There’s great efficacy in providing intense services to participants through the implementation of evidence-based practices and measurement of client improvement via the Service Prioritization Decision Assistance Tool (SPDAT). Through the use of the SPDAT, linkage to primary health care, enrollment in mainstream benefits, and intensive case management, more than 290 consumers have received services and permanent supportive housing. The Michigan Housing and Recovery Initiative (MHRI) continues to experience positive outcomes as participants move from high SPDAT score acuity to more stability among multiple life domains.

**About our Participants**

- **Age Group**
  - 18-24: 8%
  - 25-34: 25%
  - 35-44: 13%
  - 45-54: 43%
  - 55-64: 30%
  - 65-74: 1%

- **Race**
  - Caucasian: 86%
  - American Indian: 4%
  - Asian: 1%
  - American Indian: 9%

**Select SPDAT Outcomes**

- The SPDAT (Service Prioritization Decision Assistance Tool) aids in assessing individual acuity chronically along multiple indicators.
- Technical Assistance providers supported by SAMHSA’s full review of our Medicaid services, & collaborative team efforts all enhance the ability to leverage support services from local entities.
- The Steering Committee, inclusive of MDHHS staff & CABHI teams, meet monthly to discuss best practices for improving services and funding for chronically homeless program participants.

**Select Housing Outcomes**

- 86% successfully housed through June 2016
- Evidence suggests 70% retain housing beyond 6 months.
- Clients indicate high satisfaction at 90% with services and apartments.
- The program provides safe, secure and affordable housing for chronically homeless clients.
- Self-sufficiency and life skills are enhanced.
- Eviction prevention plans aid in housing retention.

**Combined Strategies Better Address Complicated Challenges**

Through intense case management, participants also experience well-rounded improvement in their lives. SPDAT scores have improved at intervals captured every 6 months, with mean scores reducing from 4 to 2 along some indicators such as physical health and wellness, meaningful daily activity, history of homelessness and housing, and self-care. Overall scores also decline in some instances from 40 indicating high acuity to 11 indicating limited chronicity.

Participants benefit from a linkage to food banks, healthcare, community involvement and, most evident permanent supportive housing. Evidence suggests housing navigation, supportive services, & collaborative team efforts all enhance the ability to leverage support services from local entities.

The state is committed to enhancing Medicaid reimbursement rates, and gathering additional information to support chronically homeless and recently housed clients going forward.

**Change in Acuity Scores**

- Managing Tenancy: Baseline 7.3, Follow-Up 3.8
- Money Management: Baseline 7.0, Follow-Up 2.7
- Mental Health: Baseline 6.4, Follow-Up 6.9
- Social Relationships: Baseline 4.3, Follow-Up 3.4
- Self Care & Daily Living Skills: Baseline 7.2, Follow-Up 6.3
- Substance Use: Baseline 5.2, Follow-Up 1.8
- High Risk Involvement: Baseline 3.9, Follow-Up 1.6
- ER Service Interactions: Baseline 4.4, Follow-Up 1.8
- Legal: Baseline 4.7, Follow-Up 0.9

*Intake = 6 Months*