CalAIM Community Supports Webinar

Housing Transition Navigation Services, Housing Deposits, and Housing Tenancy and Sustaining Services

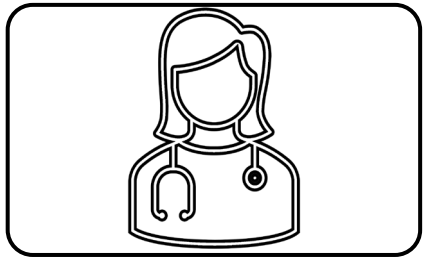
DHCS

October 20th, 2022

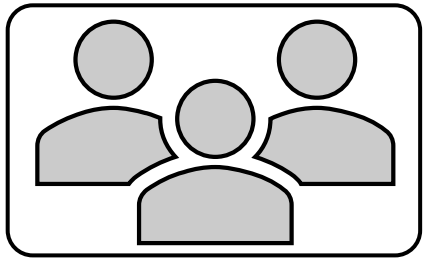
Agenda

- Welcome and Introductions
- Review of Housing Transition Navigation Services
- Review of Housing Deposits
- Review of Housing Tenancy Sustaining Services
- Promising Practices
- Q&A

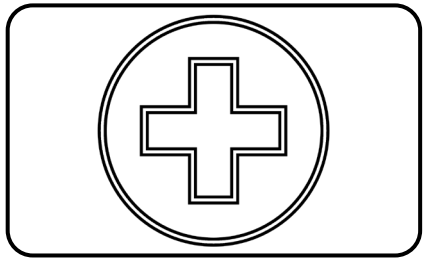
CalAIM and Community Supports



CalAIM Community Supports are **optional services** that health plans can opt to provide in lieu of higher-cost services traditionally covered by Medicaid.



CalAIM includes **14** Community Supports.



MCPs selected Community Supports to offer when CalAIM went-live on January 1, 2022 and have the **option to add new Community Supports every six months.**

In Lieu of Services (ILOS) Authority 101

What Are "In-Lieu-Of" Services"?

ILOS are **medically appropriate** and **cost-effective services or settings** offered by a managed care plan as a **substitute** for a Medicaid state plan-covered service or setting.

States to date have covered various targeted ILOS. California's recent approval, however, establishes that ILOS authority can be used to offer a ***comprehensive menu*** of health-related services in Medicaid.

*Example: Offering **home asthma remediation** in lieu of **future emergency department visits.***

Regulatory requirements: ILOS are authorized through federal regulation[1)] which specifies that services must be:

- Medically appropriate and cost-effective substitutes for a covered service or setting under the Medicaid State Plan
- Authorized and identified in the plan contract
- Offered at plan and enrollee option

The regulation also specifies that the cost of ILOS is taken into account in rate setting.

1) 42 CFR §438.3(e)(2)

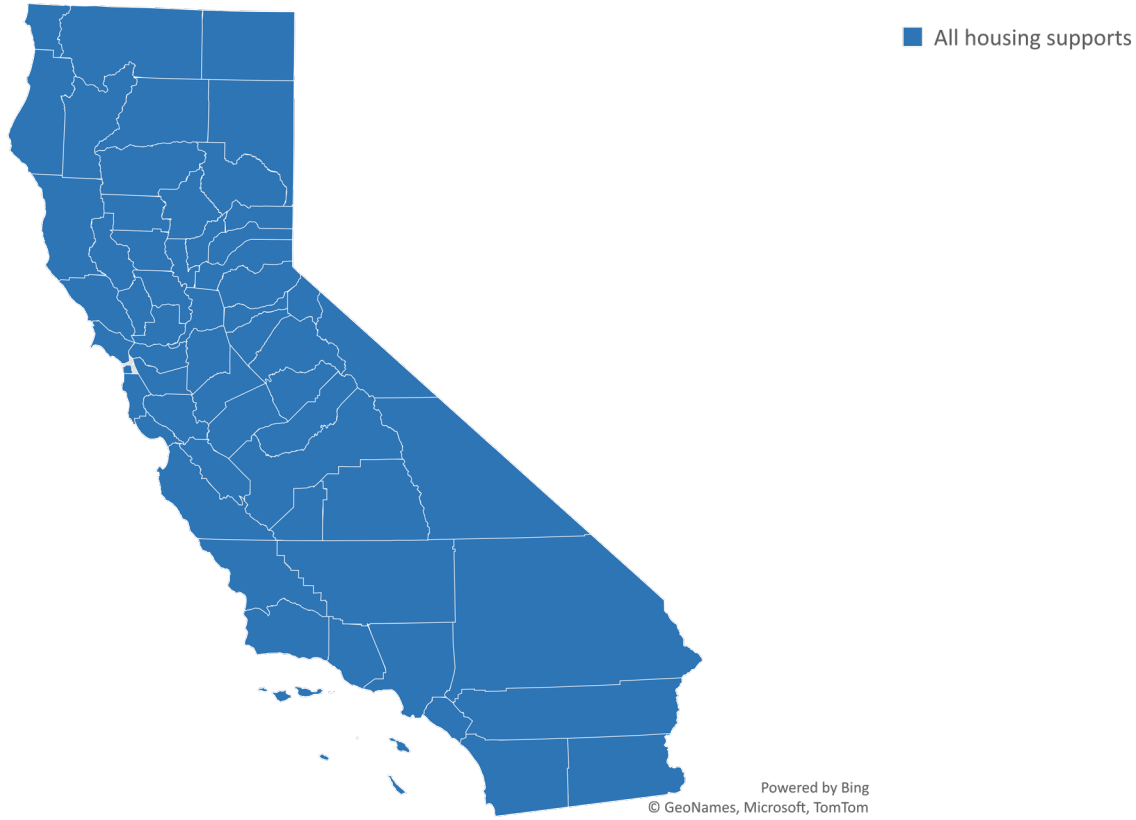
Community Supports Services Approved in California

- **Housing Transition Navigation Services**
- **Housing Deposits**
- **Housing Tenancy and Sustaining Services**
- Respite Services (for Caregivers)
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations
- Medically Tailored Meals/Medically-Supportive Food
- Sobering Centers
- Asthma Remediation
- Short-Term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)

MCP Elections

Support	Plans-by-County Offering Community Support by January 2024
Housing Transition Navigation Services	106
Housing Deposits	105
Housing Tenancy Sustaining Services	106

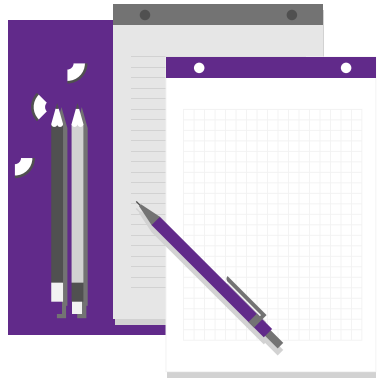
Counties offering Housing Transition Navigation Services, Housing Deposits, and Housing Tenancy and Sustaining Services by January 1, 2024



Housing Transition Navigation Services

Guidance Summary

What are Housing Transition Navigation Services? (1/3)



- Conducting a tenant screening and housing assessment
- Developing an individualized housing support plan
- Searching for housing and presenting options
- Assisting in securing housing, including housing applications and required documentation
- Assisting with benefits advocacy

Outlined by the DHCS Community Supports Policy Guidance

Housing Transition Navigation Services (2/3)

- Identifying and securing available resources to assist with subsidizing rent
- Identifying and securing resources to cover expenses, such as security deposit, moving costs, adaptive aids, environmental modifications, moving costs, and other one-time expenses
- Assisting with requests for reasonable accommodation
- Supporting environmental modifications to install necessary accommodations for accessibility
- Landlord education and engagement
- Communicating and advocating on behalf of the Member with landlords

Outlined by the DHCS Community Supports Policy Guidance

Housing Transition Navigation Services (3/3)

- Assisting in arranging for and supporting the details of the move
- Supporting non-emergency, non-medical transportation to ensure reasonable accommodations and access to housing options
- Establishing procedures and contacts to retain housing
- Ensuring that the living environment is safe and ready for move-in

Outlined by the DHCS Community Supports Policy Guidance

Service Limitations

- Housing Transition/Navigation services must be identified as reasonable and necessary in the member's individualized housing support plan
- Community supports shall supplement and not supplant services received through state, local and federally-funded programs
- Services do not include the provision of room and board or payment of rental costs

Outlined by the DHCS Community Supports Policy Guidance

Coordination With Other Entities

- County Health, Public Health, Substance Use, Mental Health, and Social Services Departments
- County and City Housing Authorities; Continuums of Care and Coordinated Entry System
- Sheriff's Department and Probation Officers
- Local legal service programs, community-based housing providers, local housing agencies, and housing development agencies
- Local rental subsidy operators
- County behavioral health agencies

Outlined by the DHCS Community Supports Policy Guidance

Eligible Populations

- **Please view the Community Supports Policy Guide for complete eligibility criteria**
- Individuals who meet the following criteria *may* qualify:
  - Prioritized for permanent supportive housing or rental subsidy
  - Meet HUD definition of homeless *and* meet one of the following:
    - Receiving ECM
    - One or more serious chronic condition and/or SED/SMI
    - At risk for institutionalization due to SUD
    - Child or youth who qualifies as "homeless" under alternate definitions
    - Transition-Age Youth with significant barriers to housing stability

Outlined by the DHCS Community Supports Policy Guidance

Allowable Providers

Examples include:

- Vocational services agencies
- Life skills training and education providers
- County agencies
- Public hospital systems
- Social services agencies
- Affordable housing providers
- Supportive housing providers
- Federally qualified health centers and rural health clinics
- Providers of services for individuals experiencing homelessness
- Substance use disorder treatment providers, including county behavioral health

Outlined by the DHCS Community Supports Policy Guidance

Housing Deposits

Guidance Summary

How Does the Housing Deposits Community Support Work?

- Identify, coordinate, and fund one-time services and modifications
- Based on individualized assessment of needs
- Documented in individualized housing support plan

Outlined by the DHCS Community Supports Policy Guidance

Service Offerings

- Security deposits required to obtain a lease on an apartment or home
- First month's and last month's rent as required by landlord
- Set-up fees/deposits for utilities
- First-month coverage of utilities
- Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy
- Goods such as an air conditioner or heater, and other medically-necessary adaptive aids and services

Outlined by the DHCS Community Supports Policy Guidance

Eligible Populations

- Any individual who **received Housing Transition/Navigation Services Community Support**
- Individuals who are **prioritized for a permanent supportive housing unit** or rental subsidy resource through the local homeless Coordinated Entry System or similar system
- Homeless individuals who **meet HUD definition** and are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or are at risk of institutionalization or requiring residential services as a result of a substance use disorder

Outlined by the DHCS Community Supports Policy Guidance

Allowable Providers

Examples include:

Entities coordinating an individual's Housing Transition Navigation Services

Medi-Cal managed care plan case manager, care coordinator, or housing navigator

Outlined by the DHCS Community Supports Policy Guidance

Service Limitations and Restrictions

- Services do not include the provision of room and board or payment of ongoing rental costs beyond the first and last month's coverage
- Available once in an individual's lifetime
  - Housing Deposits can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Deposits would be more successful on the second attempt
- These services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the Member is unable to meet such expense
- Individuals must also receive Housing Transition/Navigation services in conjunction with this service

Outlined by the DHCS Community Supports Policy Guidance

Housing Tenancy and Sustaining Services

Guidance Summary

What are Housing Tenancy and Sustaining Services?

- Provides tenancy and sustaining services with a goal of maintaining safe and stable tenancy once housing is secured
- The services may involve coordination with other entities to ensure the individual has access to supports needed to maintain successful tenancy
- Based on individualized assessment of needs and documented in the individualized housing support plan

Outlined by the DHCS Community Supports Policy Guidance

Housing Tenancy and Sustaining Service Offerings (1/2)

- Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy
- Coordination with the landlord and case management provider
- Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction
- Advocacy and linkage with community resources to prevent eviction
- Assistance with benefits advocacy
- Assistance with the annual housing recertification process

Outlined by the DHCS Community Supports Policy Guidance

Housing Tenancy and Sustaining Service Offerings (2/2)

- Providing early identification and intervention for behaviors that may jeopardize housing
- Continuing assistance with lease compliance
- Other prevention and early intervention services identified in the crisis plan
- Education and training on the role, rights, and responsibilities of the tenant and landlord
- Coordinating with the tenant to review, update, and modify their housing support and crisis plan on a regular basis
- Health and safety visits
- Providing independent living and life skills

Outlined by the DHCS Community Supports Policy Guidance

Eligible Populations

Please view the Community Supports Policy Guide for complete eligibility criteria

- Any individual who received Housing Transition/Navigation Services Community Support
- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system
- Homeless individuals who are receiving ECM, or have one or more serious chronic conditions and/or serious mental illness and/or are at risk of institutionalization or requiring residential services as a result of a substance use disorder
- Individuals at risk of experiencing homelessness who face significant barriers to housing stability and have one or more serious chronic conditions, Serious Mental Illness, are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder, or have a Serious Emotional Disturbance, are receiving ECM, or are eligible Transition-Age Youth

Outlined by the DHCS Community Supports Policy Guidance

Allowable Providers

Examples include:

- Vocational services agencies
- Providers of services for individuals experiencing homelessness
- Life skills training and education providers
- County agencies
- Public hospital systems
- Mental health or SUD treatment providers, including county behavioral health agencies
- Supportive housing providers
- Federally qualified health centers and rural health clinics

Outlined by the DHCS Community Supports Policy Guidance

Service Limitations and Restrictions

- Services are available from the initiation of services through the time when the individual's housing support plan determines they are no longer needed
- Service duration can be as long as necessary
- Available for a single duration in the individual's lifetime
  - Housing Tenancy and Sustaining Services can be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Tenancy and Sustaining Services would be more successful on the second attempt

Outlined by the DHCS Community Supports Policy Guidance

Service Limitations and Restrictions

- Services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the enrollee is unable to successfully maintain longer-term housing without such assistance
- Housing Transition/Navigation are not a prerequisite for eligibility
- Services do not include the provision of room and board or payment of rental costs.

Benefits of Comprehensive Housing Supports

- 40-77% reduction in inpatient days[1,2]
- 26-67% reduction in ED visits[1,2]
- 27% reduction in inpatient psychiatric admissions[1]
- 59% decrease in crisis stabilization service utilization[2]
- $23,000-$52,000 savings for top decile of utilizers[1]

Impact of Comprehensive Housing Supports

- Annual rate of emergency department (ED) visits is 75% lower among housed individuals compared to unhoused individuals[3]
- 17% increase in undetectable viral loads among HIV-positive individuals receiving housing and case management[4]
- Improved quality of life, reduced substance use, and improved physical and mental health[5]

Best Practices

- Housing First
- Harm Reduction
- Progressive Engagement
- Motivational Interviewing
- Trauma-Informed Care

Pricing Guidance

- The Non-Binding ILOS Pricing Guidance outlines a high-level pricing approach reflecting typical staffing ratios, caseloads, and service intensity.
- While the Pricing Guidance suggests a Recommended Maximum of $5,000 for Housing Deposits, there is no upper limit established by DHCS for the Service Rate. If an MCP determines that it would be cost-effective to offer this service to a Member beyond that limit, they may do so.

Housing Supports: Provider Promising Practices

Experiences Accessing Community Supports

Kyle Stefano, LCSW
Vice President of Clinical Programs, Sacramento Covered

Sacramento Covered At A Glance

- Community-based organization for 25 years
- Connect people to health coverage, primary care, and community resources
- Peer-driven, Data-informed approaches
- One of the largest field-based outreach teams in Sacramento County
  - Over 75 Community Health Workers, Health Navigators and Patient Navigators
  - More than 15 languages spoken

Pre-CalAIM World

» Involvement in Whole Person Care (Nov 2017 – Dec 2021)

» Involvement in Health Homes Programs (July 2019 – Dec 2021)

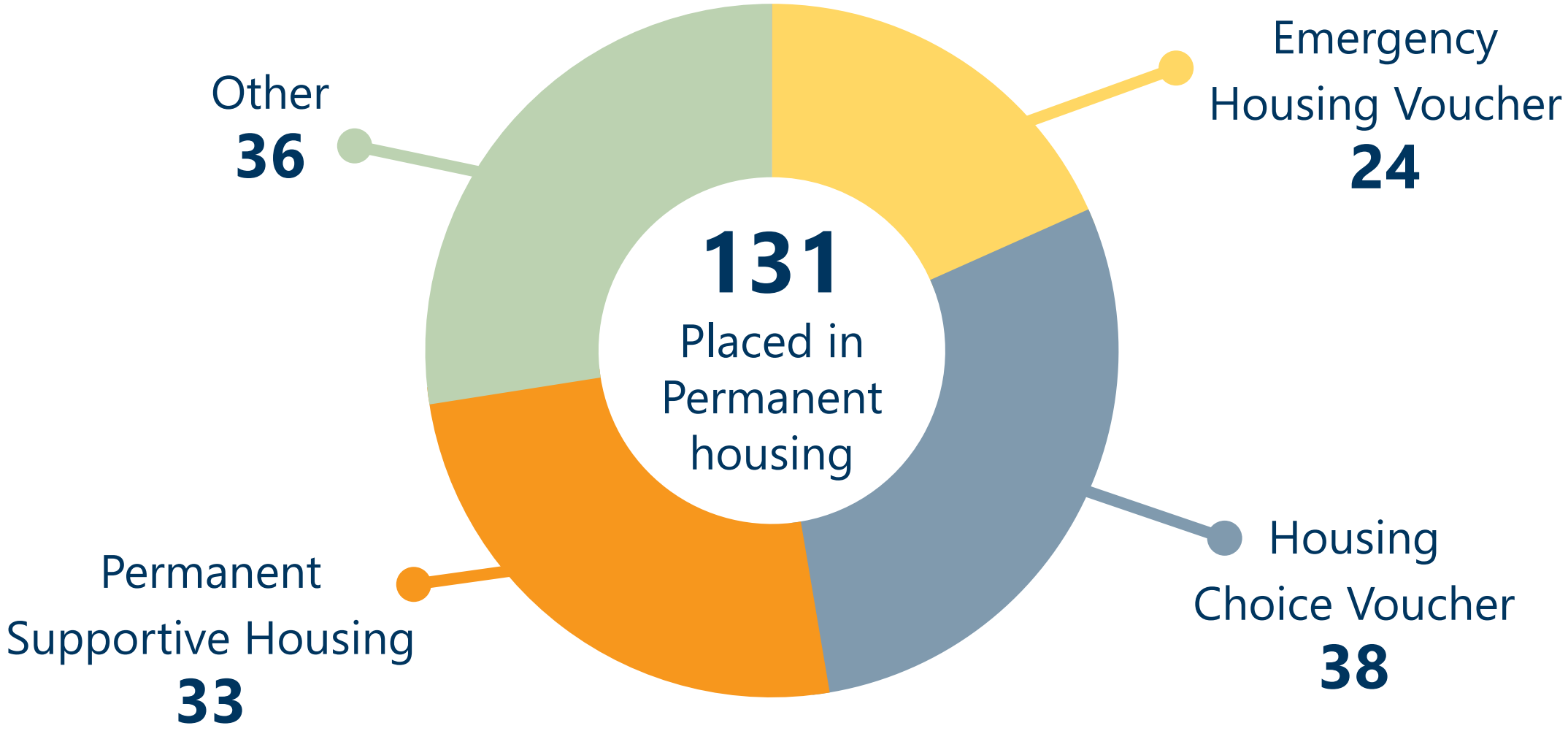
Post-CalAIM World

- Contracted with all 5 plans in Sacramento
  - Aetna, Anthem, HN, KP, Molina
    - ECM
    - CS housing trifecta:
      1) Transition/navigation
      2) Tenancy/support
      3) Housing deposits

Challenges

- Plans covering different costs in the Housing Deposit benefit
- Interpreting nuances of DHCS requirements differently
- Access to housing vouchers & other rent subsidies
- Housing stock; getting landlords to come to the table

Success (January – August 2022)



St. John's Community Health Community Supports Implementation Strategies

Ann Milton
Director of CalAIM, St. John's Community Health

St. John's Community Health

- 2nd largest non-profit healthcare provider in Los Angeles County. Our Federally Qualified Health Center serves patients of all ages.
- St. John's strives for health equity by addressing the health care needs of low-income, uninsured, and under-insured people in Central/South Los Angeles and Compton.
- 12 Community Health Centers, 6 School Based Health Centers, 3 Mobile Access Express Clinics, and 1 Homeless Service Center
- 450,891 primary care visits this year
- ECM & CS both utilize e-Clinical Works (ECW) to document patient progress

Contracted Community Supports

- Housing Transition Navigation
- Tenancy and Sustaining Services

Note: Housing Deposits will be implemented January 2023 with Health Net.

Community Supports Overview

- When did you start implementing the program?
  January 01, 2022
- Contracted Health Plans:
  LA Care, Health Net, and Anthem Blue Cross
- Serving already medically assigned members AND all members (i.e., non-patients)?
  - **Grandfathered members from LA Care only**
  - **Health Plan assigned members**
  - **Accepts existing and non-St. John's patients**

Community Supports Overview

- **Staffing Model:**
  - 1 Program Manager
  - 1 Outreach Specialist
  - 7 Housing Care Managers
- **Total Enrolled: 323 patients**
  - Housing Transition Navigation: 246
  - Tenancy and Sustaining Services: 77
- **Current caseloads:**
  - Housing Care Managers: 50 patient caseload

Internal Marketing Strategies

Strategies to promote awareness of CS Services among all staff

- Outreach Specialist is stationed at Homeless Drop-In Centers once a week; conducting outreach for both CS and ECM

- CS and ECM Care Managers are stationed at 3 of our larger clinics

- Care Managers attend community events hosted by St. Johns Programs department monthly

Strategies to train on workflows for referrals to program

- ECM & CS have individual program emails

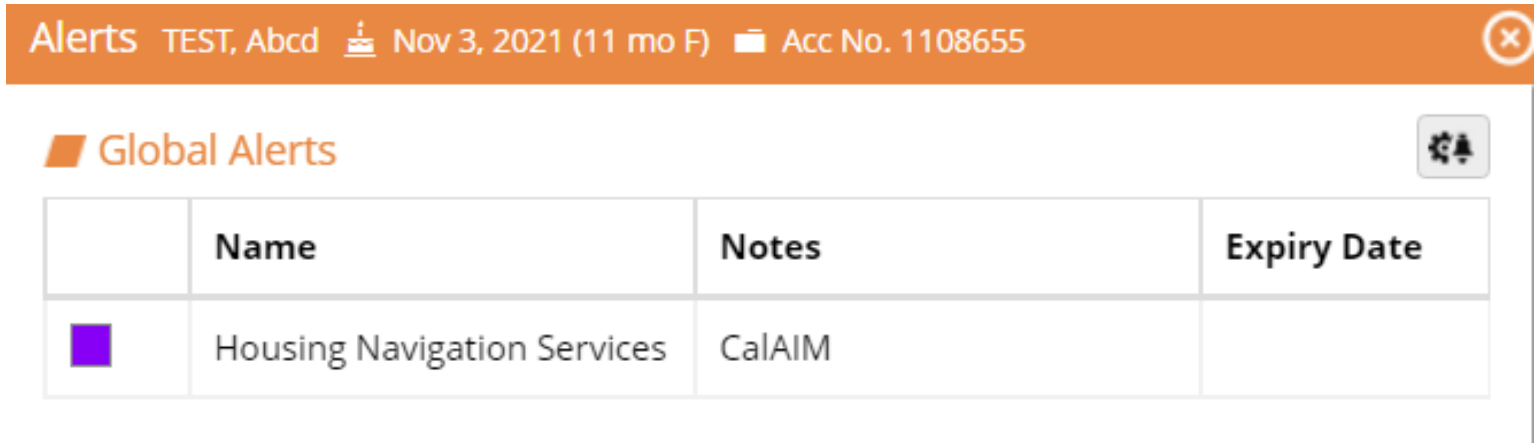
- ECM & CS flyers are displayed in clinic lobbies, exam rooms, provider areas and mobile clinics

Community Supports Integration

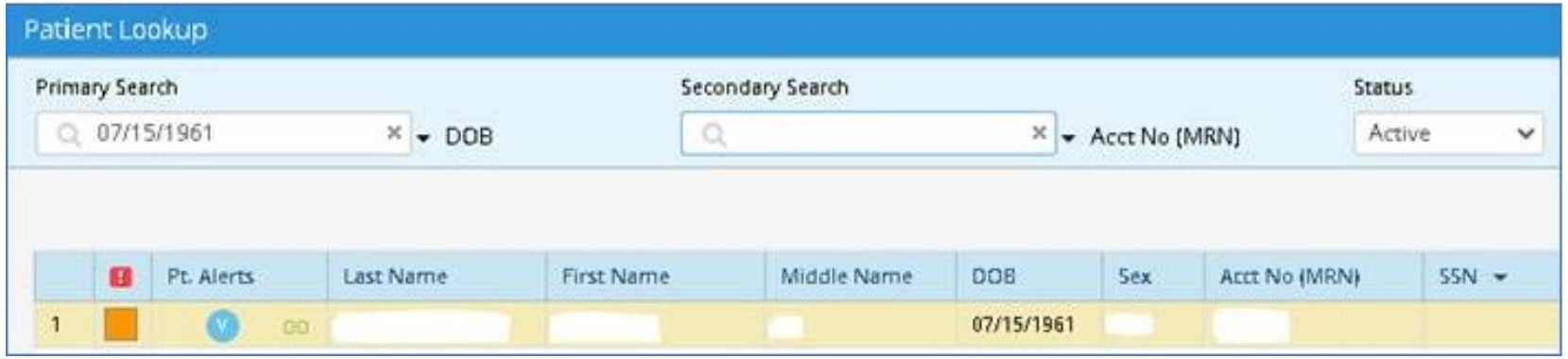
» Strategies for CS integration into clinic operations and workflows

- Monthly email sent to providers and clinic managers regarding Community Supports services, eligibility and referral process
- Program Managers hold presentations for different St. John's departments upon request
- HCM's and Program Manager provide each clinic site with flyers and contact information for LCM's assigned to a particular site
- Collaborate with external agencies around outreach and engagement of homeless population in the area
- HCM's attend monthly food pantry events in serviced communities

Utilization of eCW



Global Alerts set for all enrolled Community Supports patients



Housing Navigation Workflow

St.John's Community Health

Housing Assessment Tool

Initial Call Date ____/____/20____ **Care Manager:**_____ **Primary Language:** _____

Last Name: _____ **First:**_____ **Middle Name:**_____

Current Address:_____ **City:** _____ **State:**____**Zip:**_____

Date of Birth: _____ | **Sex:** ☐ Male ☐ Female ☐ Transgender Male (FTM) ☐ Transgender Female (MTF)

Phone #:_____ | **Social Security Number (SSN):** _____

Is client pregnant? ☐ yes ☐ no | # of Months pregnant _____ | **Is client disabled?** ☐ yes ☐ no | **Are there any identified, past or current, domestic violence issues** ☐ yes ☐ no ☐ currently | **dates of incidents** _____

Last Visit with PCP:
- ☐ This Week
- ☐ Last Week
- ☐ This Month
- ☐ Last Month
- ☐ Last 3 Months
- ☐ Last 6 Months
- ☐ Last Year
- ☐ Other: _____

Current Living:
- ☐ With family, friend, or host family
- ☐ Foster home
- ☐ Independently living alone
- ☐ Subsidized Housing
- ☐ Homeless Shelter
- ☐ Human Trafficking Shelter
- ☐ Domestic Violence Shelter
- ☐ Street/Not meant for human habitation
- ☐ Other: _____

Able to live independently?
- ☐ Yes
- ☐ No

Needs Assistance With:
- ☐ Taking a Bath/Shower
- ☐ Going Up/Down Stairs
- ☐ Eating
- ☐ Brushing Teeth/Hair
- ☐ Making/Cooking Meals
- ☐ Getting Out of Bed/Chair
- ☐ Walking
- ☐ Washing Dishes/Clothes
- ☐ Transportation
- ☐ Other _____

# of Persons in the household (include Head of Household): _____
Is client open to living in a shelter? ☐ yes ☐ no

 # weeks/months at last permanent address: _____

Family Type:
- ☐ Single Female
- ☐ Single Male
- ☐ Female w|children
- ☐ Male w|children
- ☐ Couple no children
- ☐ Couple w|children
- ☐ Extended family

Insurance Type:
- ☐ Anthem Blue Cross
- ☐ Health Net
- ☐ L.A. Care
- ☐ Other _____
- ☐ CIN# _____
- ☐ None

***List the number of homeless shelters the client has stayed at in the prior 6 months:** _____

***List the name of the homeless shelters that the client has stayed at in the prior 6 months:**

_____
_____
_____

***List the number of Emergency Department visits the client has had in the last year:** _____

Does the client have a housing voucher? ☐ yes ☐ no

Notes:

_____
_____
_____
_____
_____
_____

Where did the client stay last night?
- ☐ Non-housing (Street, park, car)

***What area/streets does the client live/stay around?*

_____
_____
_____

- ☐ Emergency Shelter
- ☐ Transitional Housing
- ☐ Psychiatric Facility
- ☐ Substance Abuse Treatment Facility
- ☐ Hospital (non-psychiatric)
- ☐ jail/prison/juvenile facility
- ☐ Domestic Violence Shelter
- ☐ Living w|relatives/friends
- ☐ Rental Housing
- ☐ Own apartment or house
- ☐ Motel/hotel
- ☐ Foster care/group home
- ☐ Permanent Supportive Housing

With regard to where the client stayed last night, how long have they stayed/resided there?
- ☐ 1 week or less
- ☐ more than 1 week, less than 1 month
- ☐ 1-3 months
- ☐ 4-6 months
- ☐ 7-12 months
- ☐ 1-2 years
- ☐ 2-4 years
- ☐ 4 years or more

Community Supports
Housing Navigation & Tenancy Services

Please complete clearly all sections of this form

St.John's Community Health

HOUSING CONSULTATION FORM

Insurance: ☐ Anthem Blue Cross or ☐ Health Net or ☐ L.A. Care | **Program:** ☐ Housing Navigation or ☐ Tenancy

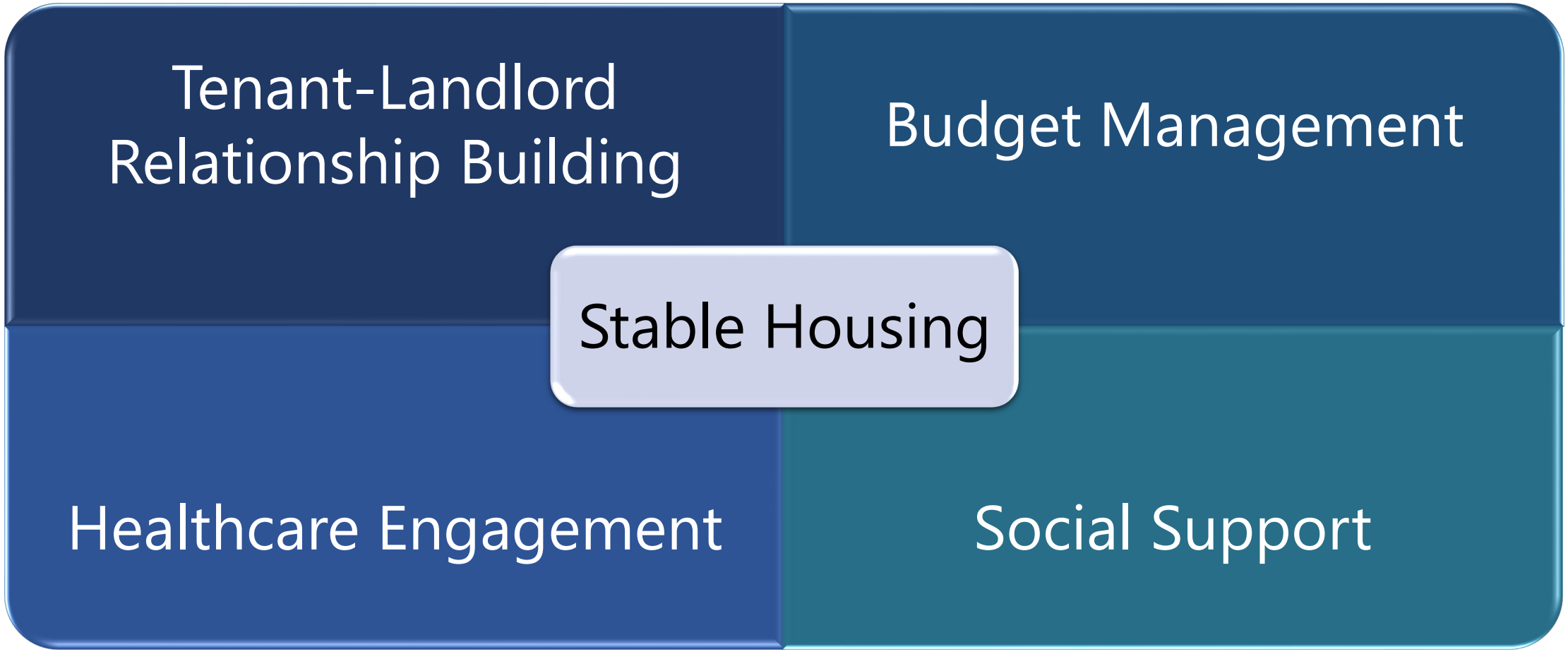
1. Patient Information					
Name:		Employment status:	☐ Full-time or ☐ Part-time or ☐ Unemployed		
Date of birth:		Income base:	$ _____		
Cell phone:		Does Patient receive SSI or SSDI?	☐ Yes or ☐ No	Amount:	$ _____
eCW Account #:		Does Patient receive Cash Aid?	☐ General Relief (GR) and/or ☐ CalWORKS		
Does patient need to be referred to another SJCH Program?	☐ Yes or ☐ No | **Program(s)**:	Cash Aid amount:	$ _____		
Gender:	☐ M or ☐ F or ☐ FTM or ☐ MTF	Is Patient seeking employment?	☐ Yes or ☐ No		
Primary language:	☐ English or ☐ Spanish	Job skills:			

2. Housing Information			
Housing Status:	☐ Street or ☐ Shelter or ☐ Transitional or ☐ Interim or ☐ Institutional or ☐ Other _____	Name of Shelter or Transitional Housing (if applicable):	
		Household size:	
		Is patient serviced by another homeless Agency?	☐ Yes or ☐ No | **Name**:

3. HMIS Information		**4. CHAMP Information**	
Is Patient on HMIS?	☐ Yes or ☐ No	Is Patient on CHAMP?	☐ Yes or ☐ No
HMIS Unique Identifier:		CHAMP Client ID:	
Has Patient's Housing Voucher Assessment been completed?	☐ Yes or ☐ No	Are there any Case Notes from other Agency's?	☐ Yes or ☐ No | Date of Last Note: _____

5. Voucher Information		**6. SMART Goals** (*Identify two SMART Goals for your Patient*):
Does your Patient have a voucher?	☐ Yes or ☐ No	**S**pecific:
What kind of voucher does your Patient have?	☐ HACLA (Housing Choice) ☐ LACDA ☐ Other _____	**M**easurable: **A**chievable:
What is the family unit size of the voucher?	☐ 1-Bedroom ☐ 2-Bedroom ☐ 3 or more Bedroom _____	**R**elevant:
What is the voucher's T-number & expiration date?	T-number: T-_____ Expires: _____	**T**ime-bound:

Tenancy and Sustaining Goals



St. John's Community Health

Individualized Housing Support Plan (IHSP)

Date of plan creation: _____ | **Insurance:** ☐ Anthem Blue Cross or ☐ Health Net or ☐ L.A. Care |
Program: ☐ Housing Navigation or ☐ Tenancy Services

1. Patient Information

Name:		Date of birth:		Care Manager:	
Address:		Landlord Name:			
Landlord phone #:		Monthly Rental Amount:			
Rent Due Date:		How long have you been at your current address?			
Other household members:	☐ Adult(s) [18+]: _____ ☐ Children (<18): _____ ☐ None:	Debt Obligations:	$ _____		

2. Housing Assessment

Reason for housing instability:	☐ Job loss, reduced income, or expense shock ☐ Rent affordability ☐ Eviction ☐ Repair needs, maintenance, or substandard housing conditions ☐ Landlord harassment or discrimination ☐ Reasonable accommodation ☐ Illegal lockout ☐ Rental increase / rent overcharges ☐ Relocation/moving out ☐ Experiencing homelessness ☐ Other: _____	Steps to achieve goals:	1. _____ 2. _____ 3. _____
		Who is doing what?	Case Manager: 1. _____ 2. _____ Patient: 1. _____ 2. _____
		Barriers to achieving goals:	

3. Financial Assessment

Total monthly income:	$ _____		
Source(s) of income:	☐ Federal wage ☐ Public benefits (SSI, CalWORKs, GR. etc) ☐ Other _____		
Has a Budget Plan been created for patient?	☐ Yes or ☐ No When? _____	Has Care Manager scheduled appointment (telehealth or in-person) to complete a Budget Plan? If so, when?	☐ Yes or ☐ No | Date: _____
Credit checked?	☐ Yes or ☐ No When? _____	Credit score (*if known*):	

4. Medical Summary

Chronic conditions/medical diagnoses?	☐ Drug Use Disorder ☐ Hypertension ☐ Bipolar Disorder ☐ Heart Failure ☐ Rheumatoid arthritis ☐ Chronic Kidney Disease	☐ Alcohol Use Disorder ☐ Chronic Liver Disease ☐ Psychotic Disorder ☐ Diabetes ☐ Epilepsy ☐ Major Depressive Disorder	☐ Chronic Heart Failure ☐ HIV/AIDS Positive ☐ Asthma ☐ Dementia ☐ Any cancer under treatment	☐ Coronary Artery Disease ☐ Traumatic Brain Injury ☐ Chronic Pulmonary Disease ☐ Lupus
	☐ Other—Specify _____			
Where do you receive care?	☐ St. John's Community Health | Clinic Name: _____ ☐ Other: | Clinic Name: _____			
Who is your PCP?	Name: _____			

5. Follow-Up Items Needed (*Examples: Vital Documents, Lease/Mortgage, Award Letters, Bills/Payments, etc.*)

6. Referrals Needed

☐ Food assistance
☐ Clothing assistance
☐ Debt management/budget counselling
☐ Rental assistance
☐ Utility or energy assistance
☐ Maintenance & repairs
☐ Environmental justice
☐ Legal assistance
☐ Other: _____

St. John's Community Health

Name:
DOB:
Date:

PROOF OF UNIT VIEWING

Property Name _____

Property Address _____

patient Signature _____

Case Manager Signature _____

Name:
DOB:
Date:

PROOF OF UNIT VIEWING

Property Name _____

Property Address _____

Patient Signature _____

Case Manager Signature _____

Budget Plan for _____ | Date: _____

Completed By: _____

The worksheet below is a sample budget that can help you manage how much you spend each month.

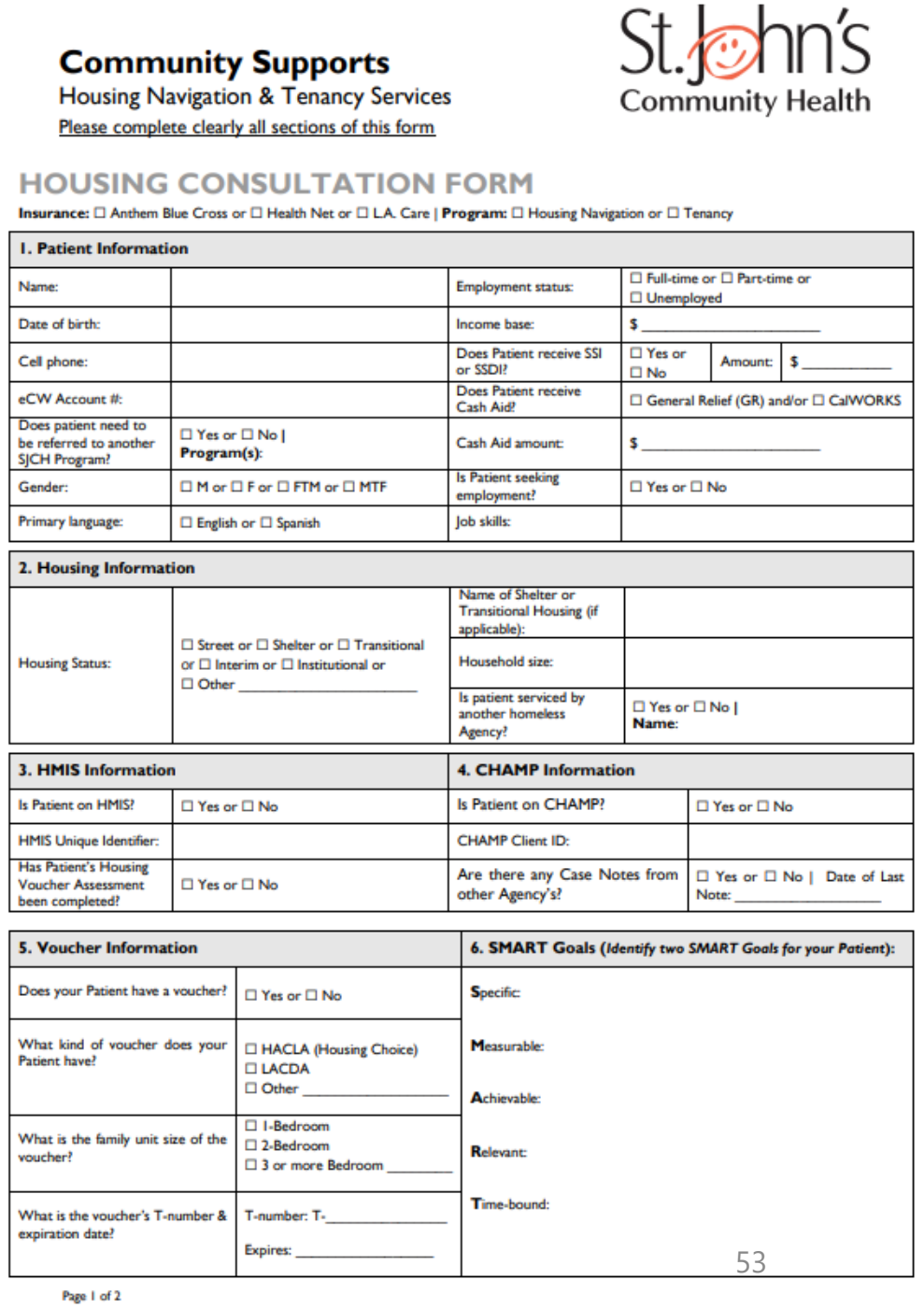
Monthly Income		Monthly total
Paychecks (*e.g.*, pay from full-time, part-time and/or independent work)		$
Other income (*e.g.*, Social Security, unemployment)		$
Total monthly income		$
Monthly Expenses		Monthly total
Saving	Emergency Fund	$
	Retirement, college fund, or major purchases	$
Housing	Rent or mortgage	$
	Renter's insurance or homeowner's insurance fees	$
	Utilities (*e.g.*, gas, electricity, and water)	$
	Internet, cable, and phones (mobile and home)	$
Food	Groceries and household supplies	$
	Eating out	$
Transportation	Car payment or public transportation	$
	Gas for car	$
	Car insurance	$
Health	Health insurance	$
	Club fees (*e.g.*, gym membership)	$
	Medical (*e.g.*, medicine, appointments)	$
Other	Child care	$
	Credit cards, personal, and/or student loans	$
	Entertainment (*e.g.*, streaming services, sports)	$
Total monthly expenses		$

$	-	$	=	$
Income		**Expenses**		**Remaining**

St. John's Community Health
808 W. 58TH STREET
LOS ANGELES, CA 90037
PHONE 323-541-1600
FAX 323-541-1661
WWW.WELLCHILD.ORG

Collaboration Methods

- Weekly housing consultation with Housing Navigator and other program case managers (internal & external)



Community Supports
Housing Navigation & Tenancy Services
Please complete clearly all sections of this form

St. John's Community Health

HOUSING CONSULTATION FORM

Insurance: ☐ Anthem Blue Cross or ☐ Health Net or ☐ L.A. Care | **Program:** ☐ Housing Navigation or ☐ Tenancy

1. Patient Information			
Name:		Employment status:	☐ Full-time or ☐ Part-time or ☐ Unemployed
Date of birth:		Income base:	$ _____
Cell phone:		Does Patient receive SSI or SSDI?	☐ Yes or ☐ No — Amount: $ _____
eCW Account #:		Does Patient receive Cash Aid?	☐ General Relief (GR) and/or ☐ CalWORKS
Does patient need to be referred to another SJCH Program?	☐ Yes or ☐ No | **Program(s):**	Cash Aid amount:	$ _____
Gender:	☐ M or ☐ F or ☐ FTM or ☐ MTF	Is Patient seeking employment?	☐ Yes or ☐ No
Primary language:	☐ English or ☐ Spanish	Job skills:	

2. Housing Information			
Housing Status:	☐ Street or ☐ Shelter or ☐ Transitional or ☐ Interim or ☐ Institutional or ☐ Other _____	Name of Shelter or Transitional Housing (if applicable):	
		Household size:	
		Is patient serviced by another homeless Agency?	☐ Yes or ☐ No | **Name:**

3. HMIS Information		**4. CHAMP Information**	
Is Patient on HMIS?	☐ Yes or ☐ No	Is Patient on CHAMP?	☐ Yes or ☐ No
HMIS Unique Identifier:		CHAMP Client ID:	
Has Patient's Housing Voucher Assessment been completed?	☐ Yes or ☐ No	Are there any Case Notes from other Agency's?	☐ Yes or ☐ No | Date of Last Note: _____

5. Voucher Information		**6. SMART Goals** (*Identify two SMART Goals for your Patient*):
Does your Patient have a voucher?	☐ Yes or ☐ No	**S**pecific:
What kind of voucher does your Patient have?	☐ HACLA (Housing Choice) ☐ LACDA ☐ Other _____	**M**easurable: **A**chievable:
What is the family unit size of the voucher?	☐ 1-Bedroom ☐ 2-Bedroom ☐ 3 or more Bedroom _____	**R**elevant:
What is the voucher's T-number & expiration date?	T-number: T-_____ Expires: _____	**T**ime-bound:

Page 1 of 2

Lessons Learned

» **What's going well?**

- ECM and CS collaboration has increased
- Increased Provider and clinic staff support
- HCM's are more comfortable with their scope of practice and workflow
- Community Support program resource catalogue is growing

» **What do you need help with?**

- More guidance from MCP's regarding billing, claims and capitation procedures and reports
- Universal rules, procedures and guidance across all MCP
- Streamlined system to identify overpayment and claims needed reports

Thank you!

- Ann Milton, Director of CalAIM
  Email: amilton@wellchild.org
  Phone: (213) 905-9877

- Jaime Lopez, Community Supports Program Manager
  Email: mcotom@wellchild.org
  Phone: (213) 713-1042

Housing for Health:
Community Supports Implementation

Sarah Mahin
Director of Housing for Health,
LA County Department of Health Services

Housing for Health (HFH)

HFH provides housing and services to people experiencing homelessness with complex health and/or behavioral health conditions, high utilizers of public services, and other vulnerable populations. HFH is a program office within the LA County Department of Health Services and operates much of LA County's homeless services and housing infrastructure.

Principles:

Housing First	Connect individuals to permanent housing without preconditions or barriers to entry
Harm Reduction	Respect, dignity, and compassion
"Whatever It Takes" Mentality	Flexible approach to service delivery and an adaptable portfolio of interventions

HFH - Overview

Street-Based Engagement

Multidisciplinary teams provide assessment, services, and connection to housing and other resources.

- Outreach

Interim Housing

Short-term housing that offers a safe space to recuperate and stabilize, connect to services and work on permanent housing.

- Stabilization Beds
- Recuperative Care

Permanent Housing

Housing assistance and individualized supportive services focused on housing retention and improving health outcomes.

- Homelessness Prevention
- Permanent Supportive Housing
- Enriched Residential Care

Benefits Advocacy

Clinical Services

HFH – CS Progress – Clients and Services

- Six local managed care plans. Currently contracted for the following CS services:
  - Housing navigation
  - Tenancy sustaining services
  - Recuperative care (medical respite)
- In process of expanding contracts to include:
  - Housing deposits
  - Personal care and homemaker services
- Over 11,000 clients grandfathered into and receiving CS services on 1/1/22
- Almost 10,000 referrals submitted during the first 10 months and over 18,000 served YTD

How HFH Implemented Community Supports

HFH – CS Progress - Infrastructure

- CS rolled out using existing infrastructure, which includes over 100 contracted community-based organization (CBO) partners and expertise braiding WPC and other funding to create and maintain housing and services for LA's Homeless Initiative
- Modified existing data system to launch services tracking, care plans, and assessment functionality on Day 1
- Leveraged staff expertise in housing services and scaling large systems to support the implementation
- Expanded our training team to support contracted partners and our staff
- Leveraged and added to in-house analytic and IT capacity to support claims and drive data-driven performance improvement focused on key areas needed for CS (opt-in agreements → assessments → care plans → service transactions → move-in dates, etc.)

HFH – Support for Providers

HFH provided the necessary administrative and operations support so that our contracted community partners can focus on delivery of care:

- With our local health plan and CoC partners, we intentionally integrated CS into existing coordinated entry system workflows for permanent supportive housing (PSH)
- We directly screen, assess and refer members for CS eligibility and complete referral authorization and appeals processes
- We built out our data system to meet CS documentation requirements so that service partners can continue to document in our primary data system, and we pull the information needed for CS claims and reporting on the backend
- We oversee the claiming process including the submission and reconciliation of claims
- We support service providers in navigating Medi-Cal, Medicare, MCP processes, etc

How MCPs and the State can Support Scaling Community Supports

Areas for Collaboration with MCPs and the State

Data Exchange, Workflow, Client Information

- Standardized member-level information/referral files to have a shared understanding of members referred, authorized, enrolled and disenrolled would improve efficiency across all areas of CS work and prevent duplication of work
- Alignment in workflows to increase efficiency, minimize risk for error, and reduce time spent completing redundant work

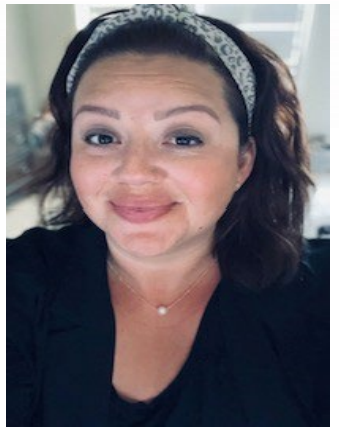
Claims, Reporting, and Supporting Documentation

- Standardization on claims structure, required data elements, use of HCPCs codes, and supporting documentation requirements
- Information regarding adjudicated claims to facilitate claiming processes as well as support in addressing any identified issues while we all learn

Housing Supports: Plan Promising Practices

Community Supports – Housing Services

Tracee Roque, Manager Community Support Services,
Inland Empire Health Plan



CalAIM Community Supports

- DHCS invited Managed Care Plans to begin offering a menu of Community Supports Services, 14 of which were pre-approved.
- IEHP chose to roll out with 11 of the services, effective January 1, 2022.
- 3 of these services focus on assisting Members with securing and maintaining a permanent home setting: Housing Transition/Navigation, Housing Tenancy/Sustaining and Housing Deposits.

Summary of Services

Housing Transition/Navigation Services: tenant screening and housing assessment that will identify the Member's preferences and barriers related to successful tenancy. Searching for housing, assisting with benefit advocacy, landlord engagement, identifying vouchers, etc.

Housing Deposits: assists with coordinating, securing or funding one-time services or modifications necessary to enable a person to establish a basic household items outside of room & board. First & last months rent, set-up fees or deposits for utilities, security deposits, etc.

Housing Tenancy/Sustaining Services: providing early identification and intervention for behaviors that may jeopardize housing, coaching and developing key relationships with landlords & property managers.

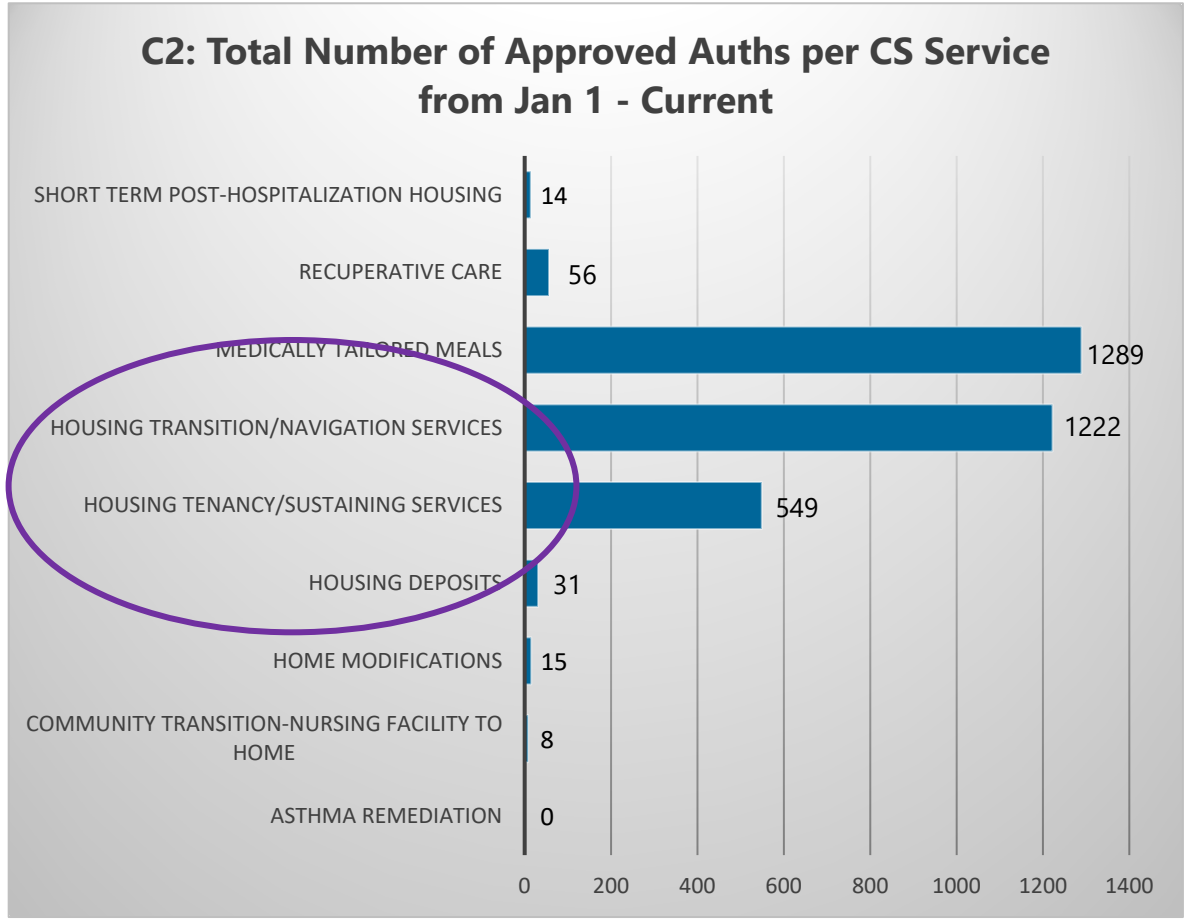
Connecting Our Members

Referral Methods:

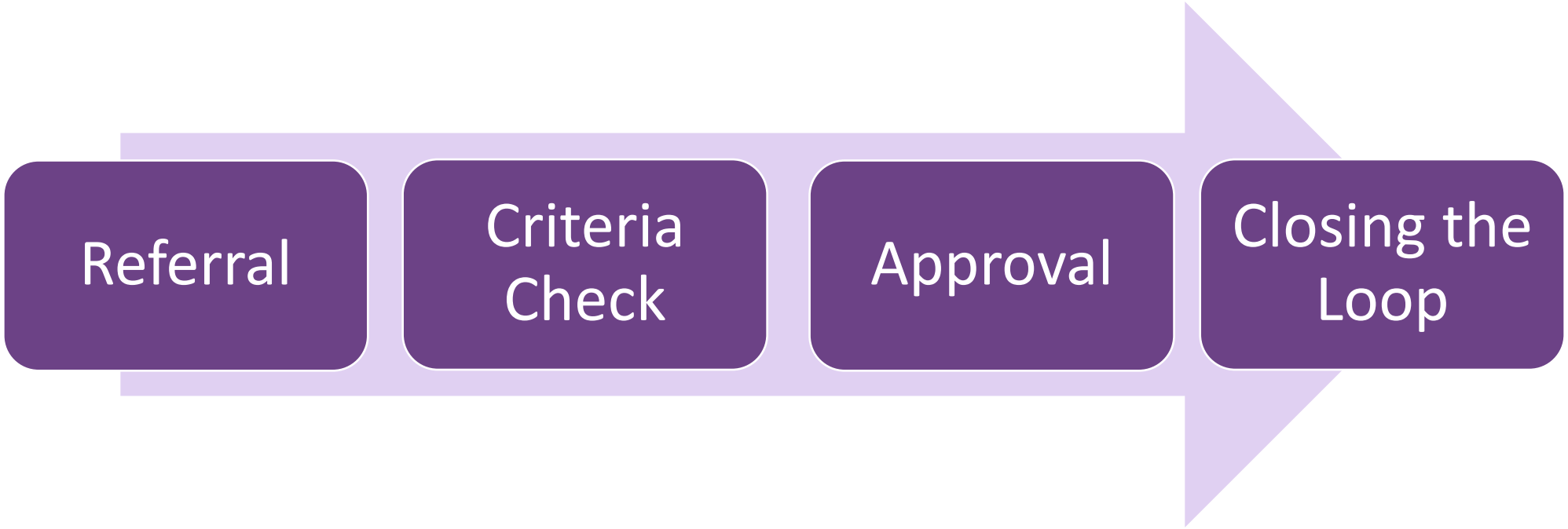
1. Fax
2. Provider Portal
3. Phone

Referral Sources:

1. Primary Care Provider
2. Specialist
3. Behavioral Health Provider
4. Internal Care Teams



Referral Workflow



Best Practices

- Confirm that contracted Providers have the ability to provide all three Housing services
- Open communication with our Housing & CS Team
- Following the sequence – Transition/Navigation > Deposits > Tenancy/Sustaining
- Internal tracking of deposits

Success Story

Member living with his brother, after recent loss of mom & sibling due to COVID-19

- Member's brother sold his home, which resulted in Member living in his car
- Member was COVID-19+ & anxious/fearful of next steps
- ECM team referred Member to ***Community Supports***

Member was approved for *Housing Transition/Navigation* services

- Temporary shelter was provided for 1 month at a hotel
- Member received assistance with applying for an Emergency Housing Voucher
- Member moved into his new home on July 6th

We will not rest until our communities enjoy optimal care and vibrant health.

IEHP

Next Steps

- Continue to evaluate volume of referrals & Provider capacity/gaps in the network
- Consider incentives via HHIP and/or IPP
- Track cost savings
- Establish an automated closed-loop process

Questions?

Closing

- Next Community Supports Webinar:
  - Personal Care and Homemaker Services and Caregiver Respite
  - 1:00 pm PT on November 3, 2022
  - Registration Link

Upcoming DHCS Office Hours

- CalAIM Office Hours
  - Housing Supports via Enhanced Care Management (ECM) and Community Supports
  - Thursday, October 27, 2-3 pm
  - Registration Link

- Participants are invited to submit questions by Monday, October 24 to CalAIMECMILOS@dhcs.ca.gov.

FAQs

- Billing and rates
- How to become a provider
- Who can refer patients and how to make a referral
- How eligibility is determined

Citations

- 1) Housing Is Healthcare: Supportive Housing Foundation
- 2) Evaluation of Housing For Health Permanent Supportive Housing Program
- 3) Rate of ED visits by Homeless Status and Geographic Regions – National Hospital Ambulatory Medical Care Survey, United States, 2015-2018
- 4) Health Impact of Supportive Housing for HIV-Positive Homeless Patients: A Randomized Controlled Trial
- 5) Medicaid and Permanent Supportive Housing for Chronically Homeless Individuals: Literature Synthesis and Environmental Scan

Resources

- DHCS Community Supports Policy Guidance
- Non-Binding ILOS Pricing Guidance