Initiatives:** There are already systems in place to identify and house this population in the urban areas where most reside – particularly Portland and Bangor. These models can be easily replicated across the state.
- **City of Portland Tax Increment Financing:** Portland has put stipulations on affordable housing supported by TIFs to be inclusive of permanent supportive housing for Long Term Stayers. This is slowly increasing the supply of housing opportunities for this population.
- **Maine Homeless Response System ReDesign:** A new regional homeless services delivery model is being implemented in the state. Nine Homeless Service Hubs are being established which will first work to build a By Name List of all sheltered and unsheltered homeless individuals in their area. This population will continue to be prioritized for permanent supportive housing resources, as it has been since 2013.
- **Built for Zero:** Maine has contracted with Community Solutions to be a part of the national Built for Zero collaborative which has demonstrated success in decreasing chronic homelessness across the country.

Recommendations

The FUSE Collaborative makes the following recommendations to MaineHousing and the Department of Health and Human Resources:

Goals/Objectives

- **Our overarching goal is to have an adequate supply of low barrier permanent supportive housing units inclusive of low barrier, flexible, and ongoing wraparound services for the target population of approximately 200 individuals, and to have all 200 access and retain their housing placement.**

More Specific Goals, Objectives and Strategies include the following:

GOAL I: House 200 Individuals Meeting FUSE Criteria by December 2026.

OBJECTIVE 1: Ensure a variety of housing and subsidy models

Strategies:

- Ensure adequate supply of rental subsidies - exploring flexible subsidies for nontraditional uses
- Explore master leasing options and shared housing

- Explore alternative housing providers/collaborators such as hospital funded and staffed PSH, and jail and DOC staffed supportive housing
- Combine comprehensive wraparound services that incorporate assertive engagement strategies (e.g. Assertive Community Treatment, Community Rehabilitation Support) with 'housing you can't get kicked out of'
- Develop funding mechanisms to cover the ongoing 24/7 building supports necessary for individuals struggling with long-term homelessness, especially for those not ready to engage in formal services, similar to the operational subsidies developed for Recovery Residence style housing. Housing supports include:
 - House managers
 - Daily living support workers
 - Front desk staff
 - Daily living supports, upkeep of housing unit, and lease adherence

OBJECTIVE 2: Create 150 new PSH units by December 2026

Strategies:

- Utilize existing and new PSH funding streams through MaineHousing – Housing Trust Fund and HOME ARP
- Develop a funding mechanism through MaineHousing that provides funding to fill operational gaps due to inability of clients to pay rent similar to the current Recovery Residence model.
- Include Project Based Vouchers with newly funded PSH projects
- Explore land acquisition of state and municipally owned land/buildings
- Engage more mission-based developers to house this population - engaging Genesis Fund for technical assistance and considering making pre-development funds available
- Create additional Housing First projects targeting this population
- Identify land zoning barriers and work to solve them
- Acquire hotels and/or office buildings and convert to housing
- Explore LIHTC inclusion, with owner engagement/commitment and adequate support services

OBJECTIVE 3: Identify short to medium term 'bridges' to PSH

Strategies:

- Use hotels as bridge to housing, especially for those barred from shelters
- Ensure funding for staffing of hotels to support individuals in experiencing a successful hotel stay

GOAL II: Ensure Long Term Support Services for the Population by December 2023.

OBJECTIVE 1: Ensure funding mechanisms for uninterrupted permanent support

Strategies:

- Target MaineCare Health Home service to this population
- Utilize Private Non-Medical Institution (PNMI) support services with an apartment as well as several one bedroom unit PNMIs in one site
- Explore changes to MaineCare Section 13 Targeted Case Management and Section 17 Community Support Services that would expand eligible activities for service providers including assertive engagement and outreach.
- Pursue Certified Community Behavioral Health Clinic model to fund a population health approach using outreach support
- Explore team-based approaches that can include wraparound support
- Ensure people don't have to drop out of services to access other forms of support
- Ensure staff have competencies to assist individuals in maintaining benefits similar to the SSI/SSDI Outreach, Access, and Recovery program
- Explore links with MaineHousing's Emergency Shelter and Housing Assistance Program

OBJECTIVE 2: Ensure engagement with individuals that incorporates long-term relationship work to build trust.

Strategies:

- Update existing MaineCare regulations to allow behavioral health and homeless service providers to participate in long-term/permanent engagement that results in housing for each individual
- Have community health workers/peer supports engage the population
- Continue direct funding through the Office of Behavioral Health that supplements MaineCare billing models to fill gaps.
- Create state-funded Intensive Case Manager (ICM) positions to flexibly serve this population.
- Create 'outreach through a closed door' models designed for persevering in engagement and relationship
- Explore sustainable funding for Community Health Outreach Workers (CHOWs), such as collaboration with OBH funded CHOWS and inclusion in MaineCare Certified Community Behavioral Health Clinic (CCBHC) model

Implementation Plan

PHASE ONE (Years 1 through 3)

Phase One will focus on the creation of new housing models/units and support services that match this population's needs. There will also be a focus on incorporating FUSE activities into the recently launched regional Homeless Response Service Hub delivery system and working towards quality data to understand what strategies are effective and what needs to improve.

Coordinate Efforts

- Incorporate FUSE efforts into the recently launched Homeless Response System Re-Design (see Appendix A), and establish local and statewide collaborations to ensure the system works well and case conferencing for this population is a priority across the nine regional Homeless Service Hubs.
- Use and enhance existing LTS focused By Name List efforts. Ensure all players are at the table.
- Ensure that everyone understands that interagency work on housing people is not to be confused with protected health information.
- Revisit data sharing agreements and solve for barriers to having housing case coordination and conferencing for these individuals.
- Find pathways to the development and utilization of Releases of Information that will ensure success – both with clients and provider requirements.

Establish Data Dashboards and Reporting Tools

- Support Homeless Service Hub Coordinators in collecting and reporting on accurate counts for this population in real time – both sheltered and unsheltered individuals.
- Utilize the Homeless Management Information System (HMIS) to track progress in housing this population and keeping them stably housed. Analyze trends for potential challenges and to develop improvement strategies.

Develop Various Models of Housing for the FUSE Population – with a goal of a minimum of 30 new units per year

Some models/strategies to consider:

- Support creative models with extremely low barrier access for this population.
- Encourage hospitals and jails/DOC to create PSH for this population.
- Expand the operations funding model for Recovery Residences so they can target this population.
- Expand the HOUSE pilot based on what is found to be working.
- Create at least one additional bricks and mortar Housing First project.
- Create a point incentive in the Housing Trust Fund RFP so that Permanent Supportive Housing targets this population.
- Create a point incentive in the Qualified Allocation Plan (QAP) and effective continuous wraparound support services so that Low Income Housing Tax Credit housing can be inclusive of this population.

Ensure Low Barrier Access and Continuity of Wraparound Support Services

Some models/strategies to consider:

- Create a network of Intensive Case Managers or similar to ensure low barrier access, gap filling, and continuity of care for this population from outreach engagement through to permanent stability, and ensure quantity of this type of staffing is commensurate with need.
- Ensure the MaineCare Homeless Health Home model is a standalone formula for the effective provision of wraparound support services from outreach engagement through permanent stability or is seamlessly braided with other chapters of MaineCare so it is a go-to model for effective services delivery.
- Review existing chapters of MaineCare to ensure they are effective with this population as well, including Section 13 and 17, Health Home Models and Assertive Community Treatment, etc.
- Explore setting up PATH (Projects for Assistance in Transition from Homelessness) or a portion of PATH is set up for continuity of services from outreach through to permanent stability.
- Ensure success of scattered site placements with S+C and BRAP through effective and continuous wraparound support services.

PHASE TWO – EVALUATION AND SUSTAINABILITY (Years 4 through 5)

Phase Two will focus on continuation of housing development and implementation of new models of housing paired with wraparound support services. It will also focus on evaluation strategies to determine which models produce the most successful outcomes for individuals. Less successful models will be adjusted as needed to improve outcomes.

By the end of Phase Two a cost effectiveness study should be completed to justify any new streams of funding attached to this initiative.

Suggested Legislation

- A bill that provides ongoing funding for the development and operations of a housing model similar to Recovery Residences for this population. This legislation should look to leverage existing local, federal and/or private grant funding to maximize the reach of the funding.
- A bill that will create and fund a statewide network of 10 to 12 Intensive Case Managers within the Department of Health and Human Services to work directly with the FUSE population.

Group Composition and Planning Process

FUSE Collaborative Members:

Member	Affiliation	Representation
Daniel Brennan	MaineHousing	Director
Lauren Bustard	MaineHousing	Senior Director Homeless Initiatives
Jessica Pollard	Department of Health and Human Services	Commissioner's Designee
Jodie Johnson	Department of Corrections	Commissioner's Designee
Stephanie Primm	Statewide Homeless Council	Chair
Joel Merry	Maine Sheriffs' Association	Sagadahoc County Sheriff
Melissa Skahan	Northern Light Health	Emergency Health Services
Lee D'Attilio	MaineHealth	Emergency Health Services
Sarah Calder	MaineHealth	Emergency Health Services
Aaron Geyer	City of Portland	Municipal Officer
Aimee Brown	Riverview Psychiatric Center	Psychiatric Hospital
Leanne Robertson	Riverview Psychiatric Center	Psychiatric Hospital
Ben Strick	Spurwink	Community-based Behavioral Health Services
Meredith Smith	Community Health and Counseling Services	Community-based Behavioral Health Services
Cullen Ryan	Maine Continuum of Care	Board Chair
Josh D'Alessio	Penobscot County Health Center	Low Barrier Emergency Shelter
Oliver Bradeen	Milestone Recovery	Substance Use Disorder Program/Shelter
Erin Kelly	Preble Street	Permanent Supportive Housing
Donna Yellen	Preble Street	HOUSE Project (FUSE Pilot) - Portland
Carter Friend	York County Community Action Corporation	HOUSE Project (FUSE Pilot) - Sanford
Cheryl Harkins	Homeless Voices for Justice	Person with Lived Experience
Victoria Morales	Quality Housing Coalition	Legislator, Housing Service Provider

Meetings

The Collaborative met four times during the months of September through December 2021.

Appendix A

Homeless System Re-Design Initiative Final Report and Recommendations – Corporation for Supportive Housing (CSH), June 2021

REGIONAL HOMELESS SYSTEM DESIGN AND IMPLEMENTATION

Based on findings from both quantitative and qualitative analysis, along with learnings from similar states such as Alaska and Connecticut, the Statewide Homeless Council (SHC) has endorsed a multi-tiered strategy that includes centralized, coordinated entry and organizes the homeless response system into nine (9) local “Service Hubs”. Additionally, the SHC has identified the overall need for housing and service interventions such as diversion, rapid rehousing and supportive housing as well as training, capacity and infrastructure recommendations to support the system for the long term. The Service Hubs will operate from a framework from which coordination of activities such as provider training, coordination, referrals and distribution of housing resources can be efficiently deployed. This new structure will allow homeless service providers to effectively plan and launch the new Coordinated Entry System, standardize training, engage other mainstream systems such as justice and healthcare and remove access barriers for individuals seeking support. Coordinated Entry is a consistent, streamlined process for accessing the resources available in the homeless crisis response system. Through coordinated entry, a Homeless Response Continuum of Care (CoC) ensures that the highest need, most vulnerable households in the community are prioritized for services and that the housing and supportive services in the system are used as efficiently and effectively as possible. Each Hub will determine its own governance structure and process for system engagement going forward, but with commitment to similar driving principles of person-centered care.

What Is the Benefit to The Current System?

Establishing Local Service Hubs allows for greater cooperation, coordination and equitable distribution of housing resources at a manageable level. Such an approach allows for local communities to serve people where they are and reduces pressure on organizations serving individuals in population centers. Furthermore, Local Service Hubs provide a local structure to engage mainstream systems such as Justice and Healthcare not well integrated with housing and shelter, but nonetheless integral components both driving homelessness and critical partners to ending homelessness.

What Are the Responsibilities of Each Hub?

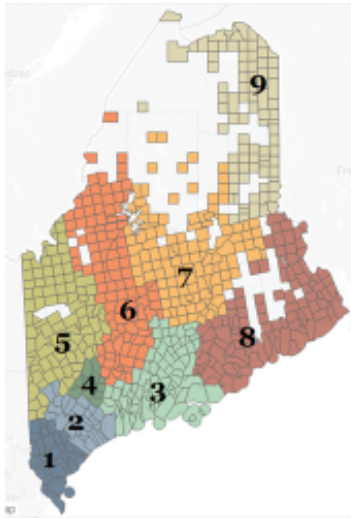
Broadly speaking, the Service Hubs will lead the processes of Coordinated Entry within their defined geographic area in accordance to outlined policies and procedures adopted by the Coordinated Entry Committee and the CoC. This includes facilitating case conferencing meetings, management of the prioritization list and matching individuals to available housing resources. Service hubs will have at least one "Access Point" for intake into HMIS and the prioritization list alongside “Referral Partners” who work regularly with individuals experiencing housing instability.

Geographic Structure of Local Service Hubs

To better understand the landscape and array of providers in Maine, CSH utilized the GIS Mapping Software Tableau to map existing providers and resources relevant to this Re-Design Initiative. The purpose is to guide decision-making relating to the re-design and ensuring equitable distribution of resources among hubs as much as possible. In addition to mapping existing resources, this tool was

used to assist providers in determining the geographic structure of local Service Hubs, a critical objective to this initiative. Interactive versions of these GIS maps visualizing the assets and resources within the Service Hubs across Maine will be made available to MaineHousing and the Statewide Homeless Council for publication.

Maine Homeless Response System Service Hub Structure



- Hub 1: York
- Hub 2: Cumberland
- Hub 3: Midcoast: Sagadahoc, Knox, Lincoln, Waldo and Towns of Brunswick and Harpswell
- Hub 4: Androscoggin
- Hub 5: Western: Oxford, Franklin and Towns of Livermore and Livermore Falls
- Hub 6: Central: Somerset and Kennebec
- Hub 7: Penquis: Penobscot and Piscataquis
- Hub 8: Downeast: Washington and Hancock
- Hub 9: Aroostook