

**Projects for Assistance in Transition  
from Homelessness (PATH)**

State of Iowa  
Site Visit

September 9 – 11, 2008

*Submitted by:*

**AFYA, Inc.  
And  
Advocates for Human Potential, Inc.**

*Submitted to:*

**Substance Abuse and Mental Health Services Administration  
Center for Mental Health Services**

## Introduction

The Center for Mental Health Services (CMHS) contracted with AFYA, Inc., to conduct site visits to States to monitor the administration and operation of the Projects for Assistance in Transition from Homelessness (PATH) program. AFYA has contracted with Advocates for Human Potential, Inc. (AHP) to coordinate the site visits with supervision and oversight by AFYA. Prior to the site visits, the AFYA/AHP team, in cooperation with HPB staff, reviewed the voluntary performance goals and revised the site visit protocol, selected site visit team members, provided site visit team training, and selected six states to be visited this fiscal year.

The Iowa site visit was conducted August, by Deborah Stone, CMHS/Homeless Programs Branch, and Ann Denton, Advocates for Human Potential. The site visit included meetings with the State PATH Contact, Becky Flores, and local administrators and providers.

Observations from the site visit were collected and organized using five voluntary performance goals approved by CMHS in September 2003. This methodology allows teams to examine the performance of the State and its contracted providers in a comprehensive and standardized way, and offers the opportunity to discuss best practices within PATH. This report uses these goals as the basis for summarizing the interviews with State staff and the interviews and observations made at each of the PATH provider organizations.

This report describes the State's performance in administering the PATH program. All formal recommendations are directed towards the State rather than to providers.

## State of Iowa – PATH Site Visit Schedule

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|--|---|
| Day 1: Tuesday, September 9, 2008 Cedar Rapids and Iowa City providers |   |
| 8:00 – 9:00  | Abbe Center<br>Meet with Administrator – Cindy Kasetner               |
| 9:00 – 9:30  | Meet with Joe Zito, PATH Outreach Worker                              |
| 9:30 – 11:30   | Staff Shadowing   |
| 11:30 – 1:00   | Lunch and drive to Iowa City  |
| 1:00 – 2:00  | Mid-Eastern Iowa Community Mental Health Center<br>Administrator: TBD |
| 2:00 – 3:00  | Meet with PATH funded staff   |
| 3:00 – 4:30  | Drive to Des Moines   |
| Day 2: Wednesday, September 10, 2008                                   |   |
| 9:00 – 11:00   | Meeting with Becky Flores   |
| 11:00 – 11:30  | Meeting with either Lyle Schwery or Eileen Mitchell                   |
| 11:30 – 1:00   | Lunch with key stakeholders   |
| 1:00 – 2:00  | Meeting with Lyle Schwery or Eileen Mitchell                          |
| 2:30 – 3:30  | Consumer Focus Group (Primary Health Care)                            |
| 3:30 – 4:30  | Debrief from Day 2  |
| Day 3: Thursday, September 11, 2008                                    |   |
| 8:30 – 10:00   |   |
| 10:00 – 10:30  | Meeting with Allen Parks (state offices)                              |
| 10:30 – 12:00  | Primary Health Care Administrator Interview, Bobbretta Brewton        |
| 12:00 – 1:00   | Lunch   |
| 1:00 – 2:30  | Staff brief interview and staff shadowing                             |
| 2:30 – 3:00  | Ann and Deborah meeting   |
| 3:00 – 4:00  | Site visit debriefing   |

## Description of State

The State of Iowa is comprised of 99 counties spanning 55,869 square miles, and is the 26<sup>th</sup> largest state in the country. According to estimates done by the Census Bureau in 2004 and 2006, Iowa has a population of 2,982,085 with 10.5 percent of its people living below the federal poverty level.

*Mental Health Services:* Iowa's Division of Mental Health and Disability Services (MHDS) is administered through the Department of Human Services (DHS). The public system of mental health and disabilities care in Iowa provides a safety net for the uninsured or those who do not have available to them commercial health insurance benefits coverage to meet their needs. This public system in Iowa includes the MHDS, the services provided by the ninety-nine (99) Iowa counties through a wide range of community providers, services offered by community mental health centers, services offered by and funded through school districts, Area Education Agencies (AEAs) and the Department of Education, Child Health Specialty Clinics and substance abuse services funded through the Department of Public Health, and public facilities such as mental health institutes and resource centers.

A large portion of the public system is federally funded through Iowa's Medicaid entity - the Iowa Medicaid Enterprise (IME). Magellan Behavioral Health has a "carve out" to fund behavioral health and substance abuse services. Some federal grants support parts of this public network. Each county determines level of service. A study in 2004 showed that of all dollars in Iowa's disability system (about \$800 million in 2002), federal spending accounted for 42 percent, state 38 percent and county 20 percent.

Most of those persons served by the Iowa public mental health and disability service system have serious mental illness or severely disabling conditions, and often as a result of their disabilities, end up poor and dependent on the public system. Last year 50,400 adults with disabilities were served by the counties. The total includes 25,500 who have mental illnesses, and 12,400 who are chronically mentally ill.

*Homelessness:* According to the 2005 Iowa Statewide Homeless Study, just over 21,000 Iowans were homeless, the most concentrated areas being the twelve most urban counties which had over 500 homeless persons. Polk County had the largest homeless population in the state, with almost three times more homeless persons (6,008) than the county with the second highest number of homeless, Scott County (2,298).

Families with children make up the majority of all homeless households in Iowa. Reflecting this shift, women are more likely than men to be homeless and minority groups have increased as a share of the homeless population. Almost one-fifth of homeless men in Iowa are veterans.

In particular, African-Americans are significantly overrepresented in Iowa's homeless population. While making up only two percent of the state population, black Iowans

make up almost one-quarter of the homeless. In addition, the majority of homeless African-Americans and Hispanic households have children compared to only 36 percent of white, homeless households. Homelessness is overwhelmingly white in rural areas. As urbanization levels increase, the percentage of the homeless who are African-American dramatically increases.

About 40 percent of homeless persons had a mental health problem, substance abuse problem or some other disability. It is estimated that 4,596 persons are PATH-eligible (serious mental illness or co-occurring disorder).

The economic mismatch between earnings and housing costs appears to be of overwhelming significance. Homeless households and service providers concurred that domestic violence, unemployment, low-wage work, and the inability to find affordable housing were the most significant factors contributing to homelessness.

The report suggests several contributing factors and causes for Iowa's homeless. Family breakup was perceived as the most significant factor contributing to homelessness across Iowa, and substance abuse was the top ranked factor in rural counties and ranked second overall. The inability to find affordable housing and unemployment/job loss were also very significant factors, especially in metropolitan areas. The lack of living wage jobs and affordable housing were seen as the most significant barriers to resolving homelessness across Iowa.

A significant factor affecting many communities in Iowa is the damage and ongoing disaster relief efforts following the spring floods this year. Over several weeks, communities throughout Iowa were flooded, including all three communities visited on this site visit. Cedar Rapids had the worst damage, with ten square miles of the city center affected by the floods, ten thousand people temporarily displaced and City infrastructure flooded, including City Hall, the Public Works Department, Police Department and Fire Department. Iowa City also had significant flooding, with major damage to portions of the University of Iowa and destroyed an estimated 500 units of affordable housing. In Des Moines, an estimated 90% of the homeless encamped in wooded areas were flooded out. Overall, 83 of 99 counties in Iowa were declared disaster areas, and the state sustained \$7 billion in damages.

In Cedar Rapids, two emergency shelters were destroyed and will not re-open, and Geneva Towers, a HUD-funded transitional living property was evacuated and flooded. It is scheduled to re-open in October, 2008.

## State of Iowa: Voluntary Performance Goals

### **Voluntary Performance Goal 1: Services are targeted to literally homeless people**

According to Annual PATH report data, PATH providers are meeting the state requirement that at least 50% of persons served are literally homeless. This is important, as it helps ensure that PATH funds are used for people who have been lost to the mainstream MH system, as well as helping link PATH eligible persons to HUD-funded programs.

The site visit team observations confirm that, at the three sites visited and by report from the Davenport outreach worker, literally homeless persons are contacted, engaged and served. Primary Health Care workers in Des Moines are working exclusively with the literally homeless population (although there are data issues, described below).

Abbe Center for Community Mental Health (Cedar Rapids) and the Community Mental Health Center for Mid-Eastern Iowa (Iowa City) accept referrals from psychiatric beds in general hospitals and from state hospital. Joe Zito, outreach worker from Abbe Center attends discharge planning team meetings and provides services to homeless persons exiting from inpatient psychiatric units. Christine Drum in Iowa City works with people exiting the psychiatric hospital in Davenport. These hospital discharges help account for persons enrolled in PATH who are not part of the literally homeless group.

Iowa has three Continuum of Care planning groups: Des Moines/Polk County; Sioux City/Dakota Woodbury Co., and Balance of State (BOS). Cedar Rapids and Iowa City PATH-funded staff participate in the BOS planning process. PATH-funded staff from Primary Health Care in Des Moines participate in that planning process. The State PATH Contact maintains contact with all three planning groups. In addition, Iowa City has a local Homelessness Coordinating Board, which is a group of providers working on coordinating services. The Homelessness Coordinating Board organizes events such as a “sleep out” to raise awareness and funds.

One barrier to ending homelessness for persons with mental illness is the structure of the mental health system itself. As noted above, access to Medicaid funded mainstream mental health services is controlled by Magellen Behavioral Health on behalf of the state. This is one layer of services. MHDS funds a network of private non-profit providers. These providers do not have to adhere to a standardized, minimum package of services, and so the type and quantity of services available in one community might not be equally available in another community. Case management/case coordination is provided by counties, by the DHS, or by regional consortium, but is NOT usually provided by community mental health centers. Beyond this disjointed system within publicly funded mental health services, there is a notable lack of coordination with the substance abuse treatment system. Finally, there are access and eligibility issues with other mainstream

systems, such as housing.

### **Voluntary Performance Goal 2: Active management and oversight of the program**

The site visit team finds the Iowa PATH program to be a model of state level organization, coordination and management. The state provides a high level of leadership for the PATH program. Commendable activities include:

- *Quarterly provider meetings:* These meetings have fostered a helpful interchange among providers, and offer an opportunity to identify and address system barriers to ending homelessness. The meetings help develop a PATH program identity for programs across the state and have allowed PATH providers to develop shared goals and strategies. In addition, the quarterly provider meetings are used by providers to brainstorm solutions to specific consumer situations. For example, the Des Moines provider is working with a Canadian citizen who needs documentation and assistance, and consideration of this problem at a quarterly meeting led to several good ideas that may result in the individual receiving assistance.
- *Competitive Proposal Process:* The competitive Request for Proposals process has several good effects: it is an opportunity to adjust the PATH program activity and focus to respond to changing needs in the state. It also helps to focus provider attention on performance measures, in an effort to remain competitive in the process.
- *Iowa Institute for Community Alliances/HMIS:* The state provides funding to the Iowa Institute for Community Alliances to support the Homeless Management Information System. The site visit team met with Eileen Mitchell and David Eberbach from that organization and reviewed HMIS procedures. Iowa's Annual PATH Report is generated from the HMIS system, which is very progressive and beneficial to the development of an annual Report to the Governor. It allows state decision makers to have access to service and shelter use data for the entire state. The practice of generating PATH data from the HMIS system helps portray a more comprehensive picture of homelessness, encompassing both HUD and SAMHSA funded programs.
- *Data Collection Procedures:* MHDS has provided written clarification to providers regarding enrollment in the PATH program. The state has directed PATH providers to count as enrolled only those persons who have accepted services and provided written consents. While there is more work to be done in this area, the leadership on this issue is commendable.

### **Voluntary Performance Goal 3: Clarity regarding data and reporting**

As noted above, statewide compliance with HMIS and the use of the ServicePoint data to generate the Annual PATH report is commendable. That said, there are a few challenges regarding data and reporting.

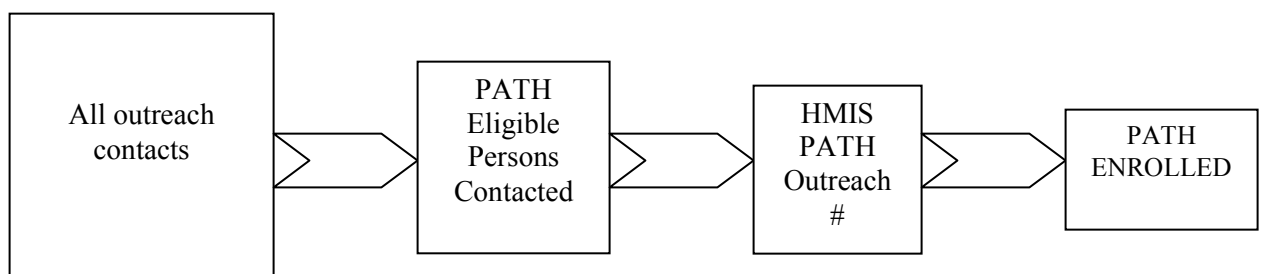
PATH providers and Iowa Institute for Community Alliances staff have not received training on the national definitions of PATH services, and the providers had been

unaware of their existence. There may be disconnects between the definitions and data elements in ServicePoint. The site visit team recommends that the state, the PATH providers and Institute staff examine the definitions and assess the degree to which the meaning of PATH services is captured in the ServicePoint system. As an example, several providers show 0% of persons served in community mental health services. Observations by the site visit team and statements from the State PATH Contact and service providers demonstrate that enrolled PATH consumers *are* receiving an array of community mental health services. The data do not match reality. The problem might be in the definition of Community Mental Health Services as understood by providers, may be related to the confusion and fragmentation of the publicly funded MH System, may be a ServicePoint data entry rule that is having an unintended effect, some other cause, or a combination of causes. The recommendation is that the PATH group work together to sort it out, and, if necessary, request technical assistance.

There is a problem with the outreach data. ServicePoint only counts an outreach contact if PATH staff is able to enter both a name and a birthdate. This means that the outreach numbers in the Annual PATH report are an undercount of actual outreach activity. That is, providers are conducting meaningful and sometimes extended outreach with PATH-eligible people that is not captured in the data system.

Effective PATH outreach includes contact and engagement with large numbers of homeless persons. Only a subset of the total number of people contacted is eligible for PATH services, i.e. have the requisite serious mental illness. Current data collection practices do not count these outreach contacts – another undercount problem. Figure 1 illustrates the typical expectation regarding declining numbers by category of outreach and enrollment. Iowa data only captures the two boxes on the right hand side of the graphic. Iowa is not reporting and not being credited for persons served in general outreach, and for PATH-eligible persons served prior to their agreement to give their birthdate for HMIS registration.

Figure 1: Outreach Data Path



The site visit team recommends that Institute staff and the State PATH Contact work with providers to create a way to accurately capture all outreach activity.

**Voluntary Performance Goal 4: PATH providers use exemplary practices**

Outreach and engagement services in Cedar Rapids, Iowa City, Davenport and Des

Moines are excellent. All teams are using street and shelter outreach to engage PATH-eligible persons. Provision of essential survival items helps to build trust with individuals who are living outdoors, and teams have had many successes in helping people obtain benefits (food stamps, housing). In Iowa City, among other communities, outreach workers tape their business cards to bottles of water, with the hope and expectation that some people will use the cards to request assistance.

The outreach workers interviewed display a high level of clinical skill, with the ability to assess and identify mental illness in informal settings. Also, every outreach worker interviewed has their own tried and true methods of gaining the trust and respect of individuals on the streets and in shelters. Almost as important, there seems to be a strong working relationship between PATH workers and emergency shelter staff. This was evident by stories told of activity during and after the floods. PATH workers became part of the community's emergency response teams in Cedar Rapids and Iowa City (the Des Moines team was out of state at the time of the floods). Finally, more experienced PATH outreach staff teach and mentor new outreach workers. This occurs in the quarterly meetings informally, but outreach staff provide this training in person as well. Experienced staff have travelled to other communities to provide this service, or new staff go to other cities to shadow and learn from their more experienced peers.

This learning community is extraordinary and commendable.

#### **Voluntary Performance Goal 5: Transition to mainstream services**

The state MH system has a number of issues that create barriers for PATH consumers. For example, CMHCs provide a "traditional" array of services, including psychiatric services, medication, therapy, and clubhouse services. Case management is not provided by CMHCs but by County, the DHS, or Regional Consortium staff. Medicaid funded services are authorized by Magellan or by DHS staff.

For PATH programs, there is no clear entry point for persons needing ongoing clinical care/mental health services. This lack of an identified transition point leads to PATH programs holding people long term, and is a barrier to recovery for individuals.

Beyond the MH system, the lack of affordable housing was cited by providers as a significant barrier. Health care is also difficult to obtain, with a new Federally Qualified Health Center (FQHC) in Cedar Rapids in operation but not yet up to speed, and access issues in other communities. At all three sites, there is a lack of coordination with Veterans Affairs. Jobs and job training programs are limited, and supported employment or supported education is not part of this state's system.

The Iowa Council on Homelessness, staffed by the Iowa Finance Authority (IFA), is active but struggling with resource and capacity issues in the state system. One notable area needing improvement is discharge planning – the state hospital system, general hospitals (including behavioral health units), and the criminal justice system are not involved in coordinated discharge planning.

## Summary and Recommendations

### **Strengths:**

1. Energetic and focused state leadership of PATH program, as evidenced by:
  - a. quarterly meetings, which allows the development of a learning community among PATH providers;
  - b. competitive RFP, which allows the state to make periodic improvements to the program, and tailor these dollars to emerging state needs;
  - c. requirement that PATH providers participate in local or balance of state Continuum of Care planning, thus facilitating coordination with HUD funded programs for PATH-eligible persons, and;
  - d. A requirement that 50% of persons served be literally homeless, which also facilitates cooperation with HUD-funded housing programs.
2. High level of service coordination at the provider level. There is an observable quality of respect and optimism. Working within sometimes difficult systems, providers have created “work-arounds” designed to assist PATH-eligible people in getting needed services; strong working relationships among providers.
3. At the state level, the Mental Health Planning Advisory Council (MHPAC) has a strong interest in the PATH program. The MHPAC Monitoring and Oversight Committee provides oversight of the PATH program. The MHPAC Chair attends PATH quarterly meetings and makes quarterly reports to MHPAC.
4. Very strong outreach staff at all sites visited. Excellent individual skills, with good mentoring among providers.
5. The state has fully implemented HMIS, and ServicePoint provides the Annual PATH report. This is excellent, providing good interface with local and balance of state Continuum of Care systems. The HMIS contractor provides direct and specific assistance to sites, thus improving data quality.

### **Challenges/Suggested Areas for Improvement:**

1. Data and reporting procedures. Outreach contacts are not included in Annual Report data unless the person is willing to supply a name and birth date. This practice artificially depresses the number of genuine outreach contacts. Definition and reporting procedures may be creating false impressions in the data (see discussion above regarding Community Mental Health Services).
2. Transition to mainstream services. Access to mainstream mental health services is problematic. There is a lack of system infrastructure. For example, case management services are not part of a core service package for Community Mental Health Centers (CMHCs), and case management becomes the responsibility of the county or a private non-profit organization separate from the CMHC. The mainstream MH system appears to lack the depth to receive and hold persons exiting homelessness.
3. The link between MH and Substance Abuse services appears to be very weak. Substance Abuse Services are administered by the Iowa Department of Public Health, and MH is in the Department of Human Services. At the state level, Ken

Minkoff is working with both departments to bridge the gaps but at the local level, the lack of coordination is very apparent.

4. The state level attention to homelessness needs to be focused. At present, membership on the Iowa Council on Homelessness has shifted and the department's participation hasn't been consistent. Since PATH is the state's only commitment of resources for homelessness, it seems logical that the State PATH Contact represent the department at the meetings.

## Recommendations

1. System issues that have a direct impact on PATH-eligible persons include access, coordination and capacity issues within the mental health system, lack of coordination with substance abuse services, and lack of coordination with other mainstream services. It is recommended that Iowa Department of Human Services/Mental Health and Disability Services (DHS/MHDS) review the impact on PATH-eligible consumers and consider the following:
  - a. Identify a point of contact/point of entry for homeless persons with mental illness who are seeking services within the mental health system.
  - b. Assess usefulness of employing a Critical Time Intervention (CTI) service between PATH and the MH system entry point for PATH-eligible persons. Implement CTI if appropriate.
  - c. Involve DHS/Medicaid and Department of Public Health in coordination of services for persons with mental illness who are homeless.
  - d. Include the needs of persons who are homeless in current state efforts to improve services for persons with co-occurring disorders. Identify things that can be done at low cost to improve identification, assessment and access to services, including system cross-training, formal COD initiatives (e.g. Minkoff), other training, etc.
  - e. Explore and implement measurable improvements for PATH-eligible persons with FQHCs, workforce/employment system, education, public health, etc.
2. Data and Reporting.
  - a. Distribute national definitions of PATH services; train providers with definitions.
  - b. Create crosswalk of ServicePoint and Annual PATH Report data elements; train providers using crosswalk. Create short fact sheet for provider use in preparing data reports.
  - c. Develop method of capturing and reporting accurate number of outreach contacts.
  - d. Document this process and provide written summary and any relevant materials to CMHS.
3. Focus DHS/MHDS activity regarding homelessness. DHS needs more than one representative on the Iowa Council on Homelessness (ICH) – the State PATH Contact and a representative from Medicaid Services. These are key stakeholders in any state efforts to mitigate or end homelessness.
4. Additional Issues:

- a. Housing – work with other agencies to increase access and availability of permanent supportive housing. Develop state housing plan.
- b. Create relationships with workforce development system to provide jobs and job training for persons with mental illness who are homeless.
- c. Legal issues – investigate allegations of discrimination in housing and employment, work with Legal Aid to resolve problems.
- d. Education – work with education system to provide educational services for PATH-eligible persons.
- e. Discharge planning – recommend a comprehensive assessment of how limited discharge planning from state hospitals, criminal justice system and general hospitals affects PATH-eligible persons. Work with ICH to create a plan to reduce incidence of homelessness among these vulnerable groups.
- f. Create and formalize working relationship with Veteran’s Affairs.