EXECUTIVE SUMMARY

Central City Concern has been providing pathways to self-sufficiency through active interventions in poverty and homelessness since 1979. Our continuum of care serves an estimated 15,000 individuals per year through our Hooper Detoxification Center, Old Town Clinic, outpatient addiction treatment, 1,300 units of affordable housing, supportive housing case management and our WorkSource employment center. The majority of CCC's health service clients are uninsured. Last year only 15% of our 3 core health service program clients were insured, while an estimated 85% could qualify for federal disability benefits and other entitlements with appropriate and concentrated assistance. This proposal would enhance addressing the social determinants of health that face homeless, uninsured individuals, by creating a highly focused team of disability specialists, thereby dramatically improving their opportunities for healthcare and housing. Since 2002, the Federal Interagency Council on Homelessness has made ending homelessness a national priority. Since this initiative was launched, 53 States and Territories and 222 Cities across the nation have developed 10 Year Plans to End Homelessness. Portland's own plan, titled "Home Again," has made significant strides: however until this year a performance measure relating to acquisition of benefits and entitlements had not been developed. Because homelessness is one of the most negative and serious social determinants of health, addressing access to housing and health care are critical to its eradication. Our homeless experience multiple chronic health and mental health conditions that can lead to and result from the harsh reality of street life. They are our healthcare system's highest utilizers of emergency rooms and hospitals. This proposal would create an innovative Benefits and Entitlement Specialist Team (BEST) to provide the intensive and coordinated effort required for submitting medical evidence of disability and the extremely complicated applications to the Social Security Administration (SSA), and Medicaid and/or Medicare. This team will use the evidence base practice programming documented to have been highly effective in other communities to increase the number of homeless individuals receiving benefits and entitlements for which they are eligible. With eligibility comes greatly enhanced access to comprehensive health care, supportive services and special needs supported housing. CCC is requesting $121,470 in year 1 and $42,870 in year 2 for this project.

1) Explanation of the need for the project, including data or documentation and the extent of engagement with the community to be served. Homelessness is an extreme and often lethal social determinant of health. Approximately 17,000 individuals are estimated to be homeless in Multnomah County each year.[1] A conservative 39% are estimated to be eligible for Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) and Medicaid based on their mental illness and 46% based on their physical health conditions, but **only 11% receive these benefits**. [2] Given the multiple chronic health conditions leading to and resulting from homelessness, acquisition of benefits and entitlements for these most vulnerable citizens is critical. It provides them access to the continuous and comprehensive healthcare and supported

[1] Home Again: A 10-Year Plan to End Homelessness in Portland and Multnomah County, 12/04,
[2]GAO Study, 2000

services needed to stabilize and improve health outcomes and promotes eventual self-sufficiency.

Central City Concern's (CCC) data show that in fiscal year 2006, our health services provided 73,272 encounters to 4,528 different homeless individuals. Of those, 2,853 (63%) were uninsured. Within just the Old Town Clinic, CCC Outpatient and Intensive Case Management services we saw 2,695 of these individuals in 43,934 encounters. The uninsured figures are even more alarming for this subset; only 15% had Medicaid, Medicare or some kind of private insurance and only 23% of encounters were reimbursed through these programs. Given national estimates that 85% of these individuals could qualify for benefits, using the formula above, 2,290 of these clients are in need of the intensive assistance required to secure SSI/SSDI and Medicaid/Medicare. These numbers only reflect CCC. There are a number of other agencies serving this population who voice the same disparity between those who are insured and those who are not, but who would qualify if a team of specialists were dedicated to the effort. JOIN, a homeless street outreach and service provider estimates that 70% of their 542 clients last year were uninsured. Additionally they are supplying a letter of support for this application.

The recognition of this unmet need has been a part of Federal, State and local efforts. In 2002 the Interagency Council on Homelessness (ICH) was assigned new leadership with the Bush appointment of Phillip Mangano as its leader. This Council brought together 20 federal agencies to dedicate an effort to ending chronic homelessness. The Social Security Administration (SSA), Health and Human Services, Housing and Urban Development, the Veteran's Administration and the Department of Labor were key participants, setting aside $55,000,000 targeted at this effort. Of these funds, SSA funded 40 projects around the country dedicated to expediting acquisition of benefits and entitlements and communicated to their field offices to do everything they could to assist homeless applicants in expedited processing. An application for SSI/DI is very complicated and lengthy, with the average length of time for those who are lucky enough to have been able to piece together documentation of disability taking two years or more. Only 10-15% of those who apply are approved on initial applications. SSA's dedication of these funds (the "HOPE projects") communicated publicly their acknowledgement of how difficult the process is for the most vulnerable, disorganized and marginalized: our homeless citizens.

The efforts moved to cities around the country with the ICH's endorsement of convening 10 Year Plans to End Homelessness. Portland's own plan was approved by City Council in 2004 and is named "Home Again". The Plan includes 10 areas of focus to ending homelessness, none of which specifically mentioned the need to assist individuals in securing benefits and entitlements. In this third year of the 10 year plan, the "Home Again" Coordinating Council adopted a measure for this area and requested the SOAR Workgroup to address this issue. The SOAR Workgroup had been assembled in January, 2006 when Oregon was selected as one of 10 States to administer a new project titled SSI/SSDI Outreach Advocacy and Recovery (SOAR) which provided technical assistance to develop 4 State-wide trainers to educate community homeless providers on how to successfully prepare a strong SSA application. The training has been provided to 237 service staff across the State, with one of the trainers being Central City Concern's

Mellani Calvin who will be the Team Lead of this project. Information disseminated was well documented and established the best practice approach of securing benefits and entitlements in an expedited manner based on the impressive successes of key projects. One of these was the SSA-funded project operated by Denver's Colorado Coalition for the Homeless. In just 3 years, this program served 1000 homeless individuals with a 70% rate of award. While the SOAR initiative came out of the need to educate communities how to achieve these same measures, it did not fund staffing capacity within agencies to dedicate the team of specialists required in the Denver project. The need for this grant is huge, given the numbers illustrated above.

Since August this local SOAR Workgroup has met with congressional delegates from Wu, Wyden, Blumenauer and Smith's offices to secure their support of this effort. Each of these Senators and Congressmen committed to send letters of support to SSA Region 10 which is responsible for the states of Oregon, Washington, Alaska and Idaho. On August 14th the SOAR Workgroup met with key administrators from Region 10, Oregon SSA, and Disability Determination Services (DDS) to request their support and active involvement with this effort. The response has been favorable and a letter of support from Region 10's Commissioner, Don Schoening is included in this application. There is every indication that they will work collaboratively with this project to expedite processing of applications for these clients.

Regarding the extent of engagement with the community to be served, CCC has been working to end homelessness in Portland for almost 30 years and has significant experience addressing the negative social determinants of health with this population. Our unique continuum of services – affordable supportive housing, primary and behavioral healthcare, addictions treatment, recovery support, and employment services – offers a path out of homelessness and into self-sufficiency and active citizenship. CCC's integrated services touch an estimated 15,000 lives each year. Key to this agency's efficacy is the fact that we are the largest employer of formerly homeless individuals in the state. Seventy percent of our 450 employees are in recovery from addiction disorders, many of whom graduated from our services. So the community representing those to be served is extremely engaged. Additionally, CCC has a Consumer Advisory Council that meets monthly to discuss the needs of the target population and we operate a consumer drop in center where clients of our chronic homeless initiative gather and participate in conversations about services. Both of these constituents fully support this effort and many of them await the support that this program will provide. Most recently, CCC was asked to host the Governor's Ending Homeless Advisory Council and convene a panel of clients to share their experiences and obstacles in ending homelessness. Eleven panelists from 5 different CCC programs spoke at length about their stories, most of them referencing frustrations and despair over the SSI/SSDI application process. One client shared that the security officers at the local SSA office won't even allow you in the SSA office without an ID, however the majority of homeless individuals are without ID as a result of their life on the streets. The homeless community is very supportive of this effort and will play an important role in the oversight of this program.

2) **Clear articulation of your strategies to meet this need by addressing social determinants of health, including your goals, objectives, and methods.** The efforts of

this project will immediately address the multifaceted social determinant of health which is homelessness. The condition of homelessness often results in or is accompanied by complex and multiple chronic health conditions. End-stage liver disease, hypertension, dental disease, tuberculosis, emphysema, diabetes, vascular disease, organic brain syndrome, Hepatitis C, cancer and HIV/AIDS are just a few of the conditions prevalent and these conditions are frequently accompanied and compounded by substance abuse, mental illness, and trauma. Furthermore, homelessness is a social determinant of the health of this community and every community. By creating greater health equity, we create a healthier community.

The BEST team will implement the SOAR best practice model to assist eligible applicants in securing their benefits and entitlements in an expedited manner. Sixty percent of those served are expected to be awarded Medicaid/Medicare and SSI/DI, thereby making their access into fully comprehensive health care guaranteed. Eligibility also provides access to special needs supported housing funded through federal HUD and HHS grants.

GOAL, OBJECTIVES AND METHODS IDENTIFIED FOR THIS PROJECT ARE: The goal of this project is to successfully and quickly connect homeless individuals to the benefits and entitlements for which they are eligible in order to improve their access to comprehensive healthcare, supportive services and housing.

Objective 1: Secure a Memorandum of Understanding between CCC and SSA and DDS that documents the partnership commitments. Activities used to meet this objective will be to a) continue meeting with Region 10 and Oregon DDS to review the Denver MOU and to adapt it to a collaborative committement locally and b) convene a BEST monthly Advisory Committee attended by all partners (CCC BEST team, JOIN, SSA, DDS Manager, and DDS Analyst).

Objective 2: Implement SOAR model. Activities that will lead to this end will include a) recruiting and training the additional staff funded through this effort b) identifying medical providers to be trained in the documentation of disability narratives, c) training medical providers via Oregon DDS and the National Health Care for the Homeless who have recently launched the provider training campaign on this issue.

Objective 3: Process 120 applications per year by end of year 2. Activities will include a) recruiting eligible applicants through the Old Town Clinic and CCC service programs, b) working intensively with clients on the application process, including collection of medical records and disability history, c) filing Medicaid/ Medicare applications, d) working closely with SSA and DDS on building the application and e) working closely with identified and trained medical providers on documenting disability.

Objective 4: Disseminate findings to the broader community. Activities that will be designed to meet this objective include a) continuing to convene the monthly Portland SOAR Workgroup which currently represents 20 stakeholder groups, b) preparing semi-annual progress reports to be distributed to Federal, State, County and City officials documenting challenges and achievments.

Outcomes anticipated:

Achieve a 60% rate of SSI/DI and Medicaid/Medicare award by the end of year 2.
Achieve a 60% rate of placement in housing for those enrolled.

Achieve a 60% rate of retention in housing.
80% of applicants who do not have a medical home will establish one through CCC.

3) **Clear statement of the timeline for achieving your goals and objectives.**
The timeline that follows on the next page illustrates the sequencing of activities to meet the above identified goal and objectives.

4) **Description of your organization, including a summary of its background, purpose, and experience in the area for which funds are sought. If other organizations will be partnering with yours in support of this project, please describe their roles and experience as well.** As noted in **Question 1**, CCC has been providing services to the homeless for nearly 30 years and serves an estimated 15,000 unduplicated homeless each year through any number of its programs. The following illustrates our background, purpose and experience.
Central City Concern Health Services, a Federally Qualified Health Center:
   - **Old Town Clinic (OTC):** This homeless primary care clinic served 2,319 individuals last year and is located at the corner of 8th and West Burnside.
   - **CCC Recovery Center**: Outpatient addiction treatment was provided to 637 homeless individuals last year.
   - **The Hooper Memorial Detoxification Center**. Fifty-four Subacute medical detoxification beds serving over 2,000 individuals each year. Hooper is the County's public inebriates service with a sobering program and an outreach van.
   - **Community Engagement Program:** Multi-disciplinary team providing intensive case management, mentoring, mental health, and supportive permanent housing for 300 plus chronically homeless individuals each year.
   - **Mentor Program:** Pairs 50 newly recovering homeless addicts with experienced Mentors in recovery from addiction, providing intensive support during an individual's first weeks in treatment.

West Portland WorkSource: This Workforce Investment Act funded program brings together under one roof a full array of training, education, and employment programs and served over 2,000 individuals last year.
CCC business enterprises: Employs 70 formerly homeless people new to recovery through a thrift store, a painting company, a property maintenance crew, Downtown Clean and Safe and a janitorial business.
CCC Housing: CCC operates several government-funded programs targeted specifically to homeless people, including:

- 230 units of Transitional Alcohol and Drug Free Community (ADFC) singles housing
- 326 units of Permanent ADFC singles housing
- 89 units of Permanent ADFC family housing
- 128 units of ADFC housing for individuals involved in Multnomah County Community Justice
- 50 units of housing for veterans involved in the WorkSource Program

BEST Implementation Timeline	**Project Manager**	**Team Lead**	**Medical Direct**	**OTC Dir.**	**Partners (DDS, SSA,)**	**Qrt 1**	**Qrt 2**	**Qrt 3**	**Qrt 4**	**Yr. 2**
Objective 1: Secure MOU 1.a Meet with SSA Region 10 and OR DDS	P				S	X				
1.b Develop an agreeable MOU	P				S	X				
1.c Convene project Advisory Board	P				S	X	x	x	x	xxxx
Objective 2.0:Implement SOAR model 2.a Hire and train BEST team	S	P				X				
2.b Identify medical providers to be trained	S		P	A		X				
2.c Provide training by DDS and HCH	A	S			P	X				
Objective 3.0: Process 120 application per year by end of year 2										
3.a Recruit eligible applicants through CCC	A	P	S			X	x	x	x	xxxx
3.b BEST staff document cases of disability using SOAR principles	A	P	S		A	X	x	x	x	xxxx
3.c File Medicaid/Medicare applications	A	P	S			X	x	x	x	xxxx
3.d Work closely with SSA and DDS on completion of application	A	P			S	X	x	x	x	xxxx
3.e BEST staff work closely with trained providers	A	S	P		A	X	x	x	x	xxxx
Objective 4.0: Disseminate findings to the broader community.										
4.a. Continue to convene monthly Portland SOAR workgroup	P	S				X	x	x	x	xxxx
4.2 Generate and disseminate semi-annual reports documenting progress	P	S			A		X		x	x x

Key: P= Primary responsibility; S= Secondary or Shared responsibility; A= Advisory capacity	**X** = event or onset activity x= ongoing activity

- 108 units of housing for individuals enrolled in Community Mental Health Programs; and
- 392 units of non-program affordable housing units.

Experience relating specifically to benefits acquisition consists of current CCC Benefits Specialist Mellani Calvin, one of the four State-wide SOAR trainers, and Project Manager, Rachel Post who was the Denver SSA HOPE Project Director and oversaw implementation of that program for its first 18 months. More detailed information related to their experience is addressed in **Question 5** below.

Other partners, as noted in the Letters of Support are SSA Region 10, Oregon DDS and JOIN. SSA and DDS have successfully partnered in this kind of collaboration in 40 SSA funded HOPE programs, including the highest performing project in Denver that has processed 1000 applications with a 70% award rate since 2004. This project succeeded in decreasing the processing time from 1-2 years down to 60 days. Their record for time between submission of application and award was 2 weeks! JOIN has been providing services to homeless since 1992, placing 350 street homeless in housing each year. JOIN has been an active partner with CCC on the chronic homeless initiative. Many of their clients are enrolled in CCC housing and will qualify for the services provided by this team.

5) Names and qualifications of the people involved.

Rachel Post, L.C.S.W., Director of Supportive Housing and Employment will contribute 20% FTE to the oversight and management of this project. Ms. Post has been practicing social work and social work administration for over 13 years and has been the Project Director on numerous federal, county and city grants. While at CCC between 2001-2003, she brought the concept, design and implementation of an intensive case management model to the organization and was the principal author for the $3.5 million Interagency Council on Homelessness Chronic Homeless Initiative (ICH/CHI) grant awarded to CCC in 2003. She then moved to Denver, Colorado where she was the Director of Substance Treatment Services, Outreach and Community Resources at Colorado Coalition for the Homeless (CCH). In this position, she was named the Project Director on the ICH/CHI awarded Denver Housing First and also served as Project Director of the SSA HOPE grant which assisted homeless individuals in an expedited SSI application process and whose success is cited in this proposal. Ms. Post returned to CCC in 2006 and currently oversees a staff of 55 and a budget of $3.5 million.

Mellani Calvin, who currently works as a Benefits and Entitlement Specialist for CCC's Community Engagement Program has been assisting people through the SSI- SSD application process for over six years. Ms. Calvin will serve as a full time Team Lead on the BEST grant, responsible for hiring, training and supervising staff. As a Social Security Disability paralegal for three and a half years prior to her employment with CCC, Ms. Calvin worked on over 700 claims. Since her tenure at CCC in January, 2005 she has represented and/or consulted on 225 cases. Of the 225 cases she has worked on, 92 are still pending approval for benefits, 80 have been approved already and 50 cases were closed. Ms. Calvin's efforts have been so well recognized that in December, 2005, she was invited to become one of Oregon's four trainers for the *SSI-SSD Outreach, Access and Recovery* (SOAR) curriculum for social workers and case managers sponsored by the federal Substance Abuse and Mental Health Services Administration (SAMHSA). Since that time she has provided 5 trainings in the northern half of Oregon to over

100 case mangers. Ms. Calvin was just awarded the 2007 Mental Health Award of Excellence from the Oregon Addiction and Mental Health Services Division for her work in this area.

Ted Amann, MPH, RN, is the Director of Healthcare and Improvement for Central City Concern in Portland, OR. Mr. Amann will be providing 10% FTE to this project. He oversees healthcare for the homeless services at Old Town Clinic and the Recuperation Care Program, and quality management for all CCC health and recovery services. Ted is recognized as an expert in the area of integrating primary care and behavioral health services, and has worked in clinical, regulatory, and managed care settings. Ted serves on the board of directors for the Addiction Counselor Certification Board of Oregon (ACCBO). Ted has a MPH in Health Management & Policy from Portland State University, a BA in Psychology from Grinnell College, and an AAS in Nursing from Community College of Philadelphia.

Rachel Solotaroff, MD, serves as the Medical Director at Central City Concern Health Services and will provide 10% FTE to the coordination of medical reviews for this project. Dr. Solotaroff maintains an assistant professorship in the Division of General Internal Medicine and Geriatrics at Oregon Health and Science University, and is the co-founder of the Division's award-winning Social Medicine Curriculum, in partnership with Central City Concern. Prior to coming to CCC, Dr. Solotaroff completed an Ambulatory Care Fellowship at the Portland VA Medical Center, where her research focused on the impact of unstable insurance on low-income individuals with chronic illness, focusing on the domain of self-management. Dr. Solotaroff did her medical training at Dartmouth Medical School, and completed a residency in Internal Medicine at the University of Virginia. She has served as Medical Director of the Charlottesville Free Clinic, and currently works as a volunteer for the Wallace Medical Concern in Portland.

6) **Comments on past or present attempts by your organization and others to address the designated need, if applicable, and what you learned from these efforts.**

CCC has been addressing the issue of the uninsured since its inception in 1979. Our full continuum of care provides services to an estimated 15,000 unduplicated individuals each year. During the height of the Oregon Health Plan, 65% of CCC's clients were insured. Since its drastic cuts, only 15% of CCC's core health care service recipients are insured. Concentrated efforts targeted to assisting individuals through the complicated process of accessing disability benefits and entitlements were first funded at CCC in 2003 with the award of the $3.5 million Collaborative Initiative to Help End Chronic Homelessness grant. This project was designed to serve and house 100 chronically homeless individuals and of the 10 person service team, 1 (Mellani Calvin) was dedicated to this effort. Ms. Calvin generated an impressive effort, serving 222 individuals since inception and securing awards for 80. However, given the unmet need documented in **Question 1** above and the latest information on evidence based practice approaches documented in many communities across the nation, CCC, the City of Portland and community stakeholders now recognize that reinforcements are needed to adequately address and resolve this critical component necessary for truly ending homelessness.

7) **Proposed methods for evaluating the impact of your program, including the resources necessary to carry out the evaluation.**

BEST will use the same methods of evaluation used by Denver's Colorado Coalition for the Homeless and will track the following data elements:

- Demographics: Age, Gender, Race, Ethnicity, Marital Status, Language, Housing status, Disability type
- Date of enrollment
- Date of medical documentation of disability by CCC
- Date of application submission
- Date received by Disability Determination Services (DDS)
- Name of DDS analyst
- Date of decision
- Decision outcome: Approved or Denied
- Date of request for Reconsideration
- Date of decision
- Decision outcome: Approved or Denied
- Date of request for Appeal Hearing
- Date Hearing scheduled
- Hearing Decision
- Total face to face encounters
- Total collateral encounters
- Type of encounter: Medical, Application preparation, Outreach, Accompanying to appointments.

The Clerical/Data Specialist funded through this grant will maintain these data fields and they will be used as a feedback loop to inform quality improvement activites to both the team and the monthly Advisory Committee comprised of CCC, JOIN, SSA and DDS. This information was critical to refining the process in the Denver program and will be essential to recording the efforts needed to document efficacy. Additionally this data will inform where we are with the outcomes identified at the end of **Question 2**.

8) **Plan for how lessons learned will be shared with policy makers and the broader community, if relevant.**

Given how much attention has been generated by the SOAR Workgroup's efforts to become a part of Portland's 10 Year Plan to End Homelessness, it is fully anticipated that this program will become very high profile. We currently have the attention of City Commissioner Erik Sten, Congressmen David Wu and Earl Blumenhauer, Senators Gordon Smith and Ron Wyden, SSA Region 10's Commissioner Don Schoening and most recently, Multnomah County Department of Human Services. The information gathered by this project will be shared with each of these stakeholders and will be reported in each semi-annual "Home Again" report generated by the City. Presentations on the efforts will be included in the state-wide SOAR trainings and at the monthly city-wide Coordinating Council to End Homelessness meetings. Local hospitals, with whom CCC currently partners on a respite program will also be included in the dissemination of findings, as they stand to gain significantly by seeing their most frequent admittants secure Medicaid and Medicare. Each of our local hospital systems has stated that they lose millions of dollars each year in unreimbursable services to the uninsured.

9) **Explanation of your strategy to fully fund this project, and what role KPCF funding would play in this strategy.**

The KPCF funds will fund 40% of the total project while the other 60% will be provided using existing internal resources within CCC, such as space, materials and supplies, and project

management. The KPCF funds will fund the Team Lead for year 1, the Clerical/Data Specialist for 2 years and the medical provider time for year 1. In addition to these staffing positions, an exisiting 5 year grant will fund a full time Benefits Specialist and funding provided through Multnomah County Human Services will fund a half time Benefits Specialist for a minimum of 2 years. Year 2 funding for the Team Lead and the medical provider is expected to be covered through Medicaid reimbursements for those who become qualified. CCC's Federally Qualified Health Center designation authorizes us to be reimbursed at a rate of $200 per encounter. The BEST team will strive to secure benefit and entitlement awards for 72 people a year. If each of those people has only 7 billable encounters per year, that will generate a revenue of $100,800 per year, more than enough to cover the costs of the Team Lead and medical provider time. Any additional revenue will be used to expand the program's capacity.

10) Explanation of how the benefits of the project will be sustained after the KPCF grant has ended.

Sustainability beyond the KPCF grant is expected to occur as a result of dissemination of successful program outcomes and through the increasing Medicaid revenue generated by assisting more individuals to become qualified for Medicaid and Medicare. Local and state policy makers will learn the impact acquisition of benefits and entitlements makes to ending homelessness and stabilizing health conditions through improved access to treatment and services. We will work with our 7 hospital partners who currently fund respite care to encourage them to dedicate funding to the expansion of the BEST team and we will continue to approach the City and County for funding targeted to this effort. The need is great and the impact of funding BEST programming will clearly reduce the total cost burden of these highest emergency health service utilizers on local General Funds, State General Funds and Hospital systems.