Integrating Behavioral Health Care into Shelter Services

An Alaskan Case Study

The journey to become a behavioral health provider

The journey to become a fee for service behavioral health provider started when the CEO of Catholic Social Services (CSS) was approached by State of Alaska (SOA) staff who were implementing a Medicaid Section 1115 Demonstration Waiver. The state believed that having a community-based organization focused on providing shelter and rehousing services would fit under the waiver.[1] They felt this would allow CSS to provide a needed service for clients, as well as add new revenue sources for the organization.

"When they're introduced to it [BH services] or they get to meet the clinician, then they're like, let me give this a try and then they see the positive outcome. So, I feel like a lot of our clients wouldn't just go into a behavioral health clinic and be like, 'Hey, I need help.' I think that is maybe a different aspect that we provide -it's, you are coming into the shelter, and we happen to be here, we can help serve you. I think some of our clients are more apt to receive services that way." -CSS staff

CSS staff believe that in-house behavioral health services are essential for shelter clients because of substantial barriers facing clients to access these services in the community. CSS leadership wanted to offer a deeper level of service that wraps around the person in a trauma-informed manner.

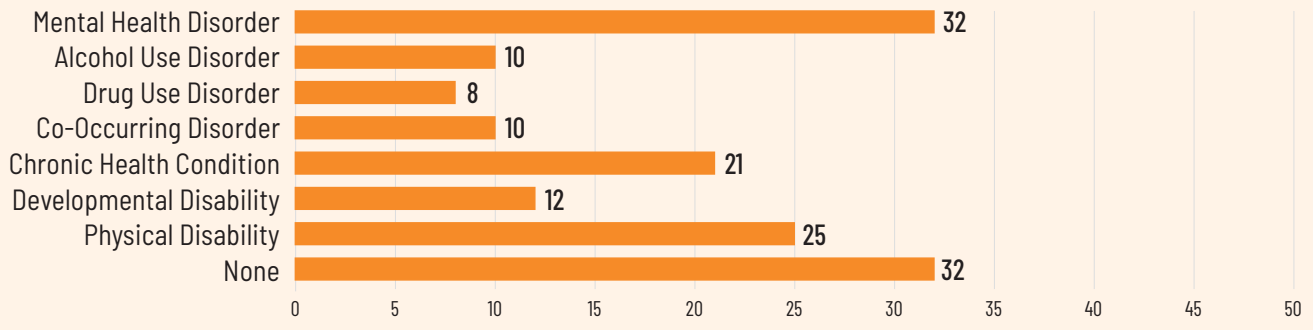
In FY25, five CSS shelters served 2,272 individuals. Table 1 shows the number and percentage of individuals served in the five shelters.

TABLE 1 - NUMBER OF SHELTER CLIENTS FOR FY25

Name of Shelter	Count
Brother Francis Shelter	799
Medical Respite	101
Clare House	369
Complex Care Shelter	301
East 56th	1,274

Males (60%) were more likely to be clients as compared to females (39%). The most common age groups served were 35-44 years (24%) and 25-34 years (20%). The most common client races were Alaska Native people[2] (47%) and White people (34%). Approximately 32% of clients had no disabling conditions, 23% had three or more conditions, and 15% had 2 conditions, and 14% had one condition. FY25 CSS data shows that the most common behavioral health disorder of clients was a mental health disorder (24%), followed by alcohol use disorder (7%), drug disorder (6%) or cooccurring disorder (9%) (see Figure 1).

FIGURE 1 - DISABLING CONDITIONS OF SHELTER CLIENTS (%) FY25



[1] Waivers are designed to provide flexibility for State Medicaid programs to test new way to innovate providing behavioral health services with Medicaid reimbursement without increasing overall State budget costs.

[2] The category Alaska Native includes those people who identify as American Indian people, as well.

Behavioral health needs of clients:

1. **Support with root causes and consequences of childhood and other trauma**
2. **Treatment for drug and alcohol addiction that is used to cover up the pain associated with trauma**
3. **Detection and treatment of undiagnosed mental illness**
4. **Support to learn coping skills and find needed resources in the community**

CSS Behavioral Health Services

CSS offers behavioral services that fall into three main categories:

1. **Clinical services:** clinicians provide mental health screenings; integrated behavioral health assessments; develop care/treatment plans that are good for 90 days; conduct care plan reviews; and provide individual psychotherapy and psychoeducation counseling.

2. **Intensive case management services:** case managers support the client's progress through their care plan including getting connected to work, school, housing, legal assistance and other community resources.

3. **Peer support services:** At Clare House peer support workers, "walk along side" the client in their journey.

Wins and Successes

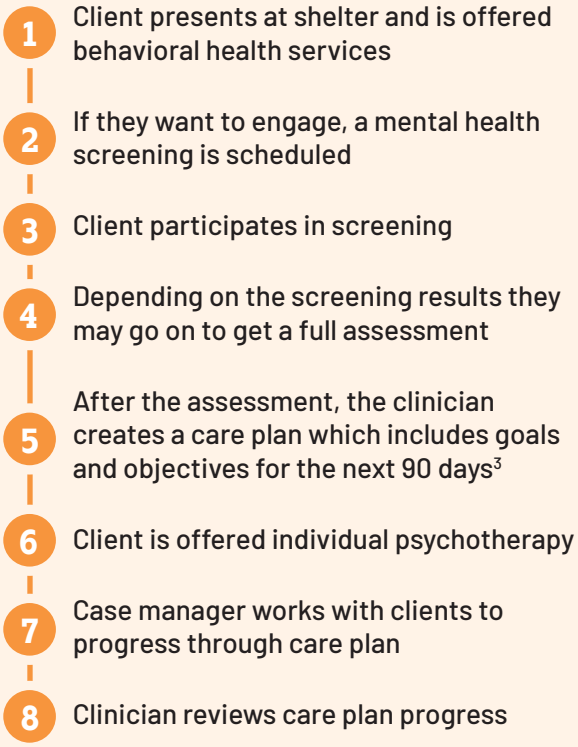
Sustainable Income Source. One of the major organizational wins is receiving consistent receipts from billing for services. From July FY25 to October FY26 $1,228,977 were submitted in charges and $854,684 was received. This represents a return on approximately 70% of all charges submitted.

Increased Organizational Awareness and Accountability: The journey has brought more accountability to shelter operations. Leadership staff report that they are becoming more aware of day-to-day operations.

Shift to a deeper service model that is person-centered and trauma-Informed: Staff reported that the journey has helped to promote a more person-centered, trauma-informed lens within the shelters. Staff are encouraged to look at problems differently, checking if barriers have been removed or necessary provisions made before discharging clients. There is a culture of cultivating "unconditional positive regard" for clients.

The organization was previously focused primarily on getting people into homes before focusing on other needs. The new model emphasizes wraparound

FIGURE 2. PROCESS FOR CLIENTS TO BE CONNECTED TO BEHAVIORAL HEALTH SERVICES



[3] If a client exits the shelter program, the care plan is left open for 90 days in case the person returns to the shelter. If they are not back in 90 days, they are discharged from services. If they return after 90 days, the clinician will do another full assessment as dictated by regulations that specify when a new assessment can be done due to a new "service cycle."

services, viewing clients as mental, spiritual, and physical beings, not just bodies that need to be housed. This shift focuses on the "totality" of the person to help them thrive and maintain housing, recognizing that sometimes something other than housing may be more important in the moment.

Formalization and Legitimacy of Services: While some believe the organization has provided some of these support services in the past, the change has formalized the services and required a change in how they are notated. This formalization adds "legitimacy" and makes the services seem more meaningful and predictable. Staff said that the role of the case manager is becoming more defined, moving away from case managers feeling like they must "do everything."

Individual Client Success Stories

The provision of behavioral health services has led to success for clients. Staff reported the following themes related to wins for clients:

1. **Consistent trauma-informed behavioral health support in the shelter can reach hard-to-reach clients**
   A woman, who said she had never stayed with a counselor for very long, showed up for her assessment with alcohol in her water bottle and was in active addiction. When the clinician asked her if she wanted to get treatment she said yes. They got her into detox and then treatment and stayed in contact throughout. She got into housing and then relapsed and lost her housing. She returned to the shelter, and they helped her get into another treatment center and get connected to a new psychiatrist and she is doing great. She is now in the Valley and becoming a peer support worker.

2. **Counseling can help clients advocate for themselves**
   A Complex Care Shelter client who was housed at the shelter for a long time was able to get counseling which helped him advocate for himself. He got his benefits in line and was able to save some money and get into housing. He still has wraparound supports and comes back to shelter because he feels like it's "his community." But he comes back as a donor now – he brings goodies to clients or he volunteers. "Without the BH services I don't think we would've seen this success for this individual."

3. **Behavioral health support helps clients with major life changes**
   A shelter client had had an established life, a job, a savings account, retirement savings and no history of substance use or mental illness. He had a medical emergency and lost everything. He never dreamed he would be homeless, and his stress level was very high, and he didn't know where to start to access support. Shelter behavioral health supports were able to wrap around him and get him on his feet again.

4. **Support for substance use disorder treatment and recovery can help people get housed**
   A man who struggled with heroin use and was unhoused is now off heroin in his own apartment for the first time in his adult life, has a job, and has significantly reduced his therapy sessions. The staff helped him with counseling and case management and now he has an apartment and has gone from seeing the clinician weekly to one time per month. A CSS staff member said, "Anytime someone gets housed, those are our wins. And that's contributable to the whole team."

5. **Behavioral health support can help clients maintain housing**
   A client, unhoused for over 10 years, was housed, connected to a provider, is losing weight, and is doing great after the team helped him stay stabilized when his delusions initially worsened after being housed. Behavioral health services allow the agency to keep clients "active" for longer and support them in maintaining housing stability, preventing them from being disconnected and losing housing.

6. **Clinical support for undiagnosed mental illness can be life changing.**
   A young lady in her mid-thirties who was "in episode" with schizophrenia when she came to the shelter. She was really struggling and the clinicians on staff could recognize that immediately. They got her stabilized and were able to get her to tell her story. She wanted them to contact her family, which they did. The family didn't know where she was and they wanted to help. The family is now supporting her in her journey on stabilizing medication and she is living independently. "If we had no clinician that woman would probably still be in our shelter and we would be trying to figure out what to do."

Considerations for becoming a behavioral health provider

The following are considerations that were mentioned by CSS staff that they learned about when they made the journey to become a behavioral health provider.

Consideration: Mission

It is important for community-based organizations to explore if being a provider of behavioral health services aligns with their mission. CSS leadership and staff felt that there was full alignment in their mission, "To promote the physical, spiritual, and mental welfare of persons in need in the community."

Consideration: Funding Diversification and Sustainability

While funding diversification with fee-for-service revenue may appear to contribute to organizational sustainability, there are some key things to consider when providing services to homeless individuals. Some in this population may be uninsured or their insurance status unknown. This will result in services that will never be billable. Developing a generous sliding scale fee policy is essential (and legally required). Additionally, some clients may not be ready to receive services when they enter the shelter for several reasons including not trusting the staff or process. Grant funding may still be required to cover shelter case management services for clients who are not comfortable receiving behavioral health services or who are uninsured.

Consideration: Financing

Becoming a behavioral health providing organization is an expensive endeavor to start up. It is important to understand how long you will be operating at a loss. Having a large, generous grant is crucial to piloting the program and helping the organization be sustainable. It is important to initially conduct an internal assessment of capacity to identify new staffing that is needed, new systems for claims, billing, and processing, and any required expert consulting. CSS had been using a case management database (Apricot) which they combined with billing software. While CSS had an experienced data and finance team, they added the following new positions: Senior Director of Medicaid Operations, Chief Behavioral Health Officer, Clinicians (3), Claims and Billing Manager, Temporary Medicaid Trainer, Quality Assurance Coordinator. CSS staff recommend bringing in a consultant who is competent in Medicaid nuances, especially during the process of state certification and accreditation.

Consideration: Culture Change

CSS staff noted that integrating behavioral health services into the shelter promotes a trauma-informed approach to shelter operations. It is important to realize and address this from the beginning because the clinical staff and shelter staff may view the same situation very differently. CSS had been providing trauma-informed services for ten years and becoming a behavioral health service provider added more depth to shelter staff's understanding of this perspective, especially when it comes to enforcing rules.

Consideration: Change Management

It is important to be intentional with rolling out the change and stating what it will look like from the get-go. Staff need to understand that the transition is not easy. This is a large-scale organizational change – it can't be done in a small way. Communication and transparency at all levels are key to successfully negotiating a significant organizational change. It is important to communicate early on and solicit feedback about staff's thoughts, suggestions on how to roll it out, and the reasons why and benefits. There will be meetings, workgroups, lots of staff time and other investments that need to happen for the change to be successful. CSS staff recommend pretending you are opening a brand-new business. You must know all the federal and state rules and administrative requirements and deadlines and then build the service model and structure. They recommend having a strategic plan that informs the structure and processes which are in place before you open the doors for these services. Know that everything you are doing is going to have a direct effect on another part of organizational operations. Adopt a tool like an "authorities' matrix" to guide large administrative changes such as keeping track of requirements, deadlines, and responsibilities for each department. It is important to look at changes that are needed in the chains of communication and supervisory oversight to ensure that behavioral service delivery is integrated with shelter services and quality assurance/billing in a way that makes operational sense.

Consideration: Staff and Training

The staff developing the new programming should have experience delivering behavioral health services. It is important to recognize that staff who were hired under a different way of doing business will need retraining and they may leave. Early on, supervisors should recognize who is not on board with the program and address their resistance. Supervise staff closely and provide a lot more support. Give existing staff time and space to catch up to the new requirements. It is key to keeping staff at all levels involved in the process (planning, rollout, implementation) to help them understand the "whys" behind the change.

It is crucial to have very detailed job descriptions for staff, especially for case managers who are now working under a different model. Required training includes clinical training such as explaining behavioral health conditions, behavioral health case management training, and training on linking clinical concepts to documentation requirements.

Consideration: Operations

It is crucial for leadership to really understand the "background piece" (quality assurance, claims management and billing) and how it affects shelter operations. The clinical staff should deeply understand social service operations. There must be close alignment between the head of clinical service delivery and the shelter operations head. CSS staff said one of the key components to creating a cohesive organizational structure is ensuring cross organizational communication structures. Standing meetings are important for this communication during implementation and then maintenance of operations. CSS implemented an *Implementation Meeting* to coordinate program development with the Chief Executive Officer, Chief Behavioral Health Officer, Chief Operations Officer, Chief Program and Impact officer, Senior Director of Data, Senior Director of Case Management, Billing Department staff, Senior Director of Homeless Family Services and the Senior Director of Grants. Ongoing weekly *Productivity Meetings* are held with the Director of Case Management, finance staff, and Chief Behavioral Health Officer to check productivity levels, reimbursement rates, and share challenges or concerns. Weekly *Clinical Case Conference Meetings* are held at each shelter with the clinical team to discuss client needs/progress.

Consideration: Revenue Cycle Management (RCM)

RCM describes all administrative and clinical functions that contribute to the capture, management and collection of patient service revenue. This includes claims processing, billing, and quality assurance. It is crucial to hire staff that have experience with RCM as it pertains to Medicaid, Medicare, and other payers. The proper data management and billing software system must be purchased and staff trained to use it. RCM staff must be integrated into staff training, supervision, and ongoing operations management. CSS uses a feedback loop for continuous improvement. The supervisors are trained in looking for quality within the case management notes even before it reaches the Quality Assurance Department (QA). The QA coordinator looks for trends in staff writing (e.g., repeating mistakes) to identify specific areas where training is needed. Training sessions are scheduled and done ad hoc when issues are noticed. There is a QA checklist system to guide staff. Training clarifies how to document specific interventions.

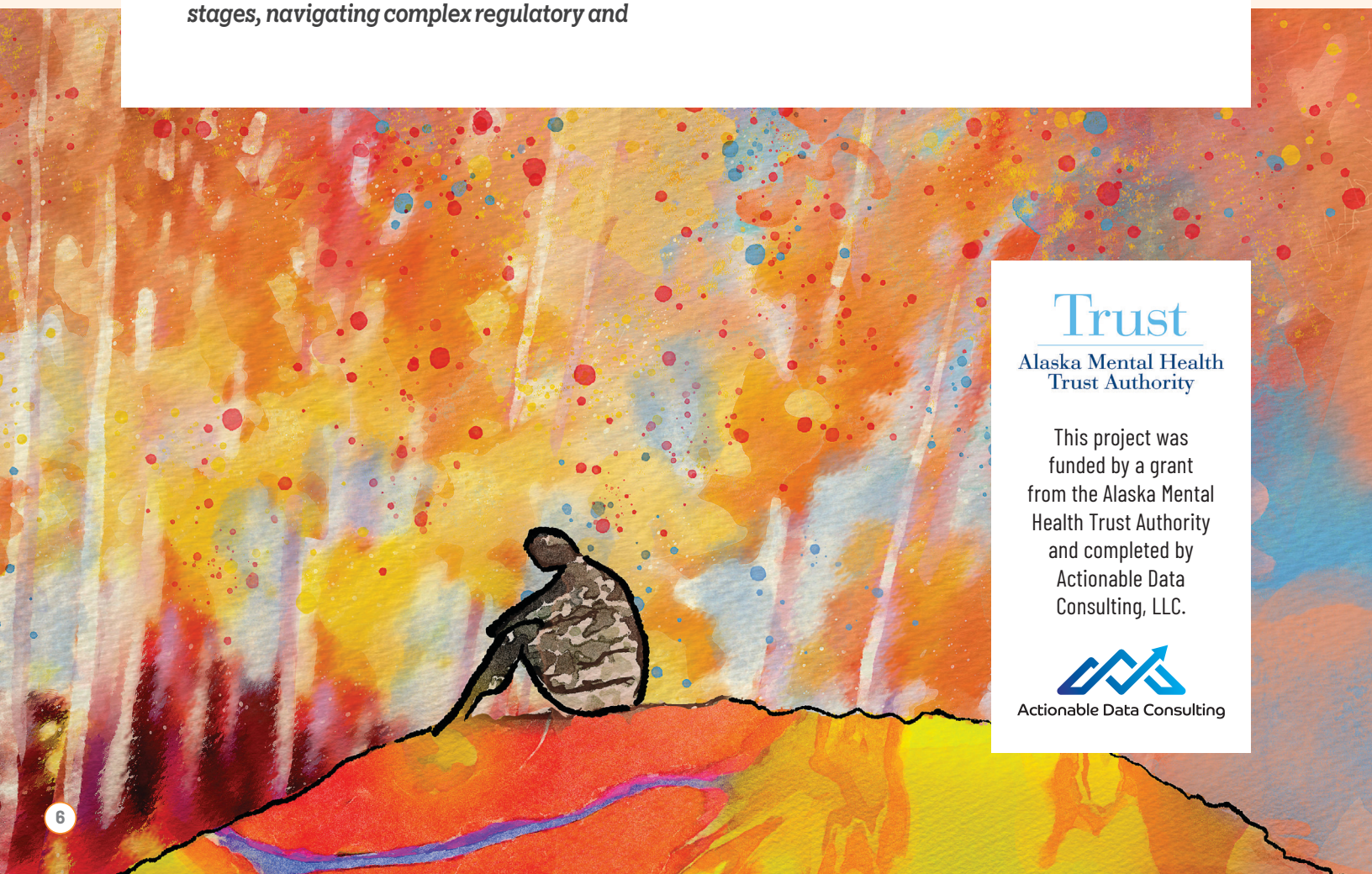
Consideration: Braiding Fee-for-Service with Grant Revenue

The three main areas where CSS faced the greatest challenges in braiding the two revenue streams are related to the role of case managers, how to code the fee-for-service revenue, and issues with handling protected health information data. Case managers may be seeing both clients who receive behavioral health services and those who do not. Thus, the case management approach would differ because clients not receiving behavioral health services would not have a care plan developed by the clinician. When the fee-for-service revenue comes in, the RCM staff need to figure out how to code the income and the appropriate way to use it. Currently, CSS is getting assistance from a consultant on this topic. Finally, the federally mandated homelessness database, HMIS (Alaska Homeless Management Information System) is not a medical database, creating issues with inputting Protected Health Information (PHI). Most of the time, if a case manager is providing services, the client is receiving behavioral health services. CSS cannot put any case management or behavioral health services data into HMIS, leading to reporting issues with some funders.

The journey continues...

Chief Operating Officer, Kim Isley, describes her view of the journey moving forward:

Catholic Social Services' journey to becoming a behavioral health provider demonstrates that this work is not simply an add-on that shelter providers can easily adopt. Integrating behavioral health into shelter and homelessness services is a transformational shift, one that requires substantial unrestricted start-up capital, specialized expertise, time to build compliant systems, and a willingness to fundamentally change organizational structures, roles, and culture. The process involves operating at a loss during early stages, navigating complex regulatory and accreditation requirements, and sustaining staff through significant change. Yet this work is essential: for many shelter guests experiencing homelessness, co-occurring trauma, mental illness, and substance use create barriers that cannot be addressed through housing alone, and access to on-site, trauma-informed behavioral health care can be the difference between cycling through homelessness and achieving lasting stability. As this journey continues, CSS remains focused on stabilizing and strengthening this integrated approach while sharing lessons learned, recognizing that meaningful system change requires long-term investment and shared commitment.



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