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Medicaid Funding for Critical Time Intervention: A Scalable Solution to Crisis Homelessness?

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Abstract

Homelessness has an outsized impact on health care systems. Recent experience demonstrates that substantial progress in reducing homelessness is possible if resources are directed towards evidence-based, housing-focused solutions. However, the homeless assistance system is not adequately resourced to assist persons experiencing “crisis homelessness,” who account for the majority of the homeless population. Thus, we present a policy proposal for using Medicaid dollars to leverage an expansion of Critical Time Intervention (CTI), an evidence-based behavioral health intervention, as a scalable solution for crisis homelessness. We discuss why this is a sound and feasible policy idea, focusing on the alignment between CTI and a promising new programmatic approach known as rapid re-housing, the CTI evidence base, and recent federal guidance on Medicaid reimbursable housing-related activities. We describe the potential benefits of enacting this proposal and conclude with a discussion of the challenges that would need to be addressed to implement it.

Introduction

In the United States, roughly 1.42 million persons will stay in a homeless shelter or transitional housing program at some point over the course of a year.[1] Research documents a clear link between homelessness and an array of adverse health outcomes.[2] Homelessness is also costly to society with studies showing that persons experiencing homelessness utilize a constellation of emergency shelter, acute health, behavioral health, criminal justice and other services that can cost tens of thousands of dollars annually.[3] The health care delivery system, and public payers in particular, often bear the brunt of these costs.

Homelessness is a serious public health problem, but it is not intractable. Recent experience demonstrates that substantial progress in reducing homelessness is possible if resources are directed towards evidence-based, housing-focused solutions. Indeed, the expansion of permanent supportive housing (PSH)—an evidenced-based intervention defined broadly as subsidized housing matched with ongoing supportive services—has been linked with reductions in chronic homelessness.[4] Nationwide, chronic homelessness declined by 27% between 2007 and 2017[5]. However, PSH is intended primarily for high-need individuals experiencing chronic homelessness, who comprise a small minority of all single homeless adults.[5] With annual costs that can exceed \$15,000, it may not be feasible or necessary to provide such an intensive intervention to all persons experiencing homelessness.

There is a need for alternative solutions that are less resource intensive, but equally effective as PSH for the bulk of the homeless population, which is comprised of individuals who are not chronically homeless. These persons might best be described as experiencing “crisis” homelessness, in that their homeless experience is brief and is often preceded by a triggering event such as an eviction, dissolution of a relationship, or transition out of an institutional living arrangement such as foster care, prison, or substance abuse treatment. By our estimates, about 1.17 million persons, or roughly 82% of the overall sheltered homeless population experience crisis homelessness each year, of whom about 887,000 (or nearly two-thirds of the overall shelter-using homeless population) are single adults.[5] As illustrated in Figure 1, progress in addressing crisis homelessness has lagged far behind that achieved for chronic homelessness.

Fortunately, the emergence of a new paradigm in the homelessness assistance sector, coupled with recent Medicaid policy developments, provide a unique opening for making progress in reducing crisis homelessness. In this paper, we present the case for using Medicaid funding to leverage an expansion of Critical Time Intervention (CTI), an evidence-based behavioral health intervention,[6] as a scalable policy solution for crisis homelessness. To provide context for this proposal, we first describe the ongoing paradigm shift in the homeless assistance system that has spurred interest in a new programmatic approach known as “rapid re-housing” (RRH). We then explain why pairing CTI and RRH makes for sound and feasible policy, highlighting the potential benefits of our proposal to individuals and society. We conclude with a discussion of the challenges that need to be addressed to make this proposal a reality.

Housing Stabilization as the Emerging Paradigm for Homelessness Assistance Systems

For much of the past 25 years (and beyond), emergency shelter and soup kitchens have represented the primary, and often only available forms of assistance for persons experiencing homelessness. While serving important survival functions, these programs offer little in the way

of practical assistance for resolving a housing crisis. In more recent years, a conceptual framework has emerged that fits a conceptual understanding of homelessness as an acute housing crisis and aligns with the observed dynamics of homelessness as a phenomenon that is, for the majority of persons, brief and non-recurrent in nature.[7] As Figure 2 shows, housing stabilization has replaced emergency shelter as the core concept in this framework in reflection of a new, narrowly focused mission for the homelessness assistance system on triage and stabilization. Policymakers have embraced this framework, with the Federal Strategic Plan to address homelessness adopting a set of goals and strategies consistent with its ideas.[8]

The emergence of this new paradigm has coincided with the introduction of programmatic approaches that have applied its concepts. The onset of the economic recession in 2008 catalyzed this process, as the *American Recovery and Reinvestment Act of 2009* included \$1.2 billion for the Homelessness Prevention and RRH Program (HPRP). Instead of paying for brick and mortar residential programs, HPRP provided funds to states and localities to be used flexibly for short-term housing costs and case management services geared towards preventing homelessness among those at-risk, and rapidly re-housing those actually experiencing homelessness. Although HPRP expired after three years, the reauthorization of federal homeless assistance programs in 2009 (the *HEARTH Act*) made an increased emphasis on RRH permanent. In 2011, the U.S. Department of Veterans Affairs launched its own homelessness prevention and RRH initiative, the Supportive Services for Veteran Families (SSVF) program, which represented the first planned, national program to adopt housing stabilization as its core purpose.

There is limited research on RRH for single, but there is evidence of its potential promise as an alternative to emergency shelter. Findings from the SSVF program show that among single adult Veterans receiving RRH services, about 15% returned to a VA homeless program within a year [9] and the most rigorous study to date of RRH for single adults found that RRH recipients were less likely to return to shelter as compared to those who exited emergency shelter without RRH assistance.[10]

However, the availability of RRH for non-veteran single adults remains highly limited. In 2017, there were only 24,893 RRH slots available for single homeless adults. By comparison, there were more than nine times as many PSH beds (227,523), more than five times as many emergency shelter beds (133,344) and more than twice as many transitional housing beds (59,924) for this population.[5]

Adapting Critical Time Intervention to Expand RRH

Taking a CTI-based RRH intervention to scale would make for a sound and feasible policy response to crisis homelessness for three reasons. First, there is close alignment between the CTI and RRH conceptual and program models, thus facilitating the implementation of an integrated CTI-RRH model. Second, CTI has a strong evidence base as an effective intervention for reducing homelessness. Third, recent guidance issued by the Centers for Medicaid and Medicare Services (CMS) suggests that most of the services at the core of a CTI-based RRH program could be reimbursed by state Medicaid programs, thereby providing the necessary funding to

scale-up the approach with federal entitlement resources. We expand on each of these points below.

Alignment of CTI and RRH

RRH and CTI share nearly identical conceptual foundations and program models, as illustrated in Table 1. Originally developed for persons with serious mental illness leaving emergency shelter, CTI seeks to foster community-based supports for highly vulnerable individuals during periods of transition with the ultimate aim of helping them to obtain stability in the community.[6] From the outset, the intervention was intended to apply to persons exiting a range of institutional settings including those exiting psychiatric hospitals, incarceration, and homelessness.[6]

In its original design, CTI is comprised of three phases, lasting three months each and involving decreasingly intensive services. The first phase is the “transition” phase, which commences prior to a participant’s discharge from a shelter or other institutional setting. This phase focuses on putting in place a transition plan to connect participants to the people and service agencies that will provide them with the necessary supports for community living. During the second “try-out” phase, CTI caseworkers monitor how well the community based forms of support are working for the client and to make adjustments as needed. In the third “transfer of care” phase, the transfer of care from the caseworker to the community-based forms of support is completed.

For its part, RRH emphasizes helping households quickly exit homelessness and stabilize in housing in the community. The three core components of RRH are: 1) Housing identification, with the goal of helping participants find housing as quickly as possible; 2) Temporary financial assistance for move-in costs, security deposits, or short-term rental assistance; and 3) Case management services, with the goal of helping households stabilize in housing.[11] RRH is highly flexible and tailored to individual needs, and like CTI, RRH is also a time-limited intervention that generally lasts from three to nine months. In concept, RRH also follows a staged approach with the first stage focused on helping participants return to former housing or to obtain new housing; the second stage geared towards helping participants access necessary supports in the community including family, friends, and mainstream health and social services; and the third stage ending services when a participant is stably housed and no longer facing a serious risk of homelessness.

The alignment of the RRH and CTI approaches means that CTI could be easily adapted to fit into RRH programs serving persons experiencing crisis homelessness. In fact, some RRH programs have already integrated CTI into their program models,[12], as we describe in more detail below. Thus, prior work provides both proof of concept and a knowledge base that could be harnessed in a larger-scale expansion of a CTI-based RRH model.

CTI is an Evidence-Based, Cost-Effective Intervention

CTI is an evidence-based intervention, with several randomized controlled trials demonstrating its effectiveness in reducing homelessness among persons with serious mental illness.[13,14] When coupled with the temporary financial assistance that is an essential component of RRH,

CTI could multiply the impact of RRH programs on a dollar-for-dollar basis. Studies have also linked CTI with reductions in inpatient hospitalizations, outpatient mental health services, emergency department use, substance abuse treatment and public assistance.[6] This evidence is particularly relevant for our proposal, as such health services reductions could greatly reduce the net cost of CTI to Medicaid programs, or in some cases, generate net cost savings.

New Medicaid Opportunities

Recent CMS guidance has opened a window of opportunity for using Medicaid dollars to finance an expansion of an adapted version of CTI as a RRH intervention. In June of 2015, CMS issued guidelines on two allowable uses of Medicaid funds for housing-related activities.[15] The first are services that support an individual's ability to *transition* into housing, including the development of an individualized housing support plan, assistance with the housing search process, and assistance in supporting other details of the move. The second type of services were those focused on helping individuals *sustain* tenancy after moving into housing, such as tenant education, assistance in resolving landlord-tenant disputes, and linkages with community resources to foster integration and well-being.

As illustrated in Table 1, CTI and its key services fit within the scope of Medicaid reimbursable activities under the CMS guidelines. While the guidelines state that such services are only reimbursable for older adults or those with disabilities, they do not appear to require an individual to have a long-term disability. Therefore, the CMS guidelines could apply to a broader group of people, including those who are temporarily disabled by an acute substance abuse disorder and who are exiting residential substance abuse treatment or incarceration. Similarly, the guidelines could apply to those who may have less permanent or severe mental illnesses, such as post-traumatic stress disorder, stemming from domestic violence or untreated trauma exposures as children that render people with temporary or remediable functional limitations. This point is crucial, as the majority of persons experiencing crisis homelessness likely do *not* have a permanent disability but may meet a broader definition of disability. Moreover, CTI-based rapid rehousing could be argued as a medical necessity for such people because homelessness would otherwise threaten their ability to recover from these disabilities or succeed in treatment.

In states that have enacted Medicaid expansion under the *Affordable Care Act*, single adults experiencing crisis homelessness constitute one of the largest groups of those newly-eligible for Medicaid and a primary target population of the expansion.[16] Thus, Medicaid offers a new pool of previously unavailable federal entitlement resources to assist this population in regaining stable housing in the community and successfully recovering from mental illness and/or substance use disorders.

Opportunity and Impact

Implementing our proposal would have benefits at multiple levels. First, at the individual level, the housing stability and connections to community-based treatment and supports afforded by CTI would lead to improved health, social and economic outcomes for those receiving assistance. Research demonstrates that access to stable housing for persons experiencing

homelessness is associated a lower risk of mortality,[17] and that housing stability provides a platform for developing stronger social ties.[18] Moreover, prior studies have documented a link between CTI and reduced utilization of public assistance,[19] thus highlighting the collateral economic benefits and improved prospects for self-sufficiency among those receiving assistance. Second, the implementation of our proposal would have a number of benefits to society, the most notable being a substantial reduction in overall homelessness. Society would also benefit from the reduced utilization of emergency shelter, health services, criminal justice system resources, public assistance and other public services that have been linked with CTI.[19]

Implementation Challenges

From a practical standpoint, scaling up integrated CTI-RRH programs as a Medicaid reimbursed service would require addressing several challenges. These challenges include the need to appropriately tailor CTI for those experiencing crisis homelessness; having a trained workforce in place to deliver CTI-based RRH; determining the best mechanism for states to include CTI in their Medicaid benefit package; and resolving how to pay for the temporary financial assistance component of RRH. We outline each of these challenges below.

Tailoring CTI

CTI is flexible by design, and while it has been adapted for different populations, some fine-tuning of the model to tailor it to the needs of those experiencing crisis homelessness is required. Recent developments are promising in this regard. The Center for Advancement of Critical Time Intervention (CACTI), which has the explicit mission of supporting the broad dissemination of CTI, recently partnered with the National Alliance to End Homelessness on a pilot project to develop and test an adapted version of CTI for RRH in Connecticut.[12] This pilot resulted in the creation of a formalized program model of CTI for RRH, which has an explicit focus on housing stabilization.[20] In comparison to the original nine-month CTI model, the CTI for RRH model lasts for six months, although it envisions that the temporary financial assistance component of RRH could last for a shorter (or longer) duration. All RRH programs in Connecticut funded by the state's Department of Housing have implemented this CTI for RRH model and evaluation of its implementation is ongoing. Importantly, the pilot project developed training and implementation materials, including a manual outlining staffing structure, caseload sizes and program practices. These materials could be leveraged to disseminate the CTI for RRH model more widely, and the broader work of the pilot project could help localities and RRH programs address implementation challenges.

Training and Workforce Issues

A large expansion of a CTI-based RRH intervention would require training a large enough workforce capable of providing the intervention with adequate quality and fidelity. The training infrastructure available through CACTI could be harnessed and expanded to support this effort. Additionally, CTI training could be integrated as a core component of professional social work training and education. Such efforts might draw on the experiences in Finland, Germany and other European countries where "housing social work" is a distinct field of practice.[21] Housing social work focuses on securing housing, facilitating access to community resources,

and promoting integration for populations with complex needs. This field of practice does not currently exist in the United States, but adopting this framework could help expand the availability of a workforce equipped to provide CTI-based RRH.

Medicaid Challenges

In order to scale-up a CTI-based RRH program, states will need to determine how to redesign their Medicaid benefits to make CTI a covered service. In some states, CTI is already a covered service under the rehabilitation option of Medicaid. The aforementioned CMS guidance provides a number of other options states could pursue including several waivers (e.g. Section 1115 waiver) and state plan options (e.g. 1915(i) HCBS State Plan Optional Benefit). Incorporating a CTI-based RRH program as part of the services provided by Medicaid Accountable Care Organizations (ACOs) may be an additional avenue that states could pursue. ACOs are provider-led organizations that typically include a network of participating providers who receive a capitated per-patient payment to assume the full financial risk of meeting all of their members' care needs. ACOs share in any savings that materialize from their members making less costly use of care than expected.[22] More than a dozen states have implemented or are in the process of implementing Medicaid ACOs. Integrating CTI-RRH into ACO service packages would be consistent with their objectives and align with their incentives.

States will also ultimately have to issue regulations that would define what the reimbursable CTI service would be, who would be eligible for it, and what its reimbursement rate would be. Federal guidance on these issues could prove useful to states in amending their state Medicaid plans to include CTI, and would also help to ensure consistency of the program model across the country. Alternatively, states may have to take a leadership role and experiment with these options to demonstrate their value and effectiveness.

The question of resources also looms large. States may be reluctant to add an additional service to their state Medicaid programs due to budgetary concerns. Or, they may tightly restrict eligibility for CTI to certain groups, such as those with serious mental illness, which would render the majority of persons experiencing crisis homelessness ineligible for the service. Thus, where applicable, it will be important to maximize the federal participation rate for CTI so as to incentivize its large-scale adoption at a relatively lower cost to states.

Temporary Financial Assistance

Temporary financial assistance for housing related needs is an essential component of the RRH, but not CTI, program model. CMS has stated that federal funds cannot be used to directly pay for housing costs, [15] and it would therefore be a challenge to find resources to pay for the temporary financial assistance component of RRH.

The most obvious source of funding for this purpose would be federal homeless assistance dollars from the Department of Housing and Urban Development (HUD). HUD makes some funds available for RRH through its Emergency Solutions Grant program, and should our proposal be implemented, any increased HUD funding for RRH could be used exclusively for temporary financial assistance. Even absent more funding, the availability of CTI as a Medicaid

reimbursable service would allow existing HUD RRH dollars to serve a larger number of recipients. Likewise, were our proposal to reduce demand for emergency shelter and transitional housing programs, resources currently used to operate these services could be shifted to temporary financial assistance for RRH thereby creating a virtuous cycle in addressing homelessness.

A reallocation of existing homeless assistance resources may not be sufficient and alternative funding streams may be needed. One approach would be to use the state portion of Medicaid dollars to pay for housing costs, which could reduce the administrative burden of using Medicaid funds to pay for the CTI component of RRH and other sources to pay for the temporary financial assistance. States and localities could also consider setting aside some of the funds that are already directed to housing subsidies and the development of affordable housing, although the limited availability of such funds in most jurisdictions could affect the viability of such a strategy. However, states and localities could also consider expansions of general relief or general assistance programs to complement and coincide with the CTI intervention period.

Conclusion

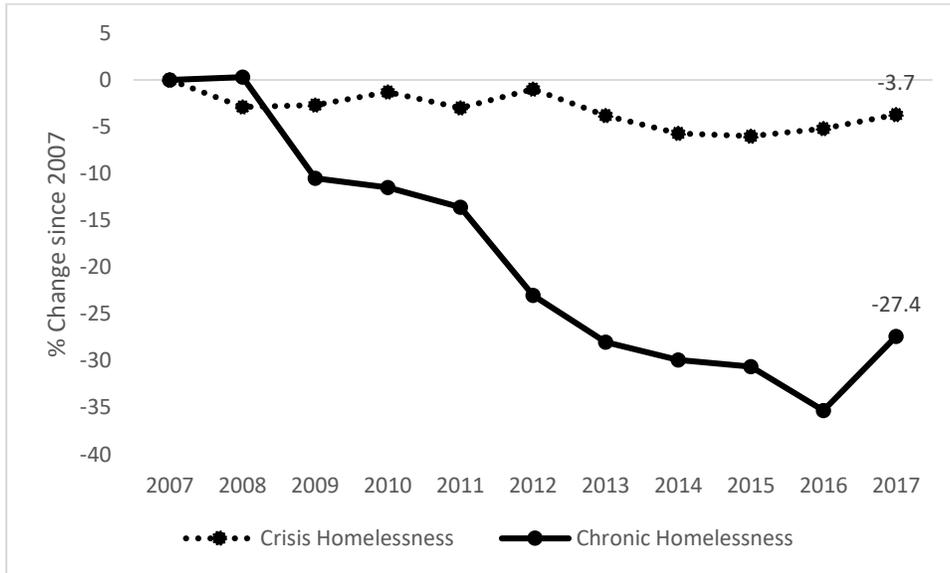
Leveraging Medicaid resources to pay for a CTI-based RRH offers an unprecedented opportunity to use funds from an entitlement source to implement a scalable solution to crisis homelessness. This proposal would allow the homelessness assistance system to be more effective in terms of stabilizing housing crises that lead to homelessness and extricating people from the potential downward spiral and negative impacts of homelessness. To ensure that this does occur, rigorous impact evaluation and model refinement are critical components of an expansion of integrated CTI/RRH programs. Of course, our proposal would not solve the broader problems of poverty and housing affordability that are ultimately at the root of homelessness, but it is not intended to do so, and addressing these issues will remain an ongoing challenge. However, as society has been willing to pay for emergency shelter and meal programs, perhaps it would be willing to pay for the emergency housing and relocation assistance that is far more humane, and can better avert the damage of homelessness.

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Figure 1- Percent Change in Point-in-Time Counts of Persons Experiencing Crisis and Chronic Homelessness, 2007-2017



Source: Author Calculations based on 2017 Annual Homeless Assessment Report to Congress, Part 1.

Notes: Number of persons experiencing crisis homelessness estimated by subtracting total number of persons experiencing chronic homelessness in each year from total number of persons experiencing homelessness as an individual. 2007 is base year.

Figure 2- Housing Stabilization as the Emerging Paradigm for Homeless Assistance Systems

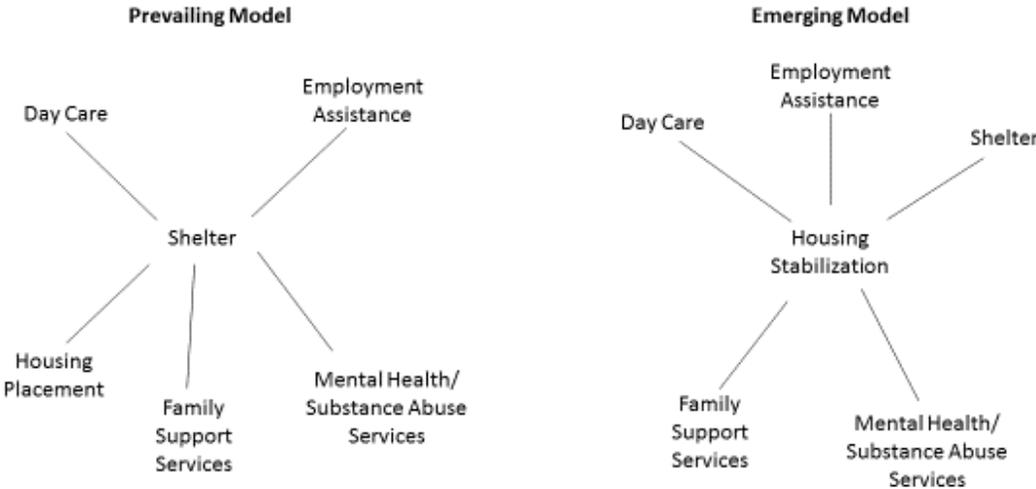


Table 1 – Alignment of Critical Time Intervention, Rapid Re-housing and CMS Guidance on Medicaid Coverage of Housing Related Activities & Services

	Critical Time Intervention	Rapid Re-housing	CMS Medicaid Information Bulletin
<i>Program Structure</i>	<ul style="list-style-type: none"> • Time-limited, flexible intervention focused on assisting persons forge connections to supports during period of transition • Three phases of decreasing intensity: <ul style="list-style-type: none"> ○ Transition phase: Establish connections to community-based supports ○ Try-out phase: Monitor strength of network of supports and adjust as necessary ○ Transfer of care: Complete transfer of care to community base supports & end services 	<ul style="list-style-type: none"> • Time-limited, flexible intervention focused on helping households exit homeless and stabilize in housing • Activities organized into three categories: <ul style="list-style-type: none"> ○ Obtain & move into housing ○ Support stabilization in housing through connections to community-based supports ○ Close the case once risk of homelessness is no longer imminent 	<ul style="list-style-type: none"> • Clarifies circumstances under which Medicaid funds can be used for housing-related services • Intended to help states design benefit programs that include housing-related activities and services
<i>Key Activities/Services</i>	<ul style="list-style-type: none"> • Case management providing flexible forms of assistance including: <ul style="list-style-type: none"> ○ Develop & implement plan to link client to family/friends, service providers and other supports ○ Mediate conflicts between client & family/other supports ○ Give support and advice to client and supports 	<ul style="list-style-type: none"> • Three key activities: <ul style="list-style-type: none"> ○ Housing identification (e.g. landlord recruitment & mediation, housing search assistance) ○ Case management focused on connection to community supports ○ Financial assistance for housing costs (e.g. security deposits, short-term rent, move-in costs) 	<ul style="list-style-type: none"> • Two types of individual-level housing-related activities & services: <ul style="list-style-type: none"> ○ Housing transition services that (e.g. develop individual housing support plan, housing search, assistance, assist with move-in) ○ Housing & tenancy sustaining services (e.g. tenant education, mediating disputes with landlords/neighbors, linkage with community resources)
<i>Target Population</i>	<ul style="list-style-type: none"> • Persons in periods of transition including those exiting: <ul style="list-style-type: none"> ○ Emergency Shelter ○ Psychiatric hospitalization ○ Incarceration 	<ul style="list-style-type: none"> • Those experiencing “crisis homelessness” including those whose homeless is triggered by: <ul style="list-style-type: none"> ○ Discharge from prison/jail ○ Discharge from detox /psychiatric hospitalization ○ Eviction 	<ul style="list-style-type: none"> • Persons with disabilities • Older adults needing long-term services and supports

		<ul style="list-style-type: none">○ Exit from foster care○ Dissolution of relationship	
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