Cross-Sector Collaboration for Comprehensive Case Management

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Our Mission

Advancing housing solutions that:

- Improve lives of vulnerable people
- Maximize public resources
- Build strong, healthy communities
Funding Required for Permanent Housing: Capital, Operating, Services

- Rental assistance
- Services to outreach, engage, build housing stability
Emergence of Housing First as Evidence-Based Model

- Housing is basic need, necessary for recovery.
  - Homeless people must be linked to housed first, before services effectively improve health.
  - Anyone is ready for housing.
- Tenant participation in services is voluntary: Housing is not contingent on compliance, or discontinued when client uses drugs/alcohol.
Accessing & Maintaining Housing Stability is Necessary for Recovery

Randomized, control-group, pre-post, pilot evaluations

People Experiencing Homelessness Cannot Get Healthy or Decrease Costs Until Housed

- ED Visits: -34%
- Inpatient Days: -27%
- Inpatient Costs: -27%

Connected to Housing
Still Homeless
Evidence-Based Housing-Related Services

**OUTREACH & ENGAGEMENT**
- Outreach
- Assessments
- Landlord & Tenant Education
- Tenant Coaching
- Agency Collaboration

**HOUSING TRANSITION SERVICES**
- Assessment of Housing Need
- Housing Support Plan
- Housing Search Assistance
- Housing Application/Documentation Assistance
- Assistance With Move-In

**TENANCY SUSTAINING SERVICES**
- Intervening in Behaviors Jeopardizing Housing
- Educating Tenants & Landlords, Lease Compliance Training
- Help Resolving Disputes
- Scheduling, Attending, Advocating for Client with Health Professionals
Housing Navigators: Connecting with Homeless Systems

1. Homeless Service Providers: Identify/Find/Engage Homeless Beneficiaries
2. Connect to Coordinated Entry
3. Link to Interim Housing or Respite Care
4. Housing Search/Assistance with Housing Applications
5. Intensive Case Management to Prepare for Move into Permanent Housing
Homeless Service Providers Form Trusting Relationships

Outreach: Multiple face-to-face contacts with patients/clients where they are (car, shelter, on the streets, etc.)

Engaging to build trust:
- Asking about client’s needs, following through
- “Whatever it takes, for as long as it takes”
- Helping build life skills

Using evidence-based tools:

Motivational interviewing to help client change behavior jeopardizing housing or stability

Trauma-informed care
Care Coordination
Core Components of Evidence-Based Services

- Face-to-face, client-directed
- Client-to-provider ratios of 1:20
- Paraprofessionals or peers with lived experience, supervised by licensed staff
- Warm hand-offs between team members
- Use of evidence-based practices
Funding for Services

- Federal Grants
  - VA Health System
  - Homeless Assistance Grants (decreased focus on services)
  - Emergency Solutions Grant

- Medi-Cal Mental Health
- Mental Health Services Act
- Emergency Solutions Grant (Rapid re-housing)

**NEW:**
- Health Home Program

- Local Funding
- Philanthropic Funding

**NEW:**
- Whole Person Care Pilots
Keys to Housing Resources: Developer and Government Partners

• Contracts with housing developers for services in SROs

• Priority access to County S+C vouchers

• Collaboration with Housing Authority/City of Oakland/Housing CBO
Challenges to Meaningfully Using Funding to Deliver Services

Restrictions: Capacity & Competency of Providers

Mismatched: Services Not Housing-Based, Medicaid System Data

Medicaid Financing Silos: Who Benefits?
Moving to a Team-Based Culture Through Partnership

Medical Homes: Physician-Centered, Medically-Focused

Person/Patient-Centered, Team-Based, Offered in Person

Care Coordinator

Physicians

Behavioral Health Professionals

Housing Case Managers

Housing, Food, Access to Benefits

Medical services

Counselling and support

Primary Health Services

Community health

Continuing care

Health promotion
Health/Housing Services Partnerships: Tulare County

“The Bridge”

Homeless Service Provider Case Manager Co-Located in Hospital
The Bridge

The Staffing

Project Director

Program Coordinator

4 Case Managers +

1 Case Manager Funded by

3 Hospitals

The Bridge: Results

- Pre (Bridge, n=50)
- 12 months (Bridge)
- Pre (All, n=241)
- 24 months (All)
Health/Housing Partnerships: 10th Decile Project, LA County

- 10% Highest-Cost Homeless Hospital Users
- 9 Communities, Organized Geographically to Form Teams:
  - 9 Homeless Service Providers (some mental health providers)
  - 9 FQHCs
  - 20 Hospitals

Monthly costs of $6,529 → annual cost: $78,348

$3,452 per month in hospital costs → annual cost: $41,424
The Glue: Homeless Service Providers Offer Intensive Case Management (Care Coordination + Housing Navigation)

**Collaborations**
- Hospitals, Federally-Qualified Health Centers, Homeless Services & Housing Providers
- Intensive Care Management/Care Coordination, Housing Navigation
- Supportive Housing
- Housing Retention

**Frequent Hospital Users**
- (8 ED Visits in 12 months or 5 in 6 months)

**Cheronyally Homeless Beneficiaries**

**Housing Case Managers**

**Primary Care**
- Mental Health Tx
- Substance Use Tx

**Supportive Housing**
10th Decile Project

169 HOUSED TO DATE

Average cost avoidance per person per year: $54,106
Est. total 10th Decile Project cost avoidance to date: $8.5 M

10th Decile Project Hospital
Partner Hospital Costs (Actual)
Average per person per year (n=77)

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<th></th>
<th>ER costs</th>
<th>IPT costs</th>
<th>Total costs</th>
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<td>12 mos. prior (baseline)</td>
<td>$7,138</td>
<td>$3,433</td>
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<td>$60,980</td>
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Total costs down 79%
LifeLong Medical Care

Hospital Partnerships

- Frequent ED Users Project
- Respite Care
- Care Transitions (ED/IP)
- Urgent Care

- MOU/Contract
- Data Driven
- IT Tools Support Daily Work
- Case Managers w/Clinical Support
- Formal communications structure
Connecting Services to Housing Through Coordinated Entry Systems

No Wrong Door: Any Entry Point (including health)

Prioritize for SH & Services

Assess Housing Needs, Assess for Right Intervention, Prioritize by Vulnerability

Coordinating Permanent Housing Resources

Services Available in Community
Using Coordinated Entry System

Referral of Patients to Coordinated Entry

Health Plans Receive Referrals for Services Programs (Health Home Program)

Connect Services Programs to Housing
LifeLong Trust Clinic

• Partnership
  • FQHC
  • Health Care for Homeless
  • County Behavioral Health
  • Coordinated Entry System

• Target population –
  • High risk, high cost
  • Homeless
  • SMI

• Access to housing subsidies

• Linked primary care and community case management

• Funding: MHSA, FQHC billing, specialty mental health billing
Using New Resources to Eliminate Silos

- Rate Based on Intensive Model, Using Per Person, Per Month Rate, Based on Intensity
- Encourage Partnerships with Agencies with Cultural Competence
- Use Coordinated Entry to Link Patients/Members in Services Programs to Housing
- Align Services & Housing Creation When Eligibility Aligned