EAST BAY GETTING TO ZERO

Regional Case Managers Meeting

Block Community Hub
Oakland, CA
April 4th, 2024

ALAMEDA COUNTY PUBLIC HEALTH DEPARTMENT

Welcome!

Housekeeping:

- Please sign-in.
- Restroom locations.
- Community table outside.
- Please take breaks when you need to.
- Light snacks and drinks available to be consumed outside the room.
- Grab & Go lunch available at the end of the meeting.

Wifi:

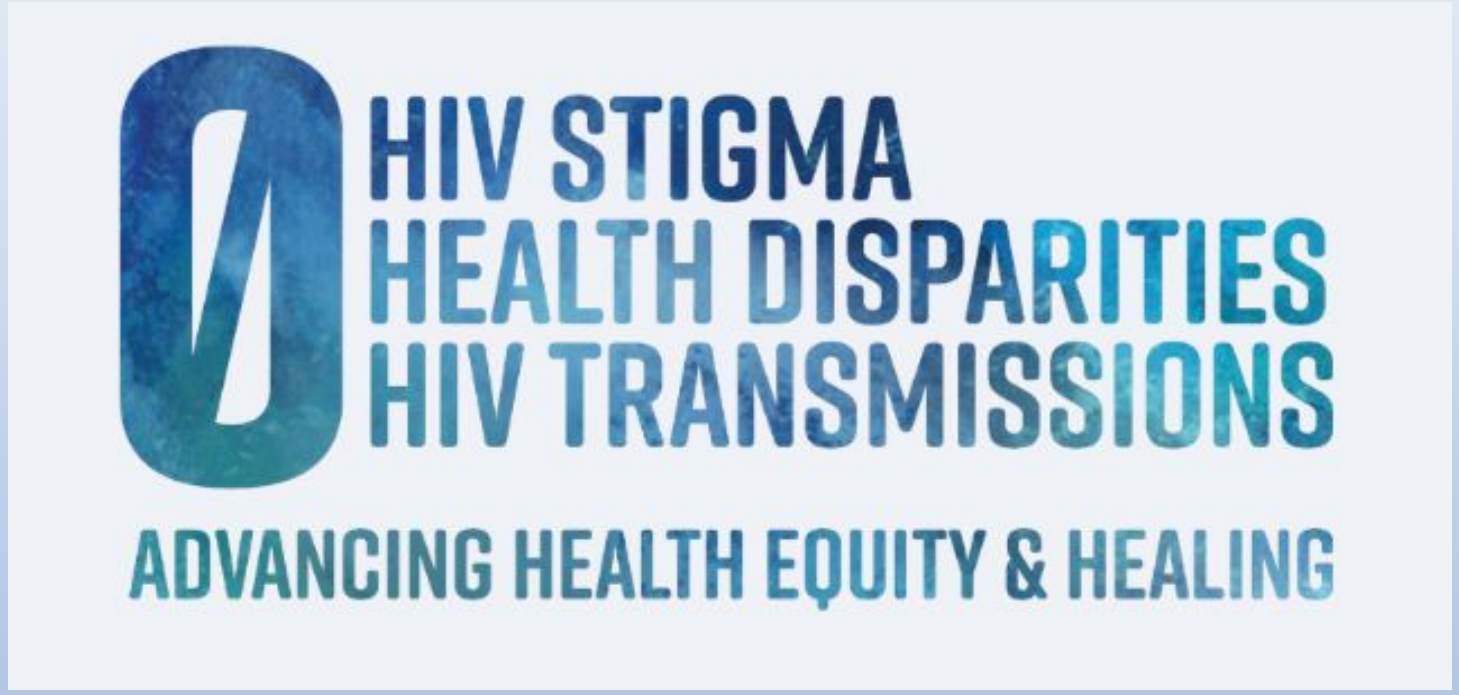
- Network: CommunityHub
- Password: oakland510

Welcome!

We are fortunate to have our elders and community members with health vulnerabilities joining us today. Please help us lower Covid risk by:

- Enjoying food outside of the room.
- Wearing a mask (over your nose) as much as possible.
- Supporting each other to go home/stay home if feeling sick.
- Getting vaccinated again.

East Bay Getting to Zero



Today's Agenda

- 10:30am: Coffee & networking
- 10:45am: Welcome, housekeeping and Round Robin Introductions - name/agency/role
- 10:55am: Resource spotlight: **Medi-Cal waiver program and home/community-based health services**
- 11:10am: Housing Updates: **Coordinated entry system, assessment & acuity scores, housing options for your homeless clients**
- 11:35am: BREAK
- 11:40am: **Enhancing Case Management Standards: A Focus on Client Relationships, Boundaries, Self-Disclosure, and Documentation**
- 12:10: Breakout group activity: Developing your case management philosophy/approach
- 12:35: Close out and next meeting
- 12:45-1pm - Grab & go lunch available

Introductions

Name

Agency

Role

Damon Powell, Primary Care at Home

Damon has been serving our unique community in various capacities since 2005.
His experience ranges from direct service provision to program management.
At present, Damon serves as the Project Director at Primary Care At Home Inc. and as a newly appointed member of the Oakland Transitional Grant Area Planning Council.

AIDS Medi-Cal Waiver Program

PRIMARY CARE AT HOME, INC.
400 – 29TH Street, Suite 306
Oakland, CA. 94609
Phone: (510) 822-2588 Fax: (510) 822-2589 Website: pcahi.org

What is AIDS Medi-Cal Waiver?

An immediate assessment and care option for persons living with HIV/AIDS who are too ill or medically fragile to continue living on their own without supportive assistance. The AIDS Medi-Cal Waiver Program (MCWP) provides community/home-based services as an alternative to nursing facility care or hospitalization.

Eligibility Criteria

A) Must be a Medi-Cal recipient.

- Medi-Cal eligibility requirements:
  a) A person whose health status qualifies them for nursing facility care or hospitalization
  b) Not enrolled in a Program of All-Inclusive Care for the Elderly (PACE)

B) Must have a written diagnosis by an attending physician of HIV disease.

C) Be certified by our Nurse Case Manager to be at the nursing facility level-of-care.

D) Must score 60 or less using the Cognitive and Functional Ability Scale assessment tool.

Services

- Comprehensive Medical Case Management (Nursing & Social Work)
- Skilled Nursing - Registered Nurse/Licensed Vocational Nurse assistance
- Home Health Aide - Attendant Care
- Homemaker
- Psychotherapy
- Nutritional Counseling & Supplements
- Food and Grocery Assistance
- Non-Emergency Medical Transportation
- Specialized Medical Equipment/Supplies
- Minor physical adaptations to the home

Referrals

- Participants who are interested in the program, or who believe they might be eligible can self-refer.
- We also welcome referrals from HIV/AIDS Service Organizations, or Medi-Cal Providers throughout Alameda and San Francisco Counties.

To make a referral contact

Damon Powell, Project Director

Phone: *(510) 551.9909*

Email: dpowell@pcahi.org

The AIDS Medi-Cal Waiver Program is Funded by the California Department of Public Health's Office of AIDS Administration

PRIMARY CARE AT HOME, INC.

Home and Community-Based Health Services

This Program is funded by Ryan White Part A:
Home and Community-Base Services from
Alameda County Office of HIV Care and Contra Costa Health Services

ELIGIBILITY

Who is Eligible ?

1. Persons living with HIV/AIDS

2. Must meet Ryan White eligibility criteria:
   - Income 500 poverty level (up to $72,900 for 2023)
   - Residency (Not Immigration Status)

3. Persons in need of home health services as an alternative to hospitalization

4. Live in Alameda or Contra Costa Counties

Primary Care at Home, Inc.

SERVICES

What Services are Provided ?

- **HOME HEALTH AIDE**
  - Bathing and personal care
  - Assistance with ADLs
  - Medication reminders
  - Light Housekeeping and meal preparation

- **SKILLED NURSING**
  - Skilled nursing assessment and care coordination
  - Wound care
  - Catheter management
  - IV Therapy
  - Lab work
  - Pain management
  - Medication administration
  - OTHER

Primary Care at Home, Inc.

REFERRAL PROCESS

How do I make a referral ?

- Community Agencies or Hospitals can refer
- Individuals may self refer

- Contact Damon Powell, Project Director
  - PHONE: (510) 551-9909
  - EMAIL: dpowell@pcahi.org
  - FAX: (510) 822-2589

- Our Nurse Case Manager will provide you with the next steps to begin the process

Primary Care at Home, Inc.

Emergency & transitional housing for people experiencing homelessness

Myeeka Calhoun, East Oakland Community Project

Myeeka Calhoun is a community activist, who has worked as a Housing Advocate in Alameda County for over 20+ years. She has been an Advanced Community Health Outreach Worker for people living with HIV within those 20 + years.

Currently, Myeeka is the Case Management Services Manager at East Oakland Community Project- Crossroads Emergency Shelter. She is also a member of the Oakland Transitional Grant Area Planning Council (OTGA).

Myeeka is also a member of the HOPE (Healthy Outcomes for People Everywhere) Coalition, which is focused on working with African-American people experiencing homelessness in Alameda County impacted by HIV, and STIs.

Recently, Myeeka has also become a member of the CAN (Community Advisory Network) facilitated by Family Paths.

Emergency & transitional housing for people experiencing homelessness

Judy Eliachar, East Bay Getting to Zero

Judy Eliachar has brought a commitment to social justice, equity and the empowerment of residents of low-income communities to each position she has held. She has worked at the Department of Housing Urban Development as a program monitor and as a public housing manager at Oakland Housing Authority. She also worked as an OHA Leased Housing Representative with the Section 8/Housing Voucher program, where she managed an East Oakland caseload and later developed and implemented various programs.
Judy has an M.A. in Counseling Psychology with a specialization in Addiction Studies and is a Licensed Marriage and Family Therapist (retired). As an LMFT, she worked with pregnant/parenting teens and at-risk children and their families, both as a school-based clinician and as a provider of therapeutic home visitation services.
Judy's work in HIV services began in 2016, with the AIDS Housing Information Project (AHIP).

She worked closely with Medical Case Managers and ASO staff to provide ongoing support, advocacy and housing navigation assistance to HOPWA-eligible People Living with HIV. Judy retired from her position as AHIP Coordinator in 2022.

Coordinated entry system, assessment & acuity scores, housing options for your homeless clients

The Coordinated Entry System (CES) is a ‘Housing Crisis Response System’
CES is not designed to create new housing resources

Purpose of CES is to ensure that all persons who are experiencing literal homelessness in the County

- Have equitable access to available and appropriate resources & services
- Are identified, assessed & prioritized through one centralized system.

Coordinated entry system, assessment & acuity scores, housing options for your homeless clients

Federal requirement that any City or County that receives funding for homelessness services from the Department of Housing & Urban Development (HUD) must administer a coordinated entry system.

CES was established in Alameda County in late 2017, with a program redesign (CES 2.0) in 2021.

Managed by the Alameda County Office of Homeless Care & Coordination, an office within the County's Health Care Services Agency (HCSA).

Made up of numerous public and non-profit agencies that are funded by a variety of programs.

Coordinated entry system, assessment & acuity scores, housing options for your homeless clients

CES is built on these premises:

- One clear point of entry for all who are seeking services
- One standardized application process & one waiting list
- All agencies that provide services are linked together in one system
- All client records, activities & program referrals must be entered in HMIS (Homeless Management Information System)
- Services are offered based on a priority system that ranks clients according to acuity (severity of need)
- All programs will be “low barrier” & will operate according to core principles of harm reduction and “Housing First”

Coordinated entry system, assessment & acuity scores, housing options for your homeless clients

1. What is an HRC?
2. 211 Is a wonderful resource however it is not necessary to get an Assessment.
3. How should a client prepare for these questions? A client should prepare to be honest about their situations. This is the rare time that the more barriers the better in a sense.

Coordinated entry system, assessment & acuity scores, housing options for your homeless clients

CES serves individuals and families experiencing literal and/or chronic homelessness.

Literal Homelessness, sometimes referred to as “HUD Homelessness”

- Sleeping in a place not suitable for habitation, e.g. vehicle, tent, sidewalk, on public transportation
- Staying in an emergency shelter or motel room paid for with a program voucher in order to divert the person from shelter or the streets
- Staying with friends or family (couch surfing) but only for less than 7 consecutive nights
- Placed in institutional setting for 90 days or less (acute medical facility, inpatient treatment for substance use or mental health, crisis residential facility, hospital, jail) but only if the person was literally homeless at entry

Coordinated entry system, assessment & acuity scores, housing options for your homeless clients

Chronic Homelessness

- Currently staying in one of the settings described above and
- Has a diagnosed and documented health condition of indefinite duration, and
- The disabling condition substantially impedes their ability to live independently and
- Is of such a nature that the ability to live independently could be improved by more suitable housing conditions

Definition of Chronic Homelessness also includes requirements as to duration of homelessness

- The individual has been homeless for at least one year continuously, or
- Has experienced at least 4 separate periods of homelessness over a 3 year period with a break of at least 7 days between each occasion, and
- The total time homeless during the last 3 years adds up to at least 12 months

Coordinated entry system, assessment & acuity scores, housing options for your homeless clients

The following living situations do not meet HUD's definition of homelessness:

- Couch surfing for seven or more consecutive nights
- Transitional housing for more than 7 days, and/or in programs that are not publicly funded
- Any institutional setting for more than 90 days
- Hotel/motel room paid for by client, relative, friend, or other person
- Sober living home
- Board and care facility

Coordinated entry system, assessment & acuity scores, housing options for your homeless clients

What is an acuity score?

- Each question is weighed to make an acuity score, clients with scores of 90 and above are placed on a community queue for Perm housing "matches or Rapid Re-Housing Queue.
- Rapid Rehousing is housing support that helps with move-in costs and subsidizes the clients' portion of the rent for up to a year.

Coordinated entry system, assessment & acuity scores, housing options for your homeless clients

What does it mean for the likelihood of a client being referred for housing? Automatic Refers to the Queue are the following:

If literally homeless and falls under these qualifications-

- Any households with a Veteran Head of Household
- Any 18-24-year-old Head of Households
- Anyone who has a HIV
- All Families with a head of household with long-term disability-HIV
- Family size 4+

Coordinated entry system, assessment & acuity scores, housing options for your homeless clients

When a client is placed on the Housing Queue, what can they (and their case manager) do to increase the chances of a successful housing referral? Gather and Upload "core documents"
Core Documents are:

- ID
- SSC
- VOD
- VOI- update every 30-90 Days
- VOH

Clients will not be considered for matches unless they are doc-ready.
**caveat I have seen HOPWA and Veterans get PSH Matches without being doc ready. It depends on the inventory.*

Coordinated entry system, assessment & acuity scores, housing options for your homeless clients

Ongoing contact between the client and all case managers, housing navigators, etc. - monthly and or when you have had the following:

- Contact information changes
- Income changes
- Living Situation changes
- Additional household member (child or adult)
- A household member is no longer part of the household
- More than 90 days have passed since the last Housing Assessment

Coordinated entry system, assessment & acuity scores, housing options for your homeless clients

Housing Problem Solving:

What types of questions are asked during the 2 types of assessment interviews?

What are assessments? Crisis Need Assessment and Housing Needs Assessment.

Crisis Assessments- Offer clients shelter beds (Shameless EOCP plug), Transitional Housing, safe parking lots

- PRIOR LIVING SITUATION
- HOUSEHOLD INFORMATION
- INCOME AND BENEFITS
- HEALTH INFORMATION

Housing Needs Assessments- Offers Permanent Supportive Housing

- HOUSING BARRIERS any convictions and/or evictions, 290 statuses
- VIOLENCE AND RISK
- HOUSING TYPES
- WHERE (All cities in Alameda County)

Clients will then be placed on the crisis queue and/or the based on their acuity scores, 90 and above

Coordinated entry system, assessment & acuity scores, housing options for your homeless clients

Types of housing offered to persons who are experiencing literal or chronic homelessness and have been placed on the Housing Queue

- Permanent Supportive Housing
- Project-based, Sponsor-Based or Tenant-Based Shelter + Care Programs
- Under some circumstances, units funded by HOPWA or Mental Health Services Act (MHSA)
- Some housing designated for homeless Transition Age Youth (TAY) or homeless Veterans
- Emergency Housing (EHV) Vouchers

Case management fundamentals: Enhancing Case Management Standards: A Focus on Client Relationships, Boundaries, Self-Disclosure, and Documentation

Kenneth Hall, Y.A. Flunder Foundation

Kenneth Hall has been a pillar of the east bay community for over 30+ years. As the Chief Operations Officer for the Yvette A. Flunder Foundation, a nonprofit that focuses on fulfilling needs within the community.

Mr. Hall's role encompasses administration and medical case management services ranging from medical case and primary care management.

The YAFF's MCM model emphasizes self-sufficiency which deconstructs dependency, and systematically impels each client toward increasing self-advocacy, treatment compliance, risk reduction,healthier relationships and lifestyle decisions, economic independence, continuing education, vocational choice, sustainable housing et al. consistent with treating HIV infection.

Among Mr. Hall's many accolades, he is the 2002 recipient of the Center of Disease Controls care and treatment award in addition to his participation on a variety of panels and committees further building the Y.A. Flunder Foundation's legacy.

Community Announcements

Breakout Group Activity

- In your small groups, discuss the following:
  - How do you motivate clients to **increase their self-efficacy**/self-sufficiency?
  - How do you approach clients who are r**eluctant or ambiguous** about their commitment to change?
  - How do you approach these situations in a way that preserves **your and your client's** boundaries?

In your group, select:
- **A note-taker**
- **A facilitator**

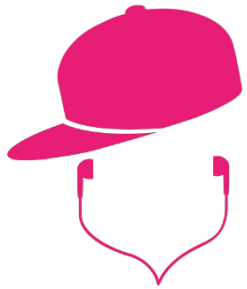
Upcoming meetings & events

Upcoming Events:

- Thurs, 4/18 **East Bay PrEP Navigators meeting** -virtual (EBGTZ)
- Wed, 4/24 **Event: CROI Report Back with Dr. Hyman Scott** (PAETC)
- Thurs, 5/2 **East Bay Care Continuum Meeting** - virtual (EBGTZ)

- **Next Regional Case Manager meeting** - Thurs, June 13th, 10:30am-1pm (ACPHD, San Leandro)




EAST BAY GETTING TO ZERO

Please complete this short evaluation: