Improving Service Provision at The John and Jill Ker Conway Residence

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EXECUTIVE SUMMARY

The John and Jill Ker Conway Residence is a 124-unit affordable housing development located in the heart of Washington, DC. The building was developed in 2016 as permanent supportive housing (PSH) for individuals exiting homelessness and includes access to voluntary supportive services. As such, over half of the building’s residents are formerly homeless individuals, the majority of whom are veterans. PSH residents have access to services via full-time, on-site property management and case management staff.

Both locally and nationally, the Conway Residence is considered a model for single-site PSH. While it is deserving of this title, the inherent nature of single-site PSH, which necessitates close contact between property management and case management staff, has resulted in some operational issues at the Conway Residence. The goal of this report is to provide recommendations to improve 1) internal coordination amongst property management and case management staff, 2) external coordination with government agencies and off-site social service agencies, and 3) processes for addressing tenant issues in an effort to increase housing retention.

The data collection for this report entailed a literature review and interviews with ten PSH staff in Washington, DC, including case management and property management staff at the Conway Residence. Both the literature review and field analysis assessed the policy and organizational context in which PSH exists, the roles and relationships of service providers within single-site PSH, and modes of client engagement. The field analysis revealed three primary areas for improvement at the Conway Residence: 1) role definition between on-site case management and property management staff, 2) social programming for Conway residents, and 3) on-site medical services for the building’s elderly and/or medically vulnerable residents.

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INTRODUCTION

The John and Jill Ker Conway Residence is a 124-unit mixed-income affordable housing development in Washington, DC. The building includes 60 units for formerly homeless veterans, 17 units for other formerly homeless individuals, and 47 units of low-income housing for DC residents making less than 60 percent of the Area Median Income (AMI). The units for formerly homeless individuals are permanent supportive housing (PSH), which is low-barrier, non-time-limited housing with access to voluntary supportive services.

Co-developed by nonprofit Community Solutions (CS) and financial guarantor McCormack Baron Salazar (MBS), the 14-story building features common areas, ground floor retail space, and office space for three agencies: Community Solutions, the Department of Veterans Affairs (VA), and McCormack Baron Management (MBM). The 60 veteran PSH residents receive services from on-site VA case managers, while the remaining 17 PSH tenants receive case management from external social service agencies.

The Conway Residence opened in Fall 2016 after eight years of development. The development process took longer than expected, primarily because of the multiple funding sources used to minimize debt. The $33 million dollar project was funded by foundation grants, federal and local funds, Low Income Housing Tax Credits (LIHTC), loans, donations, and private investors. As a result of the exceptionally long development period and the urgency of housing the building’s PSH residents—many of whom were still on the street or in shelters at the time—the three agencies providing on-site services did not have sufficient time to coordinate before residents moved in. In conjunction with the inherent pressures of cross-agency coordination in single-site PSH, this has led to operational issues within the building that are the impetus for this report.

The goal of this report is to provide recommendations to improve the provision of services for permanent supportive housing residents at the John and Jill Ker Conway Residence. Specifically, it will address: 1) internal coordination amongst property management and case management staff, 2) external coordination with government agencies and off-site social service agencies, and 3) processes for addressing tenant issues in an effort to increase housing retention.
Data Collection
The literature review addresses three questions: 1) what is the policy context in which PSH exists, 2) what are the roles of case managers and property managers, and 3) what are best practices for serving PSH clients? The author took notes, identified relevant themes, and organized them using Plectica online mapping software to determine the structure and content of the literature review.

The field analysis consisted of ten semi-structured interviews: five with Conway Residence staff and five with those employed by other agencies working on PSH in Washington, DC. The organizations for which interviewees work and their relation to the Conway Residence are below.

- **U.S. Department of Veterans Affairs (VA):** The VA employs three case managers (CMs) at the Conway Residence who provide services to the 60 project-based veterans.
- **McCormack Baron Salazar (MBS):** MBS is the co-developer of the Conway Residence. McCormack Baron Management (MBM) is MBS’s property management subsidiary, which employs the Conway Residence property manager (PM) and one PM assistant.
- **Community Solutions (CS):** Community Solutions is the nonprofit co-developer of the Conway Residence. CS currently employs one part-time staff member at the Conway Residence but will soon employ another part-time staff member.
- **Pathways to Housing DC:** Pathways is a homeless services nonprofit that provides case management to several of Conway’s non-veteran PSH residents.
- **Community Connections (CC):** CC is a homeless services nonprofit that provides case management to some of Conway’s non-veteran PSH residents.
- **DC Interagency Council on Homelessness (ICH):** the ICH coordinates systems-level responses to homelessness in DC. The ICH was involved in helping move residents into the Conway Residence when it first opened.

Seven interviews were conducted in-person in Washington, DC from March 1-2, 2018. Interviews took place in the interviewee’s office or in a conference room at the Conway Residence. The remaining three were conducted by phone on March 9, 2018. Each interview lasted approximately an hour and was recorded with the verbal consent of the interviewee. Interviewees were informed of the purpose of the interview and how their responses would be used before the interviews began. Interview questions centered around: 1) service provider roles and responsibilities, 2) client engagement, and 3) organizational context. All responses have been reported anonymously.

Data Analysis
The author used Excel to record and analyze notes from the interview recordings. She used two spreadsheets: one for Conway Residence or internal staff and one for external staff. Given that interviewees were asked the same set of questions, the author created a column for each question and roughly transcribed each interviewee’s answer in the corresponding column. Additional columns were created for questions that were not consistent with previous interviews. Using the spreadsheet as a guide, the author identified themes in the interviewee’s responses to each question and recorded them in a separate document. She then analyzed these themes and structured them similar to the literature review to create the field analysis.
LITERATURE REVIEW

Throughout the literature, authors use the terms “client,” “consumer,” “resident,” and “tenant” to refer to PSH participants. Van den Berk-Clark argues that referring to participants as residents or tenants is intended to solidify their tenant-landlord relationship with the PSH provider and undermine their role as client, thus highlighting the importance of housing and diminishing that of supportive services. While the author is not strictly adhering to this logic and will use both “client” and “resident” throughout, she believes van den Berk-Clark’s point warrants further consideration, particularly when evaluating the language used by interviewees throughout the field analysis.

CONTEXT

Housing First and Choice in PSH

Like many PSH projects, the John and Jill Ker Conway Residence adheres to the Housing First (HF) model, which provides individuals exiting homelessness with immediate access to housing. In the case of PSH, permanent housing is accompanied by voluntary supportive services. Housing First is oppositional to the traditional Continuum of Care (CoC) model, which positions housing as an incentive for behavior change and requires that clients prove “readiness” before graduating to permanent housing. Perhaps the most central component of Housing First is client choice. Facilitating client choice is also congruent with HF’s harm reduction approach to substance abuse, which allows clients to make personal choices without jeopardizing their housing. In addition to boasting higher retention rates than other models, Housing First also has the highest consumer preference when compared with obligatory or no services, suggesting that choice is important to recovery. Some research, however, suggests that choice has little actual effect on client outcomes. In their 2012 study, Tsai and Rosenheck showed that choice over case management and mental health treatment in PSH had no effect on housing or mental health outcomes, and choice over living environment was predictive only of psychological well-being, not housing outcomes.

Single-site PSH: Advantages & Disadvantages

Advantages of Single-site

Permanent supportive housing projects fall into one of two categories: scattered-site and single-site or congregate. Given that the Conway Residence is considered a single-site project, this section will focus on the latter. The primary benefit of single-site PSH is the community and trust that residents develop with one another and on-site staff as a result of frequent, informal interactions. This sense of community can lead to early detection of emergent physical or mental health issues among clients, thus enabling service providers to take a more proactive approach than may be possible in scattered-site PSH. The presence of on-site staff and community support has been shown to improve housing outcomes, namely housing retention, for clients with severe alcohol problems or those for whom scattered-site PSH was not a good fit. One comparative study also showed that on average, single-site PSH projects provided more primary services such as on-site medical care than scattered-site projects, and providers felt that clients were more likely to access and utilize appropriate services.
Disadvantages of Single-site

While community can contribute to both recovery and housing retention for those with extensive service needs, the same contributing factors can also be the source of problems. Residents in single-site PSH often reported concerns about personal safety and privacy, many of which arose from the behavior of other tenants.\(^8,10\) Such concerns are exacerbated by the urgency of moving people into PSH, as this urgency inhibits providers from ensuring that a single-site project is the best fit and increases the potential for disruptive behavior that may jeopardize other residents’ safety.\(^4\) The same sense of community that many residents enjoy can also negatively impact their sense of privacy, which may discourage them from seeking help from neighbors and case managers.\(^10\) Because residents enjoy relatively high autonomy in PSH compared to other housing models, staff often find that the boundaries with clients are blurred, leading to additional privacy and confidentiality concerns.\(^8\) Residents’ privacy concerns may also result from PSH policies, such as unit inspections, though such policies are not unique to PSH.\(^10\) In short, while single-site PSH has several benefits, it necessitates tradeoffs between community, safety, and privacy.

National Policy Context

The development and provision of PSH is heavily dependent on both federal and local policies. Given the objective of this report, this section will focus on those that impact PSH service provision and operations. At the federal level, most policies related to PSH are dictated by the U.S. Department of Housing and Urban Development (HUD). Only a decade ago, less than a third of all beds for homeless and formerly homeless individuals were dedicated to PSH. As a result of HUD’s drive to house chronically homeless individuals, the inventory of PSH beds increased by 81 percent from 2007 to 2016, surpassing the number of transitional beds for the first time.\(^11\) HUD’s decision to prioritize PSH in 2010 was in part based on the Collaborative Initiative to Help End Chronic Homelessness (CICH), a three year effort coordinated by the US Interagency Council on Homelessness and sponsored by the Department of Health and Human Services, the Health Resources and Services Administration, HUD, and the VA. The CICH culminated in 2006 and strongly illustrated PSH’s ability to improve housing retention rates for formerly homeless individuals—one of HUD’s primary goals.\(^4\)

Although HUD policies have enabled great strides in PSH development, they have come at the expense of supportive services. Since 2010, HUD has simultaneously funneled funding into the creation of new PSH units and eliminated funding for supportive services, despite the more intensive service needs of the chronically homeless individuals entering PSH.\(^12\) While HUD expected local governments to fill this funding gap, that has not been the reality in many communities due to differing political and social goals. As a result, PSH providers are incentivized to “cream” for easier to serve clients in an effort to ease the burden on service providers.\(^12\) Although HUD’s prioritization of funding for programs implementing HF is meant to prevent creaming, poor monitoring and enforcement mechanisms render it futile in many cases. For example, many PSH providers simply establish hurdles within the confines of Housing First, such as extensive paperwork and intentional “back and forth” to create a meritocracy in which only those clients who are able to jump through the hoops are rewarded with housing.\(^1\)

Local Policy Context

Because local policies vary greatly, most of the literature does not address them in detail except to note their importance in determining how communities prioritize permanent supportive housing.
Relatedly, several note the significance of the relationship between PSH and a community’s Coordinated Entry System (CES), which is intended to prioritize individuals with the highest acuity by matching them to the next available PSH unit. While there are several benefits to this system, it can also inhibit providers from ensuring that a given unit is the best fit for the individual.\(^4,10\) This is further complicated by the fact most local government funding for PSH requires that providers fill vacancies through CES. The literature shows that political relationships are often just as essential as policies: one comparative study evaluating the role of organizational practices on Housing First implementation showed that an organization’s senior leaders maintaining relationships with local elected officials was associated with better performance.\(^13\)

Despite increased demands and decreased services funding from HUD, permanent supportive housing in Washington, DC has remained stable. This is largely due to the fact that local officials have prioritized addressing homelessness in the region. Such efforts are documented in the Homeward DC Strategic Plan 2015-2020 developed by the District of Columbia Interagency Council on Homelessness (ICH). As a result of prioritizing PSH and Veterans Affairs Supportive Housing (VASH) in the preceding strategic plan, chronic homelessness amongst single adults in the region decreased by 20 percent from 2010 to 2015.\(^14\) Even so, with a projected need of over 4,000 PSH beds in 2020—a 23 percent increase from the number of beds available in 2014—the District is under pressure to develop more PSH. Like many PSH researchers, the ICH has echoed the difficulty of balancing the urgency of PSH with the need to ensure that providers have the capacity to absorb more intensive caseloads.\(^4,14,15\)

**SERVICE PROVIDERS**

The author uses the term “service providers” to refer to case managers and property managers collectively. She also uses “case manager” as an umbrella term that includes social workers, as most of the literature does not make such a distinction. Also of note, some scholars refer to PSH service providers as street-level bureaucrats (SLBs), a term coined by Lipsky in 1980.\(^1,16\) While the author will not use this term, it is important to consider, as it reflects the organizational constraints frontline public service workers face.

**Housing Retention**

Housing retention is a hallmark of PSH at a policy and organizational level.\(^4,8\) Perhaps unsurprisingly then, case managers and property managers alike overwhelmingly report that their main priority is helping clients retain housing.\(^1,8,9,16\) This adherence to housing retention on the part of PSH service providers stems largely from external organizational goals. While case managers often define other goals as contributing to housing retention—for example health, recovery, social, or financial goals—many reported dedicating significant time exclusively to retention services, which Henwood defines as “communicating with property managers, assisting with social service assistance applications, helping to resolve landlord disputes, and managing rental payments.”\(^8,9\) Several studies suggest that this focus on retention is a result not only of agency goals, but also of increasing caseloads that inhibit case managers from addressing other client needs, such as recovery or community integration.\(^9,16\) Although housing retention is widely considered the primary goal of PSH, focusing on it exclusively may inhibit providers from delivering the person-centered care that is essential to client success in PSH.
Service Providers Roles and Relationships

**Case Manager Role**

Case managers are responsible for providing clients with the supportive services they need to maintain housing stability. The definition of “supportive services” varies depending on staff capacity and client needs, from medical and recovery services to assistance with basic needs such as obtaining food. Because case managers are typically employed through external agencies, PSH projects often end up with a “patchwork approach” that may impede the availability and consistency of services. This effect has been somewhat mitigated in newer single-site PSH such as the Conway Residence by intentionally incorporating services into the program design. While case managers are available to clients throughout their tenancy, it is expected that clients’ reliance on case managers will decrease over time as they are equipped with the tools needed to achieve greater independence. However, case managers are not always able to dedicate sufficient time and resources to equipping clients with such tools. In her comparative study of transitional and permanent supportive housing case managers, Tiderington found that while PSH providers utilized a passive, consumer-driven model of client engagement that is consistent with the objectives of Housing First and PSH, many providers felt that it lacked the focus on recovery and skill-building present amongst transitional housing providers. In addition to time and resource constraints, this is in part a result of the perceived lack of a “next step” for clients in PSH.

**Property Manager Role**

While extensive research has been conducted on case managers’ roles and perceptions of PSH, relatively little has been dedicated to property managers, with the exception of that by van den Berk-Clark. Property managers often live on-site and are responsible for the administrative aspects of PSH, e.g. collecting rent, attending to maintenance issues, serving as the point of contact for external agencies, and coordinating with case managers when needed. In fulfilling this role, van den Berk-Clark argues that property managers often act as “social control agents” tasked with preserving order and maintaining physical resources in the often disorderly environment of PSH. Though property managers share case managers’ goal of increasing housing retention, their underlying motivation is economic. As a social enterprise, PSH must fulfill both its financial and social mission—meaning the property managers who are responsible for the bottom line must collect rent and minimize vacancies. The role of property managers is further complicated by the fact that they must address the conflicting goals of other actors in the PSH task environment, including investors, government agencies, legal counsel, and case managers. Van den Berk-Clark asserts that property managers handle such cost-demand constraints by using their considerable discretion to penalize clients who do not meet their expectations of a “good” tenant. While some authors reported cases in which punitive property managers were fired, others suggest that the solution to such abuse of discretion is building staff capacity. In either case, it is necessary to recognize the constraints and complexity of the property manager’s role within single-site PSH.

**Case Manager and Property Manager Relationship**

Case managers’ and property managers’ roles tend to remain distinct in scattered-site PSH, but the nature of single-site PSH sometimes leads to overlap between their roles in practice, particularly in a project such as the Conway Residence where both parties work on-site full-time. This may originate at an organizational level by facilitating a no-wrong-door approach or expecting staff to perform multiple roles. Such approaches can be useful, particularly if all service providers receive the same training. However, they still necessitate that case managers and property
managers coordinate with one another when presented with a problem beyond the scope of their role. Both parties do this to some extent: case managers engage property managers as social control agents to improve client compliance and outcomes, and property managers engage case managers to modify clients’ behavior to meet their expectations of “good” clients. However, there are incentives to avoid coordination as well. Given the inherently punitive nature of their role, property managers may appreciate the opportunity to engage with clients as sympathetic case managers. Conversely, because property managers control most resources in PSH and ultimately have discretion over eviction and other disciplinary measures, case managers may refrain from reaching out or sharing information when needed as a means of increasing their leverage. Furthermore, even when one or both parties wishes to share client information, extensive organizational and legal constraints often prevent them from doing so efficiently, particularly when government agencies with extensive confidentiality requirements such as the VA are involved.

Organizational Context

Staff Training

The inherent tension between the roles case managers and property managers fulfill within PSH can be an asset if properly leveraged at an organizational level. Several authors suggest that a key element of enhancing such relationships and addressing broader organizational goals is staff training. For example, Collins advocates for graduated crisis-management and de-escalation training that could aid both case managers and property managers in their respective roles. McGraw and van den Berk-Clark echo this, stating that trainings should be directed at the whole provider team, including oppositional organizational units and senior staff, in an effort to represent different goals and gain buy-in. This is particularly imperative for service providers in single-site PSH, as they are otherwise unlikely to receive the same trainings and opportunities for increased team-building and cohesion. Trainings are most effective when they are site-specific and interactive. When surveyed, most service providers affirmed this need, requesting more training earlier in the PSH process with periodic updates. Although staff training is a partial solution to some of the challenges PSH service providers face, authors acknowledge that some problems cannot be solved by training alone and necessitate changes at the organizational and policy levels where the problems originate.

Organizational Goals

The literature suggests that organizations can facilitate case managers’ and property managers’ roles through administrative changes as well, particularly careful goal setting. PSH service providers typically cite increasing housing retention as their primary goal in large part because this is the primary goal or is directly correlated to the primary goals of their organizations. Given that service providers have discretion over which organizational goals to pursue and how to do so, it is imperative that leaders consider their organization’s overarching philosophy when adopting and communicating goals to facilitate goal alignment. One of the main ways in which organizations do this in PSH is via meetings. In addition to facilitating information sharing and horizontal integration across organizational boundaries, effective meetings can also ensure that organizational goals are clearly communicated to staff and that staff concerns are consistently communicated to leaders. For example, Kertész’s evaluation of VA medical centers expanding PSH found that leaders at the best performing sites widely and directly communicated their goal of housing homeless veterans and invited frontline staff to top-level meetings to subvert the typical hierarchy and ensure leaders were aware of the issues on the ground. Kertész’s findings also suggest that
an intense focus on performance measures is associated with an increased sense of urgency and adherence to goals, although this can create other problems in practice.

CLIENT ENGAGEMENT

Service Provider – Client Relationships

The beliefs, perspectives, and interpersonal styles of PSH service providers influence how they engage with clients on a day-to-day basis. In particular, case managers and property managers tend to assume that tenants value housing retention. Much of the time their assumption is correct, as many PSH clients value and work hard to keep their housing. In other cases, however, service providers must train clients to value housing. They often do this before clients obtain housing by creating hurdles in the application process that force the client to invest in their housing, thus increasing its perceived value. Once a client has obtained housing, both case managers and property managers encourage clients to value housing through the articulation and utilization of consequences, namely eviction. Although PSH case managers adhere to the principle of consumer choice—including the choice to not retain housing—they nonetheless reiterate the possibility of eviction if a client does not change whatever has put them at risk of eviction, usually disruptive behavior or failure to pay rent. Given that property managers are responsible for disciplinary measures within PSH, they have a vested interest in ensuring that clients value housing, as it enables them to use eviction as an ultimatum. Yet encouraging clients to value housing benefits PSH staff at all levels, as it balances the competing agendas of case managers and property managers and helps satisfy the end goal of organizational leaders and policymakers.

In spite of sometimes conflicting values, most clients report feeling supported by PSH service providers. Nonetheless, the nature of single-site PSH lends itself to conflict between service providers and clients. For example, staff at single-site PSH note that they sometimes have trouble setting boundaries with clients due to the relatively high decision-making power PSH clients enjoy and the almost familial ties that can develop in such a community. The blurring of such boundaries in conjunction with substance abuse and severe mental illness (SMI) may contribute to a cycle of clients acting out against staff and later expressing remorse. While PSH staff typically understand this as part of the job, it nonetheless contributes to high staff turnover rates, which clients sometimes internalize. PSH clients, the majority of whom are people of color, also express a greater need for cultural awareness and diversity, particularly amongst case managers who are more likely to be white or Asian.

Client – Client Relationships

As discussed briefly, PSH clients tend to view their single-site homes as both safe and stressful, depending on the situation. Illustrating this, while clients sometimes expressed concerns for their own safety due to other residents’ behavior, they also espoused a deep sense of pride in their community and a proactive willingness to look out for another. Such client relationships are especially important for those who may not have many connections outside of PSH. In his analysis of veteran service utilization in PSH, Harris found that the average client had a social network of seven people, consisting of relatives, peers, and service providers. Though respondents reported receiving social support from only two of the people in their network on average, such support was associated with higher service utilization in many cases. While this suggests that the PSH community can act as a safety net that enables case managers and property managers to detect and
address problems early, providers must be careful about fostering such relationships between residents, as clients with substance abuse problems or SMI often intentionally refrain from forming relationships with other clients that they feel would impede their recovery. The implementation of peer support groups or other peer-led programs in PSH may encourage such relationships while mitigating the risk of impeding recovery, as well as provide another avenue for clients to access supportive services.

Program Models

Assertive Community Treatment (ACT)

While PSH programs have largely achieved housing retention, they continue to have mixed results with consumer recovery outcomes. The two program models most frequently cited in the literature are Assertive Community Treatment (ACT), which entails intensive team support to manage serious mental illness, and Motivational Interviewing (MI), which facilitates behavior change through interpersonal communication. While both are prevalent in PSH, ACT tends to be slightly more common in scattered-sites, as single-site projects are sometimes ill-suited to clients with SMI who are most likely to benefit from it. ACT requires a multidisciplinary team of providers, including case managers and mental health professionals, all of whom share the same client caseload. Such teams usually have an appointed service coordinator on-call to assist clients, though any member of the team can respond to issues. In addition to increasing clients’ access to service providers and community engagement as part of recovery, members of ACT teams often report a bolstered sense of support as well.

Motivational Interviewing (MI)

Although less intensive, Motivational Interviewing is more widely applicable than ACT. MI is compatible with Housing First, as it emphasizes a client-centered approach in which case managers facilitate client-driven goals. While MI has proven immensely successful in helping clients set and achieve recovery-related and other goals, van den Berk-Clark argues that case managers can misuse it by encouraging clients to adopt goals that align with those of the agency, most notably housing retention. For veterans, programs such as HUD-VASH may be more effective than MI or intensive case management alone. Both MI and ACT incorporate a harm reduction approach which states that clients should be able to make choices, including the choice to use drugs, without jeopardizing their housing status. Although PSH programs that utilize harm reduction produce better recovery outcomes, gaining buy-in from service providers who are accustomed to the traditional abstinence model may prove difficult. Organizational goal setting and comprehensive team trainings in delivering effective supportive services may help facilitate such buy-in.

Areas of Additional Need

Social Programming

Given the constraints service providers already face in delivering supportive services, coordinating social activities is understandably not a priority. In her research on staff perspectives of single-site PSH, however, Clifasefi found that access to consistently scheduled activities such as game nights and outings was a high priority for residents. While some activities are typically offered at single-site PSH, they are often inconsistent due to staff’s need to attend to emergent issues. Similarly, in her research on implementing peer-based programs in PSH for people with SMI, O’Hara found that scheduling sessions consistently, allowing opportunities for make-ups and brief check-ins
between sessions, and including hands-on activities bolstered clients’ satisfaction with and benefit from such programming. Together, these findings suggest that single-site PSH programs would benefit from social programming that is consistently scheduled but allows flexible attendance, enables group and individual participation, and is jointly designed by staff and residents.

**Transitions into PSH**

The role of PSH case managers and property managers is perhaps most important during clients’ transition into PSH. Given that they are typically exiting chronic homelessness, PSH clients express a mix of relief and disorientation when they first move into PSH, necessitating a formal PSH orientation. Coordinating between the service team with whom the client has been working and PSH service providers is an essential first step in orienting clients, as it ensures that both teams are best able to support the client as they acclimate to housing. This transition also requires PSH case managers to use more directive engagement than normal as they help clients with the mental, emotional, and logistical aspects of moving into PSH. In addition to one-on-one support from case managers, new clients would likely benefit from a more formal orientation that includes current clients. Clifasefi suggests that such an orientation be co-developed by current residents and staff to include information on the single-site Housing First approach, staff roles and boundaries, respect for cultural diversity, and capacity for self-care. A similar orientation may prove useful for new service providers as well.

**Transitions out of PSH**

Although it is not uncommon for residents to transition out of PSH, very few transition into independent or less intensive supported housing. This is largely due to the permanency of PSH, which leads clients and staff alike to view it as the end of the housing continuum and thus overlook the possibility of “graduating” to independent housing. However, the lack of affordable housing and employment opportunities in conjunction with the fact that many PSH clients have project-based vouchers makes moving out of PSH difficult even for those who many no longer require services. Such low turnover in PSH stifles efforts to end chronic homelessness in many communities. In Washington, DC, however, a relatively high turnover rate of 12 percent in PSH for single adults and an increasing PSH inventory has enabled the city to subvert this issue. The city has also implemented Targeted Affordable Housing (TAH) as a step-down from PSH, which may help clients who couldn’t otherwise transition out. Clients that do transition out of PSH most commonly do so because of medical reasons or eviction. Several authors advocate for providers to move clients to another program rather than evicting them, which is a reality in many but certainly not all social service agencies.
FIELD ANALYSIS

The field analysis is based on responses gathered during ten interviews: five with Conway Residence staff members and five with staff employed by external agencies working on PSH in Washington, DC. All responses have been reported anonymously.

CONTEXT

Housing First

Service Providers’ Understanding of HF

The impact of Housing First at the Conway Residence is vast, affecting all aspects of a client’s life from lease application to daily interactions with case managers (CMs). Despite this, formal knowledge and informal understanding of HF varies greatly amongst the service providers. Only one case manager reported receiving formal Housing First training administered by the VA. Those without training nonetheless expressed a comprehensive understanding of and adherence to HF in regards to prioritizing client choice in housing, voluntary supportive services, and lack of preconditions to obtain housing. One case manager illustrated this emphasis on choice saying, “Our goal is to make sure veterans are stably and comfortably housed—comfortably meaning with their preference; that we provide them the housing options and they choose this.”

Staff at MBS had a clear understanding of HF and the changes it necessitated to their normal lease application process. This knowledge was not entirely shared by the property manager (PM) at the Conway Residence, though she had an understanding of the supportive services component. Given that only a few of MBS’s properties operate under the HF model, the corporate staff member explained that most HF training for property managers is conducted on the ground by working with service providers. While external social service agency leaders expressed that a lack of understanding of HF is common, even encouraged, amongst the scattered-site landlords and PMs with whom they work, one expected the opposite would be true at a single-site HF project:

“Conway... they built the building intentionally to serve this population of folks, so the property manager there is or I should expect to be much more informed about how these things work, like how you access the care, but it’s complicated because you have people getting support services from ten different agencies, so it’s all about the coordination.”

Regardless of their current understanding of HF, managing a project under the model presents difficulties for any for-profit property management company. As one interviewee stated in reference to MBM starting out at Conway, “This [Housing First] is where the property management staff are very different from the case management and VA staff... that paradigm shift for a regular property management group was a huge challenge.”

Single-site PSH

Advantages for Residents

Despite some of the negative attributes of single-site PSH discussed in the literature review, Conway staff and external staff alike espoused the many ways in which the Conway Residence has benefitted certain resident populations. One interviewee who was a proponent of scattered-site
PSH conceded that, “There are great Housing First single sites, and it's about giving people choice, and usually what it comes down to is location.” Location is a factor for many Conway residents, many of whom grew up close to the site and were happy to return to the neighborhood. For others, particularly the building’s veterans, it provided a rare opportunity to move into permanent housing with their existing community. As one external agency leader reported, “There were a number of people from Federal City [shelter in DC] that we were able to move into Conway that had been refusing any other options that we were presenting them.”

Challenges for Staff
While the single-site model has proved beneficial for residents, it has presented challenges for several service providers who had never worked in such an environment. As one staff member stated, “I’ve never worked in a building like that before. It was totally new to me. I had no idea what it should look like or what I want it to be like.” The concerns staff members expressed about the work environment stemmed largely from cross-agency coordination and the need to interact closely with staff who sometimes had conflicting goals: “Before this job I’ve never worked in such close quarters with other people particularly who have different work styles than I do. I think I thought that I was much better at navigating that and that it wouldn’t affect me as much as it has.” Conway staff members also expressed concern about the separation of roles within the building, which will be discussed in detail in the next section. While some issues stem from the nature of single-site PSH itself, one staff member suggested that problems amongst staff could have been avoided with more careful cross-agency planning at the onset, saying, “It in some ways has nothing to do with the housing project and everything to do with hiring and personnel issues.”

SERVICE PROVIDERS

Service Provider Roles

Case Manager Role
Each of the three case managers at the Conway Residence is the lead CM for 20 of the building’s 60 project-based veterans. Case managers meet with clients at least once per month, however they often see clients more frequently based on the client’s wishes and the case manager’s clinical assessment. In addition to creating individualized service plans to help clients identify and work towards their goals—ranging from maintaining sobriety to reconnecting with family—case management staff reported helping clients with basic needs services such as obtaining food and coordinating on-site activities such as therapy groups as part of their responsibilities. Consistent with the evidence cited in the literature review, case managers at the Conway Residence reported housing choice and retention as their overarching organizational goal. However, they also emphasized the importance of client-based goals, regardless of their relation to housing retention. CMs repeatedly illustrated this in their responses, saying “I think a lot about their preference—what do they want?—and not forcing my goals on them but helping them with their goals.” Throughout their responses, case managers stressed the importance of “meeting clients where they are” and respecting their wishes, even when they conflicted with broader agency goals.

Every case manager reiterated the sentiment that “HUD-VASH considers all of it [supportive services] housing retention.” Nonetheless, CMs reported dedicating 10-20 percent of their time to retention services when defined as “communicating with property managers, assisting with social service assistance applications, helping to resolve landlord disputes, and managing rental
One case manager attributed this to the nature of single-site PSH, saying “we have such a stronger relationship with the on-site property manager so we’re much more involved in problem solving any issues that are going on with property management.” Case managers also reported encouraging clients to take more responsibility for paying rent, which has been largely successful in reducing delinquencies. While most CMs didn’t mind taking on this responsibility, they expressed that it sometimes inhibited them from fostering a more clinical relationship with clients and focusing on other services that may be helpful. Illustrating this point, one CM stated, “Making sure people pay their rent isn’t our top priority… whether they pay their rent or not, they won’t be successful in housing if all the other things aren’t working for them.”

Property Manager Role
At any property, including the Conway Residence, property managers are responsible for maintaining the property physically, financially, and administratively. This includes operating within financial guidelines, leasing units, enforcing lease compliance, supervising concierge and custodial staff, ensuring compliance with company policies, record keeping and reporting, and attending to resident requests (Appendix A). At the Conway Residence, however, the “property manager also has to make sure they accommodate a multi-layered customer base” consisting of residents, investors, other on-site agency staff, local government agencies, and neighborhood stakeholders such as the police department. Given the various sources used to subsidize units at the Conway Residence, the PM must also ensure compliance with the requirements of different agencies, namely the DC Department of Housing and Community Development (DHCD), the DC Housing Authority (DCHA), and the Low Income Housing Tax Credit (LIHTC) program. Though MBS reported making every effort to outsource data entry and reporting tasks and ease the burden on property management staff, their role remains difficult.

While her responses incorporated all the responsibilities named above, the property manager described her primary role at the Conway Residence as being a “strong leader” for those both on and off her payroll. In accordance with her role as a leader, the property manager expressed attempts to align the goals of all staff within the building, saying, “no matter what your job title is, we all have one common goal and I think that's just to provide excellent customer service and treat people as professional and kind as you can.” Perhaps most central to her role was achieving MBS’s goal of stabilizing the property financially, largely by increasing housing retention and minimizing rent delinquencies and vacancies. Despite ample experience as a property manager, this was the PM’s first time working with formerly homeless residents, which she described as a “huge transition for me and my staff.” Like other staff, she noted that the normal property management approach didn’t apply, and expressed the difficulty of fulfilling the enforcement aspect of her role given the compassion she had for the unique needs of Conway’s residents:

“No only am I supposed to do property management, but in some way and shape and form I also have to be case management. I have to understand my client and understand their background so I can try to be effective in my job and try to reach them in a way that they can understand.”

Corporate property management staff echoed this sentiment, stating that the property management position at the Conway Residence required someone who could handle both the technical and emotional aspects of the job:
“When we have supportive services connected with our property, I think it takes a different kind of property management and it’s the reason I’m more involved than I would be on another property. It is much more nuanced and I think particularly in a building like [Conway] where we’re able to have the service providers on the same floor as the property management staff—it’s different.”

Although MBS staff knew that the Conway Residence required a property manager who could shoulder the emotional burden, they also understood that such sites necessitate careful coordination and distinction between property management and case management staff:

“There was a time period early on at McCormack Baron where there was this assumption that the property management staff could also be social service providers and that did a disservice to people that are trained as service providers, and it took us a little while to realize that the property management brain and the social service brain operate differently.”

Case Manager and Property Manager Relationship

Most staff members at the Conway Residence expressed that while they enjoyed their jobs, the lack of boundaries between case managers’ and property managers’ responsibilities sometimes impeded their ability to fulfill their roles. The case managers, in particular, felt that this stemmed from a lack of clear role definition when the Conway Residence first opened: “From the beginning there was a disconnect between MBM and us [case managers] about what our jobs were, what our roles were, what our responsibilities were, and it’s been difficult to kind of make that connection while being here. I think the ideas are still very different of what we do.” Another case manager reflected this sentiment, saying, “They need to do their job as property management and I'll do my job as case manager—that line is really blurred here.” That blurred line manifested in several ways, from case managers helping clients with unit applications to property managers attempting to coach clients through crises. In addition to taking on each other’s responsibilities, there were other responsibilities such as planning social activities that each felt was part of the other’s role. Perhaps as a result of the tension that has arisen from unclear professional boundaries, staff within each agency have created interpersonal boundaries, isolating themselves from informal interaction with staff from other agencies, leading one staff member to comment, “I like the work environment, however, I wish it wasn't as separate.”

Although case managers were critical of property management’s tendency to engage in case management or enlist CMs to help with unit applications or rent payments, they also expressed empathy for the complexity of the PM’s role: “They [property managers] have a challenging position to be in. It’s not easy to just draw a line.” External agency leaders also appreciated the challenges PMs face at single-site PSH: “Property managers are great, they’re like frontline social workers, I mean they do so much, they’re so amazing, but sometimes their roles get a little blurry.”

The capacity for blurred lines is particularly great at sites like the Conway Residence where the property manager lives on-site and interacts with clients the most frequently and often in times of crisis. Agency leaders argued that single-sites with different care providers merely increase the need for clear role definitions for the sake of both staff and tenants:
“We also need to acknowledge that we need to have some clear lines, not just for us but for our tenants, because it’s ultimately not fair to our tenants if they don’t understand the roles either... the thing is everybody has power except for the tenant; the tenant is the one who should feel empowered.”

Service Provider Coordination

Internal Coordination

Despite tension between case managers and property managers at the Conway Residence, all staff members reported that their internal communication was generally effective. Given the proximity of their offices, staff expressed a preference for face-to-face communication except when looping in outside staff members necessitated email. However, some suggested that increased use of email or other written communication may be beneficial in some cases: “For the most part it [in-person communication] works, but there were times where we heard one thing and then the next day it was something completely different, so I think having a firmer method of communication would be helpful.” All Conway Residence staff members as well as external staff members who have attended commented on the benefit of the weekly services and operations meetings.

One impediment to cross-agency communication at the Conway Residence is confidentiality and information sharing constraints. Clients receiving case management have the option to sign a Release of Information (ROI) form that permits their case managers to disclose their personal information to specified individuals or agencies. These forms vary in nature depending on the agency: some permit the release of general medical information to a specified individual or agency, while others require the client to specify each piece of information they wish to have disclosed, as is the case with the ROI used by the VA case managers at the Conway Residence (Appendices B-D). In any case, case managers are not permitted to share a client’s diagnostic information with property managers unless they have an ROI, which many clients opt not to sign. Even with an ROI, however, case managers reported only sharing information if it was in the best interest of the client. Though sympathetic to such constraints, MBS staff felt that the lack of information sharing inhibited property management from taking a proactive approach to protect residents:

“It sometimes feels like we’re surprising each other and it’s sort of being driven by case management reacting to what management does and I’d like to see if there’s a way, particularly with the challenging folks, to have case management present it to property management... without revealing privacy issues.”

While understanding of property manager’s desire to know, agency leaders on the case management side expressed the opposite view, insisting that information about a client’s diagnosis was not necessary for PMs to fulfill their role. They suggested that property management should instead focus on enforcement (i.e. lease violations) and report clients’ behavior so that CMs could assess it and work with the client on solutions. Though unrelated to confidentiality, case managers at the Conway Residence also lamented their ability to retrieve information from property management, particularly in regards to clients’ rent payment status: “There was information withheld [by property management] that I felt there was no reason to withhold—it's not like rent arrearages are someone's protected health information.” Others echoed this sentiment, again suggesting that the problem was not communication, but the parties involved and their understanding of their roles.
External Coordination

External agency staff responsible for case management for non-veteran clients at the Conway Residence staff reported good experiences with both property managers and case managers. They said that the former was particularly important, stating: “We have to be a support to the tenant because they’re our client, but the landlord’s also our client too. It doesn’t mean we’re gonna side with the landlord, but we’re gonna try to mediate and bring it together.” External agency staff emphasized maintaining good relationships with property managers primarily because it increased the likelihood of PMs reporting a problem to them early and thus preempting a crisis, though they were subject to the same information sharing constraints as internal case managers. The property manager shared this sentiment, reporting that she reached out to external CMs early and often and that they were always responsive.

Interviewees from two of the agencies that provide external case management to Conway residents identified the property manager as their point of contact. One agency leader emphasized the importance of having a single point of contact within their agency as well, alleviating property managers of the need to keep track of different clients’ case managers, especially given staff turnover. However, they also stated that PMs could reach out to clinical staff directly if they preferred. Other agency leaders expressed that communication with PMs was more relationship-based, and while a central contact person should be available, property managers should reach out to those with whom they and/or the client are most comfortable.

Organizational Context

Department of Veterans Affairs (VA)

Case managers reported that the VA’s goals were consistent with their own goals of ensuring that veterans were safely and stably housed in housing of their choice. However, they also cited minimal leadership within the VA. Because they do not currently have a direct supervisor, CMs relied on senior-level case managers for support with clients. While they felt that the VA had faith in them and their abilities, they expressed a desire for more support. Some case managers also felt that they were expected to do more than was realistic: though their entire caseload is comprised of veterans at the Conway Residence, one case manager reported spending about 25 percent of her time off-site, attending to responsibilities she had prior to transitioning to her role at the Conway Residence. Another CM expressed that though she felt her superiors listened to and understood her work-related concerns, they were unable to effectively address them given the cross-agency environment of the Conway Residence.

McCormack Baron Management (MBM)

Property management staff at all levels reported strong leadership within MBS and MBM. The property manager’s goals aligned with those of MBS, both regarding the need for financial stability and the need to adapt the typical PM approach to better assist Conway’s residents. MBS’s leadership expressed a clear understanding of the challenges property managers face and a dedication to providing ongoing support to prevent burnout. This was evident in practice as well: the property manager reported feeling supported by her superiors and felt that she could reach out to any person within the company with concerns. Similar to the VA staff, the property manager expressed concerns about the dynamic of the different agencies at the Conway Residence, though more so in reference to the lack of informal interaction.
Community Solutions (CS)

Given that Community Solutions currently only has one staff member and thus a somewhat limited role at the Conway Residence, most staff members did not reference CS except to mention occasionally reaching out to that staff member about issues in the building. Some external staff felt that everything that needed to be done in the building could be completed by case management or property management staff and thus wasn’t sure what role CS needed to play. Another external agency staff member, however, suggested that having an organization such as CS in the building is an asset in facilitating cross-agency dynamics:

“I think that the presence of [CS staff] was very important in various coordination kinds of things… to have somebody who is hanging on to whole narrative rather than just people hanging onto pieces of it… what are the dynamics of the different players and are there things, professional development kind of things that need to go on, when it's this kind of a building where there's lots of different people and lots of different issues.”

CLIENT ENGAGEMENT

Service Provider – Client Relationships

Though the field analysis did not include resident interviews, all Conway Residence staff members reported feeling that clients trusted them and were generally grateful and appreciative. When asked what they thought clients value most, staff frequently said consistency and structure: “That structure is something that not all but many of our veterans value—which is why I think that following through on our promises about paying rent impacted behavior.” Though the property manager reported being lenient with clients when the building opened, particularly with rent payments, she and the case managers agreed that clients responded best to clear consequences, as evinced by the drastic decrease in rent delinquencies since they started going forth with eviction proceedings. Others reported that clients value their housing, citing the pride they took in their units as an example, as well as the safety of having a place to call home. Several also acknowledged the inherent challenges of working with such a population, particularly when facilitating client choice, but they seemed adept at removing themselves from it when needed. Case managers also expressed that mass communication with clients (e.g. building notices) was sometimes inconsistent between agencies and necessitated more staff coordination.

Client – Client Relationships

Occasional disputes aside, staff cited the quality of relationships and sense of community they have created in the building as one of their clients’ greatest strengths. Staff reported that many clients expressed an exceptional sense of “community responsibility” and willingness to check-in on one another. For example, while the VA case managers can only serve the project-based veterans, those clients often share resources and information with non-veteran residents, helping to bridge the divide. Staff also mentioned that clients are extremely resilient—which can be both good and bad in terms of relationships with other clients: “They can get stabbed and keep doing whatever it is they do. They keep going no matter what happens.” While there have been some attempts at peer-led groups, namely Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) residents have had trouble getting them going without substantial support from staff, and thus their supportive relationships have remained more informal.
Program Models
The case managers at the Conway Residence reported using Motivational Interviewing (MI), Critical Time Intervention (CTI), and/or Cognitive Behavioral Therapy (CBT) depending on the client and situation. They typically used CTI when a resident was first transitioning into PSH as well as when they were contemplating substance abuse. Two case managers reported using CBT in both group and individual settings to help high functioning residents reach the next step of their goal(s). MI was used the most regularly, both by itself and incorporated into other program models. Regardless of which model they employed, case managers emphasized that client choice and dignity was paramount. External case management staff reported using MI, CTI, and ACT with their clients at the Conway Residence. The property manager did not report using any specific program models, but said she listened to clients when they sought her out and shared her thoughts and stories from her own life, though she explicitly refrained from giving advice.

Areas of Additional Need
Medical Care
Partially by design, the Conway Residence is home to some of DC’s oldest and most medically vulnerable formerly homeless veterans—one of the groups that interviewees cited as being most likely to prefer and/or benefit from a single-site project. However, the benefit of single-site PSH for an older population stems largely from the availability of on-site medical services. While case management and property management staff strongly agree that an on-site nurse is needed, none is currently available. The VA case managers are in the process of coordinating with the VA to get an on-site nurse but are uncertain about if and when that will come to fruition.

Another issue that case managers cited is the absence of Housing First assisted living offered through HUD-VASH. This represents a gap in services for the most senior veterans exiting homelessness who ideally need assisted living but only qualify for housing through HF—a population that comprises a significant proportion of the 60 project-based veterans at the Conway Residence. While several clients at the Conway Residence have Home Health Aides (HHAs), staff members noted problems with the insurance and HHA systems. For example, VA insurance will cover an HHA for 10 hours/week and Medicaid for 8 hours/day, but acquiring either is a long process—something the case managers didn’t feel their superiors understood. Given that clients live in efficiency units, having an HHA for several hours a day, even if needed, is not always comfortable. Furthermore, both internal and external staff cited the difficulty of finding quality HHAs given that it is both a difficult and low-paying job.

Social Programming
Every staff member at the Conway Residence expressed a need for more on-site social programing. Although they felt the resources were available (i.e. space and money) each felt it was not part of their job responsibilities. Case managers currently offer some activities for veterans, including therapy groups and cooking classes, but expressed frustration that many residents simultaneously don’t attend and complain about a lack of activities. One CM inferred that this represented a need for more varied, non-skill-based activities such as outings and game nights. Another mentioned the importance of activities being on-site, consistent, and allowing for clients to pop-in—citing the widely-attended monthly cookouts Community Solutions staff coordinated the previous summer.
While VA case managers practiced leniency when possible, they can only offer activities for their clients, furthering the gap between veteran and non-veteran residents. Some staff suggested that this could be remedied by having more external agencies offer activities on-site. While there has been some progress in this area—namely the recent addition of monthly, on-site nutrition classes—agencies offering activities nearby, such as the Hayes Wellness Center, often insist that clients come to them and/or have minimum attendance requirements that are difficult to meet, at least initially. Another external staff member suggested that Community Solutions could help bridge that gap as well, saying, “Having somebody here who thinks programmatically about community and how to draw together people, who’s not building management, who is clinical, I think would be a really good idea for a next effort.”
Conclusion and Recommendations

Conclusion

The Conway Residence mirrors many aspects of permanent supportive housing discussed in the literature review. Based on staff perceptions, most Conway Residence clients appreciate and benefit from the community at the single-site project, perhaps as a result of the VA’s emphasis on facilitating housing choice. Because this report did not incorporate resident feedback, however, the disadvantages of a single-site project may have been underreported. Although Conway Residence staff did not report encountering many residents for whom single-site PSH was not a good fit due to SMI, they lamented the lack of Housing First assisted living facilities, as they felt single-site, independent housing did not meet the needs of their most senior and medically vulnerable clients. Relatedly, Henwood’s finding that single-site PSH projects are more likely to offer primary services does not ring true at the Conway Residence, though the staff’s push for on-site medical care suggests that such services are needed.

Consistent with the evidence presented in the literature review, both case managers and property managers at the Conway Residence cited increasing housing retention as one of their primary goals. However, case managers expressed an even stronger allegiance to facilitating client-centered goals, opposing evidence that CMs sometimes attempt to align client goals with agency goals. The potential overlap between CMs and PMs roles within single-site PSH identified in the literature was particularly evident at the Conway Residence. Several staff members suggested that this was the result of a lack of cross-agency coordination and role definition when the Conway Residence first opened. Information sharing constraints on the part of case management and lack of understanding of such constraints on the part of property management added additional stress to this relationship. However, there are some issues in the building on which CMs and PMs have successfully collaborated, namely the reduction of rent delinquencies.

Residents’ desire for on-site social programming cited in the literature review was strongly evident at the Conway Residence. While all staff members cited this desire on the part of residents, none considered implementing activities as part of their job description. Furthermore, all identified the need to provide activities that were open to both veteran and non-veteran residents—something the VA case managers were not able to provide. The need to facilitate transitions into and out of PSH did not seem as prevalent at the Conway Residence as in the literature, though CMs did report using different program models, namely CTI, to engage with clients when they first moved in. Both internal and external CM staff reported implementing some sort of safety net for residents who were evicted from or otherwise transitioned out of the Conway Residence.

Recommendations

Based on the field analysis, the three primary areas for improvement at the Conway Residence are: 1) case manager and property manager boundaries, 2) social programming, and 3) on-site medical care. Recommendations for addressing each follow.

Case Manager and Property Manager Boundaries

Many Conway Residence staff members felt that the lack of boundaries between case management and property management staff arose from a lack of cross-agency coordination at the project onset.
Though not ideal timing, facilitating such coordination now could nonetheless resolve some of the problems that have arisen as a result. This would first require MBM, VA, and CS leadership to coordinate a meeting for all Conway Residence staff—though the lack of VA leadership may complicate this. The meeting should be facilitated by a third party and focus on a) defining agency roles and constraints, b) establishing shared cross-agency goal(s), c) defining CM and PM roles and responsibilities and areas of overlap, d) brainstorming and agreeing upon new processes to mitigate areas of overlap, and e) applying such processes to a hypothetical case(s) in the building with actual residents. The staff meeting, which may take place over one or multiple sessions, should be followed by joint staff trainings that would benefit both CMs and PMs.\textsuperscript{15,17} Suggestions from staff included leadership development and interpersonal communication training, though trainings on conflict resolution/de-escalation may prove useful as well.

\textit{Social Programming}

Given that all staff members emphasized the need for more resident activities at the Conway Residence, the problem is one of assigning responsibility. Because the role of Community Solutions staff is flexible relative to those of CMs and PMs, the author suggests that the former spearhead this effort—particularly since CS has the capacity to provide services to both veterans and non-veterans. CS staff should start by engaging residents to determine which activities would be of most interest to them and coordinating one or two consistent weekly or monthly activities open to all residents. Though perhaps not directly involved, residents on the Veterans Advisory Board, coordinated by the VA staff, could assist with this process. Property management staff have plans to assemble a tenant council as well, which may also prove useful. In addition to coordinating on-site activities, CS should reach out to more outside agencies that may be willing to offer classes or other activities on-site. In either case, the essential elements are that such activities be offered consistently, allow for flexible resident attendance, and be planned jointly with residents to ensure their buy-in and participation.\textsuperscript{8,18}

\textit{On-site Medical Care}

Every staff member at the Conway Residence cited the need for on-site medical care, particularly for the building’s elderly veteran residents. The VA case managers have already begun pursuing arguably the best solution of hiring a VA nurse case manager to work on-site. However, given that the timeline is uncertain and the VA nurse will only be able to serve veteran residents, it would be beneficial for other service providers, namely CS, to find other care providers willing to come on-site as well. While no mobile clinics are available in the area, coordinating with one of the local clinics or universities to have someone provide basic services on-site even once each month would prove helpful for many residents and help alleviate some of the burden on current staff.
REFERENCES


16 Tiderington, E. (2017). “We always think you’re here permanently”: the paradox of “permanent” housing and other barriers to recovery-oriented practice in supportive housing services. Administration and Policy in Mental Health and Mental Health Services Research, 44(1), 103-114.


**APPENDIX A**

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<thead>
<tr>
<th><strong>Job Title:</strong></th>
<th>Property Manager</th>
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**Position Summary:** Responsible for insuring the efficient operation of the property under the direction of the Area Manager.

**Duties and Responsibilities:** Essential duties and responsibilities include the following but are not limited to the job specifications contained herein. Additional duties or job functions that can be performed safely may be required as deemed necessary by MBM and its affiliated companies.

- Operating the property within the financial guidelines, i.e., the budget, established by the Area Manager and Owner.

- Daily physical inspections of the property and direct supervision of the service, grounds and custodial personnel.

- Direct supervision of the office staff and bookkeeping functions.

- Responsible for the final interviewing and hiring all property employees under the direction of the Area Manager.

- Responsible for ensuring a professional appearance and attitude at all times for yourself and all property employees.

- Responsible for the thorough knowledge, implementation and enforcement of all policies and procedures of MBM and its affiliated companies; insuring through constant supervision and review that all personnel in all departments are operating within those regulations.

- Responsible for the leasing of the property; ensuring through supervision of the office and leasing personnel that all sales techniques and methods required by the management company are being used effectively and in a professional manner.

- Responsible for ensuring that all personnel respond to resident requests or complaints in a timely, efficient and courteous manner.

- Responsible for generating various reports, i.e., Company-required reports, HUD information, Housing Agency information, Housing Authority information, etc.

- Responsible for implementing, designing and maintaining a resident retention program, i.e., newsletter, resident referral program or social activities.

- Responsible for insuring that all personnel in all departments operate within OSHA (Occupational Safety & Health Act) standards and company safety policies at all times.
• Responsible for reporting any unusual extraordinary circumstances regarding the residents or the property.

• Responsible for seeking educational opportunities and self-improvement for personal growth and development.

SUPERVISORY RESPONSIBILITIES: Directly supervises two or more employees in the Service Department and Leasing Staff. Carries out supervisory responsibilities in accordance with the organization’s policies and applicable laws. Responsibilities include interviewing, hiring, and training employees; planning, assigning, and directing work; appraising performance; rewarding and disciplining employees; addressing complaints and resolving problems.

QUALIFICATIONS: To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. The requirements listed below are representative of the knowledge, skill, and/or ability required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

EDUCATION and/or EXPERIENCE: High school diploma or general education degree (GED); or one to three months related experience and/or training; or equivalent combination of education and experience.

PHYSICAL DEMANDS: The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions. While performing the duties of this job, the employee is regularly required to use hands to finger, handle, or feel and talk or hear. The employee frequently is required to stand, walk, and sit. The employee is occasionally required to reach with hands and arms; climb or balance; stoop, kneel, crouch, or crawl; and taste or smell. The employee must occasionally lift and/or move up to 10 pounds. Specific vision abilities required by this job include close vision, distance vision, color vision, peripheral vision, depth perception, and ability to adjust focus.

WORK ENVIRONMENT: The work environment characteristics described here are representative of those an employee encounters while performing the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions. While performing the duties of this job, the employee is frequently exposed to outside weather conditions. The noise level in the work environment is usually moderate.

Employee Date Supervisor Date

To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. The requirements listed above are representative of the knowledge, skill, and/or abilities required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions. Management reserves the right to add, modify, change or rescind work assignments, as required by your supervisor. The job description should not be construed to imply that these requirements are the exclusive standards of the position.
REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT INFORMATION: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38 U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S.C. 552a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including the last four of your Social Security Number (SSN) and Date of Birth (used to locate records for release) is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VHA may make a “routine use” disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10P2 “Patient Medical Record – VA” and in accordance with the VHA Notice of Privacy Practices. VA may also use this information to identify Veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS (Name and Address of VA Health Care Facility)
Washington DC VA Medical Center
50 Irving Street NW
Washington, DC 20422

LAST NAME- FIRST NAME- MIDDLE INITIAL

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

VETERAN’S REQUEST

I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

☐ DRUG ABUSE  ☐ SICKLE CELL ANEMIA
☐ ALCOHOLISM OR ALCOHOL ABUSE  ☐ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV)

DESCRIPTION OF INFORMATION REQUESTED

Check applicable box(es) and state the extent or nature of information to be provided:

☐ HEALTH SUMMARY (Prior 2 Years)
☐ INPATIENT DISCHARGE SUMMARY (Dates): ________________________________
☐ PROGRESS NOTES:
  ☐ SPECIFIC CLINICS (Name & Date Range): ________________________________
  ☐ SPECIFIC PROVIDERS (Name & Date Range): ________________________________
  ☐ DATE RANGE: ________________________________
☐ OPERATIVE/CLINICAL PROCEDURES (Name & Date): ________________________________
☐ LAB RESULTS:
  ☐ SPECIFIC TESTS (Name & Date): ________________________________
  ☐ DATE RANGE: ________________________________
☐ RADIOLOGY REPORTS (Name & Date): ________________________________
☐ LIST OF ACTIVE MEDICATIONS ________________________________
☐ OTHER (Describe): ________________________________

PURPOSE(S) OR NEED

Information is to be used by the individual for:

☐ TREATMENT  ☐ BENEFITS  ☐ LEGAL  ☐ OTHER (Specify below)
I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

I understand that the VA health care provider’s opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

Without my express revocation, the authorization will automatically expire.

- [ ] UPON SATISFACTION OF THE NEED FOR DISCLOSURE
- [ ] ON _______________ (enter a future date other than date signed by patient)
- [ ] UNDER THE FOLLOWING CONDITION(S): ____________________________

<table>
<thead>
<tr>
<th>PATIENT SIGNATURE (Sign in ink)</th>
<th>DATE (mm/dd/yyyy)</th>
</tr>
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<tbody>
<tr>
<td>LEGAL REPRESENTATIVE SIGNATURE (if applicable) (Sign in ink)</td>
<td>DATE (mm/dd/yyyy)</td>
</tr>
<tr>
<td>PRINT NAME OF LEGAL REPRESENTATIVE</td>
<td>RELATIONSHIP TO PATIENT</td>
</tr>
</tbody>
</table>

**FOR VA USE ONLY**

**TYPE AND EXTENT OF MATERIAL RELEASED**

<table>
<thead>
<tr>
<th>DATE RELEASED</th>
<th>RELEASED BY:</th>
</tr>
</thead>
</table>
AUTHORIZATION FOR DISCLOSURE OF
HEALTH INFORMATION

I, _______________________________, hereby request that the following information:

(print full name)
Annual physical examination, medical medication prescription information, laboratory results and relevant
diagnostic test results, be disclosed by my physician or other medical institution:

_____________________________ (Doctor/Facility Name)
_____________________________ (Address)
_____________________________ (Phone/Fax Number)

To: Community Connections, Inc (Attn. Medical Records Dept.)
801 Pennsylvania Ave SE Suite 201
Washington, DC 20003
Ph. 202-546-1512 Fax: 202-544-5365

In authorizing this disclosure, I understand that this information will be used solely for the purpose of: Assisting
the mental health treatment team provide continuous and comprehensive psychiatric care including but not
limited to: psychiatry service & medication management, case management/community support services,
substance abuse treatment, residential service, and referral & advocacy.

Both now and in the future, and that this authorization for disclosure is limited to information that is now in
existence.

I understand that I have a right to inspect my record of mental health information.

I further understand that this information cannot be disclosed or re-disclosed without my authorization.

This consent is subject to revocation in writing at any time. If not revoked by writing, this authorization will
expire _______________________ (no later than 360 days from date below).

_____________________________________________________
Signature of person giving authorization                     Date

_____________________________________________________
Signature of witness                                       Date

Copies to:      (1) consumer; (2) consumer’s record; (3) accompany disclosed information
Rev. 10-01

NOTE: This information is not to be used in connection with obtaining life or health insurance.
AUTHORIZATION FOR DISCLOSURE OF MENTAL HEALTH INFORMATION

I, ________________________, hereby request that the following information:

_________________________________________________________________

_________________________________________________________________

be disclosed by my physician or other mental health professional to:

_________________________________________________________________

In authorizing this disclosure, I understand that this information will be used solely for the purpose of my coordination of care both now and in the future, and that this authorization for disclosure is limited to information that is now in existence.

I understand that I have a right to inspect my record of mental health information.

I further understand that this information cannot be disclosed or redisclosed without my authorization and that the law requires the following notice relative to mental health information.

The unauthorized disclosure of mental health information violates the provisions of the DC Mental Health Information Act of 1978. Disclosures may only be made pursuant to a valid authorization by the client, or as provided in Titles III or IV of that Act. The Act provides for civil damages and criminal penalties for violations.

This consent is subject to revocation in writing at any time. If not revoked by writing, this authorization shall expire _________________ (no later than one year from date below).

_________________________________________  ______________________________________________
 (signature of client)  (date)

_________________________________________
 (signature of witness)  (date)