Serving High Acuity Populations w/Rapid Re-housing

Technical Assistance Collaborative
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Agenda

- Icebreaker
- Crowd-Sourced COVID Practice Tips & Sharing
- Case Management Tips & Discussion
  - RRH service framework
  - Service Structure
  - Wraparound Supports
- Close Out: One thing you heard or thought of today you may try

Who is here?

In the chat, share…

- Name
- Organization & Role
- Favorite Halloween Candy

Poll: RRH Case Management

How experienced are you with providing RRH case management to high acuity households?

1- No experience, this is all new!

2- Some experience

3- Very experienced

Webinar Format

- Interactive, foster discussion and group learning
- Success = building relationships to lean on in the future
- Join us on camera!
- Safe venue to share challenges

Questions?

Service Delivery During COVID

Service Delivery During COVID: Crowd-Sourced Tips

- Sample tips we’re seeing emerge

- These may be dinosaurs by the end of the hour- things are changing so rapidly

- Be thinking about sharing additional tips you have and challenges/needs with the group to keep learning moving

COVID Information- Housed Participants

Written tips for clients on…

- When to call healthcare provider and how
- When to call 911
- How to quarantine yourself if you have COVID and asked to stay home
- How to live with someone else who contracts COVID
- Helpful as people are hearing verbal information through worried/scared/tired ears- easy to forget

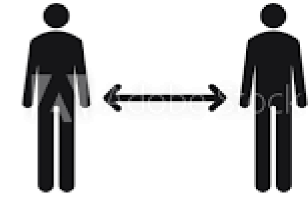
See Seattle/King County sample

COVID Diagnosis Preparedness

Preparing residents for contracting COVID- Supplies/Planning

- Non-perishable food for several weeks- could arrange for delivery
- Over the counter medicine needs if applicable
- Prescriptions (1-3 months if available)
- Access to a phone to make emergency calls/maintain social community
- Planning for substance use considerations during an isolation period (preventing/managing withdrawals)
- Planning for isolation in shared housing situations
    - Separate sides of units; separate trash, dishes, etc; disinfecting supplies; mask supply for in-home use
- Planning frequent remote check-ins with both client and landlord if lack of support network
    - Ex- Tom, every other day at 4pm

Service Delivery- Social Distancing



- **Phones** can be used to:
  - Conduct screening interviews
  - Any other conversations

- **Video & Photo Technology** can be used to:
  - View units
  - Conduct HQS or habitability checks (but when normalcy resumes, HUD expects a full in-person HQS)

- **Social Distancing** During In Person Meetings
  - People take turns entering empty rooms or empty units
    - i.e. if a landlord shows a unit in person, landlord stays outside while tenant views
    - i.e. tenant stays outside while bed is delivered
  - Maintain 6 feet of distance
  - People travel to units separately- participant in ride share/taxi to minimize exposure to public
  - Talk through windows/structures

Questions?

Case Management

- **Tip Sharing: One case management practice in your program you are proud of**

- **Presentation & Discussion**
  - Structure of Services (Staffing; Caseload ratios; roles)
  - Wraparound Services Provided

Shared Learning

What is a case management practice you have implemented (even if it's on a small scale) that you are proud of?

Structure of Services

Structure of Services (Staffing)- Tips

- Team-based case conferencing or team-based service delivery

- Multi-disciplinary teams
  - Behavioral health
  - Income maximization
  - Peers with lived experience of homelessness
  - High availability- 24 hours/7 days a week
  - Healthcare (health plan case manager; health navigator; healthcare for the homeless; etc.)

- Negotiate with funder- lower caseload ratios to reduce high turnover
  - Philanthropy to supplement
  - HUD grant amendments- move dollars to supportive services

Structure of Services (Caseload ratios; roles)- Tips

- Home visits- minimum monthly as staff policy; low threshold for participant
  - Some agencies found clients were not comfortable asking for them
- Team-based case conferencing or team-based service delivery
- Caseloads based on acuity to set staff workload up for success with high acuity population

Homelessness service providers should review caseload assignments to ensure equitable staffing that considers both caseload sizes (the number of households an RRH case manager is responsible for) and acuity level in the assessment of each household. A review of caseload sizes and acuity levels can help to ensure that staff have adequate time to provide the correct level of service—based on acuity—when it is needed, with fewer staff members understaffed or overstaffed.

Example of Mixed-Acuity Staffing Review Activity

	Case Manager A	Case Manager B	Case Manager C
Low-Acuity (1–3)	4 households=12	30 households=90	0 households
Moderate-Acuity (4–7)	1 household=5	2 households=11	20 households=113
High-Acuity (8–10)	10 households=92 total acuity score	1 household=9	0 households
Caseload Size	15 households	33 households	20 households
Caseload Acuity Total	107	110	113

Caseload acuity totals are calculated by adding the caseload acuity assessment scores assigned to each case manager together to get a caseload acuity total per case manager. These caseload acuity totals are then compared to each other to determine the total difference in acuity with which various case managers are working. In this case, the difference in acuity scores between the lowest total (Case Manager A) and the highest total (Case Manager C) is 6 (about one moderate-acuity household); therefore, these caseloads are fairly even. Adjustments to caseload sizes should be made when caseloads are not even in order to achieve similar caseload acuity scores for all case managers, regardless of the actual number of clients served by each. This comparison of caseload acuity can help to ensure adequate and equitable staffing for mixed-acuity caseloads.

Examples- Acuity Assessments

- Programs serving high acuity households frequently assess the acuity of their participants to ensure caseloads are distributed equitably and correspond to staff expertise.

- Assessments look at domains such as recent overdoses, medical fragility, crisis service usage, financial management, etc.

- Example: Columbus Severity of Service Needs Tool

Structure of Services (Caseload ratios; roles)- Discussion

- What are your typical caseload ratios?
- What policies do you have around minimum engagement for staff?

CTI & RRH- A sample framework for Case Management

- Framework of case management to support people through a critical time (or transition) in their life
  - Ex. Moving to permanent housing
- Gear participants up for success by providing thorough case management to connect participants to community supports that help tenancies succeed
- Critical Time Intervention:
  - Six-month, three-phase model with a defined beginning, middle, end
  - Emphasize active linking with services and supports that will persist after intervention ends
  - Limit focus to factors that directly influence housing stability, tailored to individual clients
  - Frequent, group-supervision is emphasized

CTI & RRH- A framework for Case Management

3 Key Phases of the Transition

1.) Transition

2.) Try Out & Test

3.) Transfer

Sample CTI/RRH Approach from state of CT's RRH Programs

	Pre-CTI	Phase 1: Transition	Phase 2: Try- Out	Phase 3: Transfer
Time frame/Intensity of Contact	Flexible	2 Months/Intense Weekly	2 Months Moderate Bi-weekly	2 Months/Low Monthly
Objective	Housing Location/Move in; Begin CM Assessment and Housing Plan	Complete Housing Plan; Identify Resources and connect client	Monitor resource impact and client access	Complete transfer of services to the community
Action Steps	Negotiate Lease Educate/Advocate Relationship Building	Accompany client to appointments, follow up to ensure connection	Make adjustments to plan in collaboration with client	Meet with new service providers or others in the support system; reflect on work with client
Strategies	Take opportunities to teach/model housing location process; present services as a resource, not an obligation	Do advance work of creating resource networks	Empower client to do what they can on their own; create alternative plans if necessary	Reduce involvement gradually and inform client early on about the length and nature of CM support

Questions?

Housing Stability Plans

Housing Stability Plans: Emphasize Tenancy Supports

What can case management do to assist the person to be able to:

- Pay the rent on time?
- Treat the building with respect?
- Treat other people with respect?
- Follow the lease?
- Avoid getting the landlord in trouble with the police?

Housing Stability Plans:
Emphasize Tenancy Supports

Example: “Success Plan”

- Wheel of categories (health, mental health, income, education, etc)
- Color it in
- Visual

Sample Monthly Housing Stability Plan

- Is client/household able to resolve or advocate for unit failures? ◻ **yes** ◻ **no**
- Is client/household able access or complete laundry/house chores/clean apartment? ◻ **yes** ◻ **no**
- Is client/household able to grocery shop/obtain food from appropriates sources/store food safely? ◻ **yes** ◻ **no**
- Is client/household able to pay rent/aware or rent portion they are responsible for? ◻ **yes** ◻ **no**
- Is client/household able to communicate with landlord/property manager in appropriate ways, at appropriate times, for appropriate requests? ◻ **yes** ◻ **no**
- Is client/household able to follow guest policy's and be a responsible tenant? ◻ **yes** ◻ **no**
- Is client/household able to pay other bills associated with housing (electricity/heat/gas etc.)? ◻ **yes** ◻ **no**
- Is client/household able maintain medical (physical AND mental health) appointment, prescriptions, doctors' orders? OR Does client have an in-home health care providers or assistance to support in medical adherence? ◻ **yes** ◻ **no**
- Does client/household have ability to identify and participate in meaningful, safe, and fulfilling daily activities? ◻ **yes** ◻ **no**
- Does client/household have a crisis plan? ◻ **yes** ◻ **no**
- Are they able to identify when and how to use it? ◻ **yes** ◻ **no**

Proposed **Action Steps** to Discuss with Client at Re Certification

Action Step:____
____
Action Step:____
____
Action Step:____
____

Questions?

Wraparound Supports

Wraparound Supports- Tips for Programs

- In-home case management; securing other in-home services
  - Life skills emphasis- using stove, laundry, LL communication
- Clinicians on RRH team to consult on cases OR to do crisis intervention
  - Addressing and continually finding ways to combat loneliness and isolation
- Transportation
- Food shopping
  - Accompany; show how to find deals to buy food for a week
- Medical appointments
- Helping believe in themselves
- Connect to natural supports
- "Ride or die" case management
- Culture of feedback- "let them tell us when we're not doing well"
- Exit planning from Day 1- natural supports mapping; continuing subz. Hsg search; back pocket housing resources

Wraparound Supports- Complex Care

Understand the systems of care your client may be served by and how to navigate those systems

- Dept. of Mental Health
- Dept. of Developmental Services
- Elder services and/or municipal and state departments focused on elder health
- Health Plans- Often there are services provided under state-funded health plans to reduce one's usage of emergency medical services
  - In-home case management
  - In-home visiting nurses
  - Transportation, particularly to medical care

Wraparound Supports- Approaches to $ Max

- All RRH Case Managers trained in workforce development
  - One specialist who trains all CM's
  - Job apps, resume building, finding jobs
- SOAR-certified case managers on staff
- Care team, or medical home model
  - Team-based staff, rather than siloed referrals between staff
- Staff trained in employment, benefits and in-kind resource navigation
- Employing a "Work First" model
  - Same principles as Housing First; very low-threshold; harm reduction-based

Wraparound Supports- Subsidized Housing

Incorporate continued search for subsidized housing into your service package to bridge to affordable opportunities

- Should be optional for the participant and only pursued if interested
- Administrative work should be managed by the RRH staff, not the participant

Subsidized housing search entails staff to:

- Understand which housing programs to apply for
- Assist the participant to obtain credit and criminal reports to mitigate any barriers
- Obtain reference letters to offset any negative information
- Maintain records of all applications and documents
- Follow up with housing providers to ensure applications remain active; respond to mailing requests

Wraparound Supports- Subsidized Housing

Key housing programs staff should know how to navigate.

Housing Type	Things to Know
Continuum of Care (CoC) Permanent Supportive Housing (PSH)	This resource, dedicated to households experiencing homelessness, provides a long-term, deep subsidy paired with supportive services that last through the duration of tenancy/enrollment. Connect with the local CoC for information on how to access.
Local Public Housing Authorities (PHAs)	Identify the towns/cities in which the participant is interested in living and apply at the local PHAs. Opportunities may include federal/state-funded public housing, project-based Section 8, Moderate Rehabilitation (Mod Rehab) units, 811 Mainstream vouchers, and more. Some PHAs have preference or priority points for households experiencing homelessness.
Housing Choice Voucher Program	Commonly referred to as "Section 8 vouchers," this long-term subsidy often has a very long waitlist. That said, interested tenants should be encouraged to apply and secure a place on the list.
Low Income Housing Tax Credit (LIHTC) Program	LIHTC properties often have units set aside that are lower rent or income-based. These properties often have very specific income eligibility criteria. In many communities, the units are offered via a housing lottery.
Section 811 Project Rental Assistance (PRA)	This federally funded program offers project-based units with a deep subsidy to households in which at least one non-elderly member has a long-term disability. Section 811 PRA is currently available in 27 states.

Questions?

Wraparound Supports- Discussion

- How do you incorporate income maximization services into RRH?

- What supports seem to work the best, or are most used by your participants?

- What supports do you think are critical for high acuity households in RRH?

Group Share

What is one thing you heard today or thought about to try in your own program?

Next Session & Thank You!

- Our next session will cover the topic of progressive engagement.

- Are there any immediate questions you have for that session?