Strategies for serving highly acute households and making better connections to other systems/other County departments (APS, ADVSD, BH) to support PSH residents

October 31, 2023 Provider Conference

Notes - Session 1:
Facilitators: Katie Dineen and Kristina Goodman
Moderators: Adam Yang and Kanoe Egleston
Goals: System needs, service connections, existing pathways, etc.

Introduction

- Goal: To identify system needs, service connections, existing pathways and strategies for serving highly acute households
- Examples:
    - ADVSD training to internal staff about how to make referrals, access to services, etc. Outcome was an uptick in coordinated access for households with in home care - ADVSD services
    - Provider connections and building partnerships
    - JOHS hears about situations, challenges, issues once provider agencies have tried many routes/strategies. Would like to elevate those strategies for others to hear.

Small Break Out Discussions - 15 minutes
Large Group Discussions - 30 minutes

Knowing serving acute households is a challenge everyone is facing, what are you doing that has been working?

- Interdisciplinary teams
- Building partnerships
- Intentional programming and service delivery
- Training from service providers/service system to learn how to access services, make referrals and learn more about the program
- Resource round up in teams meetings
- Wellness plans that identify support network that can impact a person's overall well being
- Flexible client assistance programs
- Culturally specific case workers that work within the housing units (in house caseworkers)
- Behavioral health case workers embedded within the housing programs
- Psychiatric services that are mobile
- Bring services to the housing program. Example - Supportive housing program that integrates IDD/DD services

Where have you hit barriers in serving these households and connecting them to services?

- Behavioral health needs and the lack of services
- Increased coordination across county departments and intentional investments
- Gap in services
    - Medication management
    - Increased daily living skills
- Crisis and de-escalation training for property management/ non clinical folx who might work with higher acuity people in various capacities
- Difficulty in accessing services
- Lack of services and funding to children
- Balance needs of community as a whole in housing program and continue to provide services
- Need for more intentional culturally specific services
- Racism
- Lack of knowledge about existing services
- Impact towards other clients/tenants
- Symptoms exacerbated by substance use
- How do we go beyond immediate needs to a holistic approach to ensure folks in overall living/wellbeing (also that will help maintain their housing)
- Deteriorating while in housing - physical needs specifically; mental health; landlord impact/anger/frustration even when it is out of those person ability
- Client impact that comes with such high acuity. Struggling without the right tools at the local level
- Challenging referrals to PSH units - connect with individuals at lease up and not before. The mental health needs are so high that it is hard to determine if they can independently live on their own

What existing programs or services are helpful but are difficult to connect participants either due to funding or eligibility requirements?

- Medication management before moving into a PSH unit
- More African American behavioral health services for the BIPOC community. Therapists embedded in programs would be the best, and at the least within the community that have availability.
- Increase culturally specific housing programs
- Motel shelters work well for some to build a community and not be alone in an apartment. They feel safe, have access to meals, housekeeping, etc. Need for mental health services. - *Behavioral Health Motel programs*
- Built in homecare, meals, and housekeeping services (that still encompass individual living within their own apartments) - *Home Forward Congregate Housing Services Program*

What are programs or services that do not exist but would help with acute populations (i.e. PSH programs with medicine management, etc.)?

- County provided mobile nurses and psychiatric to scattered site programs that were free/no service
- Peer to peer support with young adults

Breakout #1 Notes
Strategies for serving highly acute households and making better connections to other systems/other County departments (APS, ADVSD, BH) to support PSH resident (PART 2)

Questions for small group:
Knowing serving acute households is a challenge everyone is facing, what are you doing that has been working?

Where have you hit barriers in serving these households and connecting them to services?

What is Working:
- Mobile Homeless Intake Team
- EHV Vouchers
- Long Term Rent Assistance and the success in vouchers
- Access to legal services to help folks retain housing or get into housing
- Participant got connected to CA and then CCC and then MPD and lots of barriers being removed
- Consistency in staff management so that relationships can be built
- Meeting in person and not just relying on technology
- Motel shelter - working on skill building so that they can be successful in housing
- Utilizing reasonable accommodation for people who have acute disabilities
- Move towards self-certification

Barriers:
A lot of people who are dealing with a situation who don't want to give up their money to nursing facilities and then there is a less than desirable amount is left to them

A lot of inconsistencies with peoples stories and there a lot of people who

Putting someone who has experienced long term homelessness in a nursing facility with other folks in the facilities and the dynamics of that can be difficult
- Some folks are not used to structure and want to continue previous behaviors they practiced outside

Lack of resources - when folks are ready to address their SUD there are long waits to get into treatment and help is not available when they need it. Can lead to exclusion from their programs because of BH issues

Increase in fentanyl use and overdoses and those not being just difficult for people suffering from them but for staff bring retraumatized

Lack of sufficient resources for mental health, DV resources, and the challenges in serving an aging population

Not enough staffing and finding staff to fill positions and remain in the positions

Folks getting into RRH housing but really needing PSH level of services

Matching the resources with capacity - EHV vouchers working but the amount of coordination required was a lot

Not all programs are shaped the same - 1:40 caseloads; the sustainability of them handling 40 people just to keep documentation and annuals and get rental checks out etc. is not sustainable for one person. When they are out someone needs to bear that load and then the program budget does not support this. You can get the same job at Target working as a cashier and the budget does not fit the position. The budget pays 70% of staff and we costshare 30% of that. The eco-system for this program never changes for staffing and supportive services. [CoC program] It is good to add to the system but if it cannot continue at this same pace and now you are caught in the continuum loop you cannot change the program budget or the outcomes and if you want to change it you have to apply for a new program. As things change and cost of living goes up it makes the program unsustainable. Needing to fundraise to operate these programs is difficult. Need to discuss with the program administrators - sustainability is not going to be forever and need the ability to come to the table and discuss how this is going to continue to work → having healthy programs to engage system wide to see how meaningful they can be into the future

Not the right resources in the community to meet needs and even if there are the right - understanding what all the resources are and how they are accessible

VI-SPDAT not accurately capturing person's acuity or situation

Housing case managers need to have linkages to other services to have a person's full needs met

Skilled nursing facilities are not equipped to serve people with behavioral needs and vise versa

Need for CHW in primary care clinics to coordinate with each other - has been working for some agencies but privacy barriers can get in the way. Often in the housing world we rely on participants to give medical information, but sometimes they don't have all the information. When there is coordination it works well

No free real IDs may be a barrier to getting benefits

Questions for large group:
What existing programs or services are helpful but are difficult to connect participants to either due to funding or eligibility requirements? What are programs or services that do not exist but would help with acute populations (i.e. PSH programs with medicine management, etc.)?

Transitional Housing attached to PSH vouchers that helps with skill building and med management while a participant is stabilizing

Unless someone's support service for mental health has a housing specialist on their team there is not the ability to provide housing support and that is hit or miss depending on what folks are connected to. A sole resource for housing specialist connected to mental health teams.

Retention services - programs that are actively working and doing case managements that have been housed and follow them for a year or two and adapting to this new situation and supporting with skill building. Post housing services case management particularly for shelter services. Continuity with case management for participants

In between housing that is not fully PSH and is not just RRH

BEST referrals are difficult - they have a 9 month waitlist and sometimes the biggest barrier to housing is getting the income ruling

Language on applications for apartments can be difficult → access to reasonable accommodations

- Modifying applications at properties to streamline or remove some of the things that may be challenging
- Working with property managers for housing to accommodate barriers and removing barriers
- Low barrier screening criteria

Breakout #2 Notes

- Older adult population – chronic health issues – aging – want to remain independent
    - Becomes clear that even with all the in home care – needs are not met
    - Create linkage to higher level of care and more supportive living but they decline
    - Issue is that it takes a lot of their income away to move into these assisted living spaces
- Smooth transition into BH services
- MPD has been a huge support – expungements, efficient, transparent about what can and can't be taken off the record, got denials overturned
- Barrier of housing people with criminal convictions
- Housing registered sex offenders – waitlist for few resources

- Acuity and finding external supports for crisis interventions. Have heavy case management team at sites, but acuity between MH and substance use is so intense that these interventions do not help. So far in psychosis and addiction
    - Trying to find very early intervention to help before
    - Re-engage a weekly meeting with JOHS to staff the people being served in the program
    - Weekly on site meetings with the team and external partners – talk about creative solutions
        - Sometimes participants trust external partners more – self-admittance to Unity
        - Talk about what are their warning signs, what is helpful from staff, ask if they are comfortable with them contacting external supports (sometimes family so they get ROIs), try to get as many people on the wellness plan
        - Do this at time of lease signing when people are often at a better place
        - What should we do and what should we not do
        - Biggest help is Unity and most helpful when they are self-admitting
    - Disheartening when they have done everything they can
- Lack of options for people even with robust PSH and can't live independently anymore
- Rent assistance provider:
    - Issue of people getting into programs that aren't PSH but needing that
    - People in crisis and ability to respond
    - Don't know if people are connected to a provider, don't have capacity to check, to get releases, etc.
- Using CA ROI is helpful to see where people are connected and to see where there are additional resources
- RLRA – great to pay deposits and move in fees with client assistance funds. Wouldn't happen without this. Helps place people faster. Community warehouse appointments.
    - Have moved people into housing in the past where they moved in with nothing

Breakout #3 Notes

- Community health workers in primary care clinics (not just in ERs) collaborate with one each other – MH stabilization needs, medical needs, and housing needs –
    - Privacy barriers in the way
    - People doing that housing work rely on participants to be the information giver but they are often not able to or equipped to
- Communication with participants and wraparound services – we follow the participant's lead
    - Challenge to communicate across providers and find resources
    - Eviction prevention is a huge need – seeing rents skyrocket
    - Need more open communication with rental assistance providers
- Hard to get participants to be honest about their criminal history – or for them to remember in a lot of cases – major barrier to housing
- Proof of homelessness is a barrier – move toward self-certification makes a huge difference

- Real IDs – IDs that unhoused people can get won't qualify as Real ID which means people can't use them for SS purposes

Notes - Session 2:
Facilitators: Katie Dineen and Kristina Goodman
Moderators: Adam Yang and Alyssa Plesser
Goals: System needs, service connections, existing pathways, etc.

Breakout #4 Notes

What have you been doing that has been working with folks with acute needs?

- Reaching out and trying to make partnerships with folks who can provide services - Outside In, Portland Street Response, Bridges Collaborative (?)
- Being flexible with needs seeing in our community
- At Clifford - bringing on a peer, trying to bring services back in that lost in pandemic like AA and NA
- Renovation happening at building - will be outreaching throughout renovation period to make sure folks stay stable
- [MHT Staff] - don't have a lot of resources to serve families this way. Have rent assistance and can connect folks to PSH. House people longer with RRH assistance that we have - it becomes longer than it normally would to bridge connection to PSH. Not necessarily direct support for acute situations, but keeping people stably housed is one of the most important things. This is what we focus on.
- [MPSH Staff] - multi agency team, have mental health provider, peer support and community health provider. Goal is to make sure families maintain housing. Before COVID would meet with property managers every three months, that's starting again in December. Importance of partnering with property managers
- See a lot of need for culturally specific services
- [Family Provider] - having PSH services for a lot of participants. Mental health is a huge barrier - don't feel like we're meeting people where they're at in the adult system. Lot of need out there and a lot of gap. Seeing a lot of gaps for people with a higher level of mental health need. Especially gap for people who aren't aware of their own need for mental health services - may not say the language we need them to say to meet the criteria.

What are the barriers?

- People have to want mental health services and have to be able to say the right things to be determined eligible
- Mental health as a barrier especially if have property managers calling case managers because there is a crisis. Not mental health providers - case managers are trained, but not experts in that field.
- People getting evicted because of mental health

- Resident services coordinators who have often times fallen into role of crisis management - not what they're set up to be. See a lot of capacity issues - agencies at capacity and not able to provide the expanded services that we need to see. Often times we'll call Project Respond and they can't come out, or will call APS and they're not able to do anything. So we're left to try and provide what services we can.
- Working at housing authority, when working with someone with behavioral health challenges and services aren't in place and also responsible for community as a whole. Have to make a decision about how much disruption we can handle while person is working to get connected to services that we can't provide directly
- Property management and other supports when mental health services aren't available - not having the training they need to support people
- Issue with building - office space often flooding so not always able to be on site
- More training for staff who aren't traditionally clinical or haven't thought of that as part of their role
- [DV Provider] - one barrier we see for people of color experiencing mental health challenges is racism. Residents are free to share, but we can't share information about residents with others. Have to be careful when someone experiencing mental health and white people are demeaning them in a racist way. Mainly towards people of color who have mental health challenges - described as "aggressive", "explosive", etc. Can be harmful in a community setting.
- [Housing Authority] - also see this challenge with staff of color. When clients are experiencing mental health challenges and using racist slurs or exhibiting other racist behaviors.
- [MHT Staff] - children with severe mental health and developmental issues, needing more support around that. Homeless children are probably the most underserved population / underfunded population. Lack of support and qualification for programs - a lot of family system will focus on the adults and not the children

Breakout #5 notes

Feedback for overall conference: Titles to conference are esoteric - not sure what means; work on clarity in what the topics are. Wasn't sure what "acute households" meant.

What's working well?

- Meeting in person and not relying on technology. Easier to understand how people are doing, read body language, etc.
- While folks at motel focusing on skills training that will support being successful in housing. Often with referrals we have an idea of what didn't go well with housing they're coming from so can focus on skills related to those areas.
- Utilizing legal process around reasonable accommodation to connect someone with their legal right to have landlord or housing provider modify their physical space or policies to accommodate whatever issue. Sometimes creative and also practical solution - when this works, it's

- Seeing clients with case manager that has been working with them for some time and know what they're doing - tend to have higher placements into programs. People do well when they have a consistent case manager.
- Piloting cross-department case consultation to help connect folks across systems to the services that they need

Barriers?

- Technology and scheduling appointments. Making initial contact. Consistent engagement is a challenge.
- So many folks whose symptoms present in a way that hard to find housing that meets their needs. Environmental hygiene, responding to various stimuli at night, etc. Folks who have sex offense status and not many options for them.
- Not knowing what is available - residential treatment, supportive housing, semi independent. Not a clear place to understand what the resources are and how to connect people. See a lot being on site that we can advocate for, but not knowing what is open and when.
- VI-SPDAT - folks are extremely vulnerable but not captured in the questions asked. If don't have medical complications won't score high. Area where they may only score one point even though it's a really significant vulnerability.
- Ideally folks would be connected to ACT/ICM Team but not available, wait lists are long. Availability of community-based resources to support households. Not having an external housing specialist to connect to unless it's with someone's treatment team - having specific resource that we can connect people to to help with the housing process (feedback from MH motel shelter provider)
- Job retention - struggle to hire and retain staff because work is so hard. Turnover of case managers is a big challenge.
- People come to you with lots of different needs and you can only do so much as a housing person. Everyone needs someone who can help them navigate all of the systems/resources.
- Someone who has high medical complications but skilled living facility is not equipped to support mental health side and mental health side is not equipped to support physical ends