Best Practices for Serving People With High Acuity Needs

October 20, 2020

Housekeeping

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https://www.hudexchange.info/homelessness-assistance/diseases/#covid-19-webinars-and-office-hours

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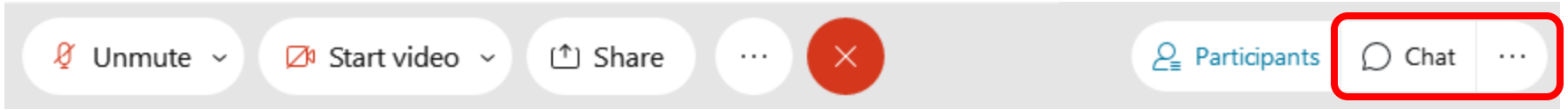
Chat Feature



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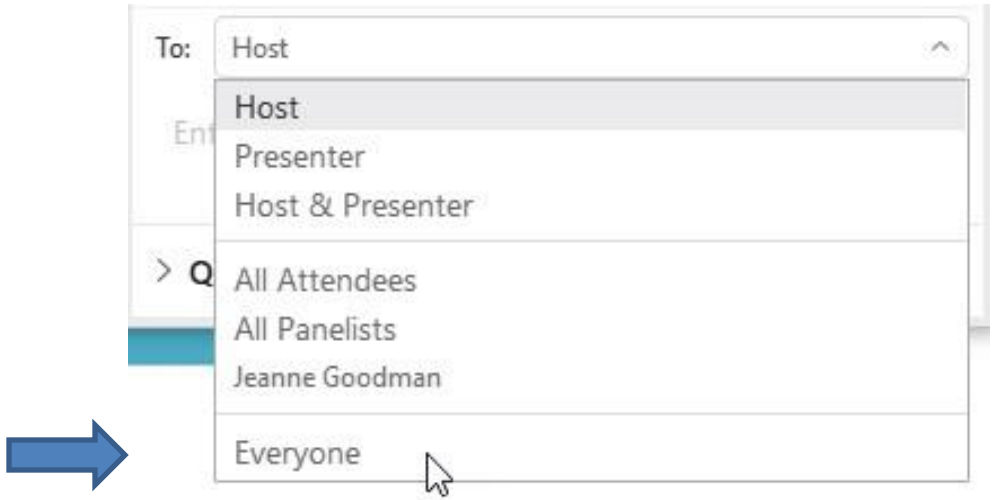

Presenters

- Brett Esders, Senior Program Specialist, HUD-SNAPS
- Dana Woolfolk, QMHP-A, National Coalition for the Homeless
- Kim Keaton, Director of Data & Analytics, CSH
- Derek Wentorf, Senior Program Manager, CSH
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Webinar Overview and Objectives

- Understand acuity definitions and the different service approaches for people with low, medium, and high acuity.
- Deepen understanding of how RRH can serve populations with different acuity levels.
- Provide guidance on how CES can be adapted to better serve and prioritize people with high acuity

PERSPECTIVE FROM DANA WOOLFOLK

HIGH ACUITY DEFINITIONS

Acuity Definition in Housing Context

Consider:

- Severity and chronicity of illness and disabilities;
- Level of care needed to support activities of daily living, including assessing assistance required to support communication, decision-making, mobility, and managing challenging behaviors; and
- Recognition of the exponential effects that multiple co-occurring chronic health and behavioral health conditions can have, particularly when coupled with the effects of systemic racism and historical trauma, adverse childhood experiences, isolation from family and friends, lack of safety net in times of crisis and disconnection from mainstream community health providers.

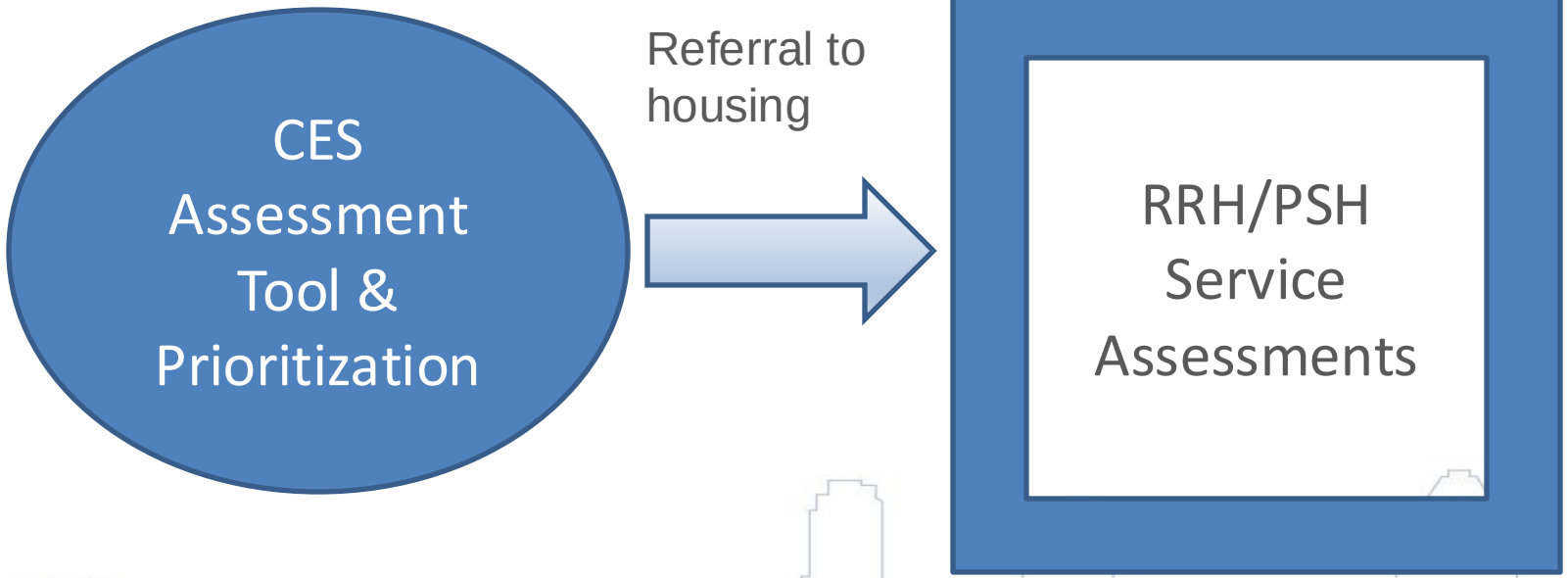
Factors Influencing High Acuity

- Illness, physical, mental, behavioral health (diagnoses, chronicity of illness, severity)
- Cognitive functioning (memory, thinking, reasoning, decision making and communication skills)
- Independence in activities of daily living (e.g. showering/tending to personal hygiene; cleaning/maintaining living space; taking out trash, grocery shopping, cooking/preparing food, taking medications)
- History of trauma and adverse childhood experiences
- Levels of natural supports and connectedness to family, friends, community, resources
- Housing history (chronicity of experience of homelessness) and past tenant experiences

Acuity Classifications and Service Needs

Acuity Classification	Caseload Size	
High acuity	1:10-1:15	• High levels of coordination with mental/behavioral/health • Likely to need PSH in long run to support housing stability • High acuity in RRH can be addressed with mixed caseloads
Moderate acuity	1:16-1:30	• Similar need for coordination • Many may need longer support than time-limited RRH, particularly true of BIPOC disproportionately impacted by pandemic
Low acuity	1:31-1:50	• Coordination combined with warm handoffs to other community providers • Need for RRH services should be reassessed every 3-6 months to determine the need for continued services to promote housing stability and retention.

Assessing for Acuity



- Specific needs and vulnerabilities to assure safety from COVID-19
- Comprehensive biopsychosocial assessment of acuity – medical conditions, mental health/substance use, mobility, visual/hearing impairment, memory, natural supports, housing history and ADLs

MIXED ACUITY LEVELS AND STAFFING MODELS

Operating Housing with Mixed Acuity Tenants

- **Systems** need to evaluate ways that referrals are sent to programs (*covered in the previous section on acuity and CES*)
- **Housing providers** need to evaluate how they are supporting individuals that are in housing
- Looking at the capacity of staff, evaluating and responding to the time requests that each tenant is making for support and then pivoting as you learn more about what the tenant would like and what support services are available takes a sophisticated and nimble service provider network
- **The most important metric is how can each community support every individual to stay in housing**

Example of Mixed Acuity Staffing Review Matrix

	Case Manger A	Case Manager B
Low Acuity (Scores of 1-3)	4 households = 12 Acuity Score	25 households = 68
Moderate Acuity (Scores of 4-7)	1 household = 5 Acuity Score	2 Households = 11
High Acuity (Scores of 8-10)	8 households = 78 Acuity Score	1 Household = 9
Caseload Size	13 Households Acuity Score = 95	28 Households Acuity Score = 88

Multidisciplinary Teams in Housing

- Tenants in housing programs should be leading the process and service providers should be actively engaging each tenant
- Service providers need to think about how they are incorporating access and connections to:
  - Peer supports
  - Other professional supports (mental and physical health, employment, education, etc.)
  - Community connections (family, friends, neighborhood, arts communities, etc.)
- Providers should not assume they need to do everything: Teams working to support tenants should have a wide array of supports available and work hard to communicate and coordinate with each other

Minimize Transitions: A Strengths-Based Approach

- **Belief**: Culture of belief in strengths and success is contagious
- **Assets**: Highlight the assets that every tenant brings into their housing situation
- **Tenant Centered**: Follow their lead and work to alleviate barriers not create more hurdles
- **Trauma-Informed**: People who have experienced homelessness have trauma associated with housing and that can get in the way of self belief

Preparing for Transitions to Different Subsidies

System Responsibilities

- Understand the barriers your system might have in place
- Work to implement a process that can expedite transitions when deemed necessary
- Track the number of transitions happening
- Evaluate what that means for your system

Direct Service Provider Responsibilities

- Build connections to the providers operating different subsidy level programs
- Provide a “warm hand off” between programs if a transition does take place based in relationship and transparency
- Work collaboratively to find the best support for that tenant

EVIDENCE-BASED SERVICE DELIVERY

Evidence-based Practice

- Evidence-based practice refers to a rigorously and scientifically evaluated practice designed to achieve specific outcomes
- Critical time intervention (CTI), Assertive Community Treatment (ACT), and Intensive Case Management (ICM) are examples of evidence-based practices
- For more information about each of these interventions, please visit the Disease Risks and Homelessness page on the HUD Exchange and search for Evidence-based Service Delivery (https://files.hudexchange.info/resources/documents/COVID-19-Homeless-System-Response-Evidence-based-Service-Delivery.pdf)

Start with the Client and Build Trust

- Regardless of what evidence-based practice you use, the most important thing to remember is to start with the client, specifically focusing on the immediate needs of client at the time that you are working with them.
- Key characteristic of any evidence-based practice is trust – all successful client/service provider relationships are built on trust
- Case managers must build trust with the client – be honest and genuine, and be clear about what you can and cannot offer to the client
- This is a tumultuous time for everyone. However, the ongoing violence toward and oppression of BIPOC has likely created additional stress for many clients, worsening the effects of the concern over COVID-19.

Critical Time Intervention (CTI)

- Developed in the 1980s to address the homeless response system's approach to housing and services for individuals experiencing homelessness that also were living with mental illness
- The CTI approach supports clients going through a transition (ex. moving from shelter to rapid rehousing) with a time-limited and phased intervention
- Connecting clients to a support network within their environment and building clients' abilities to navigate this network and the larger community are key features of this approach

Assertive Community Treatment (ACT)

- Developed to support individuals with serious mental illness (SMI) and help them thrive in their communities
- Characterized by multidisciplinary teams (ex. psychiatrist, nurse, social worker) that are available 24/7 and can offer support, treatment, and rehabilitation services
- Services are voluntary, individualized, and based upon client needs
- ACT teams are typically used for individuals with high acuity, meaning those that require the most intense services to remain stably housed and engaged in care

Intensive Case Management

- Primary goal of case management is to help enhance and improve a client's wellbeing and ability to function by providing and coordinating high-quality services
- Core functions of case management include assessment, goal setting, service coordination, discharge planning, and termination
- Intensive case management can be used for individuals with high acuity, although it is a less intense approach then ACT

In Conclusion

- Regardless of the evidence-based practice(s) you choose, the focus is the client's needs and how you, as case manager, can support the client's success (which can and will look different for everyone)
- Building trust and being genuine will result in a successful therapeutic relationship
- This work is challenging, and successful case managers find space to engage in self-care.

PERSPECTIVE FROM DANA WOOLFOLK

USING COORDINATED ENTRY TO SERVE HIGHLY ACUTE PEOPLE

CE Requirements

Goal of Coordinated Entry (CE): to prioritize and match people who are most in need of assistance with resources to quickly and effectively end their homelessness.

"[The] coordinated entry process must, to the maximum extent feasible, ensure that people with more severe service needs and levels of vulnerability are prioritized for housing and homeless assistance before those with less severe service needs and lower levels of vulnerability."

Notice CPD-17-01

Focus on Who's Actually There

- Center **the actual people** most in need of services and resources in operating your CE system, rather than centering the ideal system design or a projects' preferred clients.
- Ensure racial equity by **assessing a person's acuity level holistically**, not just using documented medical diagnoses or healthcare system usage.
- For CE to meet its goals and requirements, **projects should be flexible** in their design to meet the needs of the people who present for resources

Prioritize Highly Acute People for All PH Resources

- Use CE to prioritize highly acute people for **all available permanent housing resources**, not just PSH.
  - CE policies may need to change to allow for people with high acuity needs to be matched with RRH resources
  - RRH may typically be reserved for people with less intensive service needs, but the urgency of COVID-19 highlights the need for communities and projects to adapt to ensure that people with higher acuity levels do not remain homeless while lower acuity households access services more quickly

HUD FAQ 3735 on Prioritizing Persons at Increased Risk from COVID-19

Given the significant public health crisis and the unique circumstances of the COVID-19 pandemic, it may be appropriate for CoCs to prioritize households *who are at increased risk for severe illness from COVID-19 based on objective factors.*

Given the urgency of the present situation and taking into account the specific subpopulations served by HUD's homelessness programs and the demonstrated impact homelessness has on aging, it may be permissible to prioritize the following categories of persons for assistance within a CE process, provided that the persons in these categories are eligible for programs receiving CE referrals and the process is applied consistent with federal nondiscrimination requirements:

1. People 50 years and older
2. People of all ages with the following underlying medical conditions:
    - Cancer
    - Chronic kidney disease
    - Chronic obstructive pulmonary disease (COPD)
    - Immunocompromised state (weakened immune system) from solid organ transplant
    - Obesity (body mass index [BMI] of 30 or higher)
    - Serious heart conditions, such as heart failure, coronary artery disease, or cardiomyopathies
    - Sickle cell disease
    - Type 2 diabetes mellitus

FAQ 3735

HUD FAQ 3735 (continued)

Additional Objective CE Factors to Address the Impact of COVID-19

In addition, CoCs may also choose to incorporate additional objective factors into their CE process to address the impact of COVID-19 on individuals and families who are homeless or at risk of homelessness. Permissible factors may include any of the following factors:

- Elevated risk of transmission at the location where the person is currently living (e.g., on the street, in a congregate setting such as a shelter, jail, or prison, or other arrangements)
- Inability to take steps to avoid transmission where the person lives or works (e.g., multiple people sharing a sleeping space, work or living environment with close physical interactions and inadequate personal protective equipment (PPE), or living in a place without access to running water)
- Lack of access to healthcare (e.g., lack of health insurance, lack of primary care provider, or use of ER for all medical care)

FAQ 3735

Establish Clear CE Policies & Procedures

- Ensure CE policies and procedures for both **prioritization** and **referral/matching** connect high-acuity people with all available permanent housing resources for which they are eligible, and honor client choice.
  - Update written CE policies & procedures to account for all CoC- and ESG-funded projects (including ESG-CV)
  - Set standards for determining who gets referred to PSH vs. RRH
- Establish clear and standardized **project rejection policies**, and track all rejected referrals to ensure consistency and accountability.

Prioritization Changes to Account for High-Acuity People during COVID-19

- Update existing prioritization processes to incorporate people who are at risk of severe illness or death from COVID-19
- Consider creating an addendum to existing CE policies & procedures that could set rules for a specific time period or for specific funding sources (e.g., ESG-CV)

CE Prioritization Considerations: COVID-19

How to Identify People at Risk

- Update CE Assessment with COVID-19 risk factors
- Partner with the Department of Public Health to identify people at risk of severe illness from COVID-19 (e.g., Chicago)

Limits

- Estimate the period of time that the new prioritization will be in effect and review regularly

Who or What the Prioritization Covers

- Define whether the prioritization covers all program models (e.g., Rhode Island) or only specific resources (e.g., only for ESG-CV)

Establish Clear Feedback Loops & Transition Protocols

- Embed feedback loops between CE system and projects to plan for transitions to longer-term supports when needed.
  - It is impossible to predict how a person's needs may change once they are housed. System flexibility is key in responding to people's changing needs

Adopt a "Yes, And" Approach

Adopt a community-wide "yes, and" approach instead of a "yes, but" approach

Examples of a "yes, but" approach	Examples of a "yes, and" approach
• We have many people experiencing homelessness with high-acuity needs who are awaiting resources, **but** my RRH project cannot meet their needs	• We have many people with high-acuity needs, **and** we are working to shift our RRH staffing model and provide additional training and support to direct service staff to quickly and effectively rehouse our community's highest-acuity people.
• We have many people on our by-name list who've "scored" for PSH, **but** our CE system can't match them because none of our PSH projects have openings.	• We have many people who've "scored" for PSH with no PSH project openings, **and** we are supporting RRH projects to build capacity to serve higher-acuity clients, **and** we are ensuring our CE system plans for connections to longer-term resources when needed.

Q & A

CE Resources

- Advancing Racial Equity through Assessments and Prioritization (*August 10, 2020*)
- Changes to CE Prioritization to Support and Respond to COVID-19 *(May 8, 2020)*
- High Acuity: Transition from Short-Term to Long-Term Subsidy *(August 11, 2020)*
- FAQ 3735: Are there actions a CoC may take within its CE process to prioritize persons who are at increased risk of severe illness from COVID-19? *(August 25, 2020)*
- Notice CPD-17-01: Notice Establishing Additional Requirements for CoC Centralized or Coordinated Access System

Further Resources

High Acuity Primer: https://www.hudexchange.info/resource/6182/covid19-homeless-system-response-primer-on-serving-people-with-high-acuity-needs/

Evidence Based Practices: https://files.hudexchange.info/resources/documents/COVID-19-Homeless-System-Response-Evidence-based-Service-Delivery.pdf

Case Management Ratios: https://files.hudexchange.info/resources/documents/COVID-19-Homeless-System-Response-Case-Management-Ratios.pdf?utm_source=HUD+Exchange+Mailing+List&utm_campaign=c0d038d823-SNAPS-COVID-19-Digest-08-11-2020&utm_medium=email&utm_term=0_f32b935a5f-c0d038d823-18477021