Rapid Re-Housing: An Inclusive Model

Rapid Re-Housing Training Series
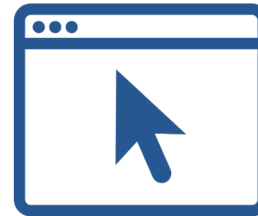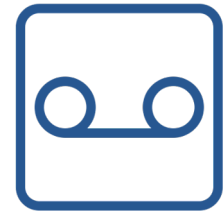
October 5, 2021

Webinar Information

All participants lines are muted.

Use the questions feature in the GoToWebinar control panel to submit questions.

This webinar will be posted to COHHIO's website.

This webinar is being recorded.

Your Presenters

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C4 Innovations

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Webinar Objectives

1. Advance your knowledge of acuity in a Rapid Rehousing model

2. Identify which of the high acuity models would be best for your community

3. Obtain evidence-based guidance that will improve Rapid Rehousing in your community

Agenda

- Acuity

- Staffing for Acuity

- High-Acuity Service Approaches
  - Critical Time Intervention
  - Assertive Community Teams
  - Intensive Case Management
  - Progressive Engagement

- Community Example

- Questions

Poll: Does your RRH project serve households with higher needs?

What is "Acuity"?

Acuity is the degree or severity of a participants' conditions or needs. It is an instrument or classification system used to categorize care requirements and participant needs.

How Do We Determine Acuity Levels?

Acuity refers to an individual's level of need measured by:

- Illness
- Cognitive functioning
- Activities of daily living
- History of trauma and adverse childhood experiences
- Natural support
- Housing history

Prioritize People with High Acuity Needs 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

Adopt a 'Yes, and' approach

"Yes, but…"

- 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 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.

"Yes, and…"

- We have many PEH with high-acuity needs, and we are working to shift our RRH staffing model and provide additional training to quickly and effectively rehouse our community's highest-acuity people.

- 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.

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Staffing for Acuity

Acuity	Caseload	Details
High	1:10 - 1:15	• High levels of coordination with mental, behavioral, physical health supports • Likely to need PSH eventually to support housing stability • High acuity in RRH can be addressed with mixed caseloads
Moderate	1:16 - 1:30	• High levels of coordination with mental, behavioral, physical health supports • Less likely to need longer support than time limited RRH
Low	1:31 - 1:50	• Coordination combined with warm handoff to other community providers • Need for RRH services should be reassessed every 3-6 months to determine need for continued services

Mixed-Acuity Staffing Models

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

CE systems, providers, and RRH program supervisors must consider acuity levels when assigning clients to direct service staff caseloads.

High-Acuity Staffing Models

Evidence-based service approaches for all acuity levels include:

- Trauma-informed care;
- Training for anti-bias, cultural humility and cultural competency;
- A person-centered, holistic approach to assessments and service delivery that honors client choice and self-determination;
- Harm reduction;
- Motivational interviewing;
- Care coordination across multiple service sectors; and
- A focus on including people with lived expertise in decision-making.

Chat Box Question:

Identify a key practice you have implemented to help you successfully serve higher needs clients

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Critical Time Intervention (CTI)

CTI supports clients moving from shelter to rapid rehousing with a time-limited and phased intervention, connects clients to a support network in their environment, and builds their abilities to navigate the network and larger community

CTI Model

Phase	Transition	Try-Out	Transfer of Care
Timing	Months 1-3	Months 4-7	Months 8-9
Purpose	Provide specialized support & implement transition plan	Facilitate and test client's problem-solving skills	Terminate CTI services with support network safely in place
Activities	• CTI worker makes home visits • Accompanies clients to community providers • Meets with caregivers • Substitutes for caregivers when necessary • Gives support and advice to client and caregivers • Mediates conflicts between client and caregivers	• CTI worker observes operation of support network • Helps to modify network as necessary	• CTI worker reaffirms roles of support network members • Develops and begins to set in motion plan for long-term goals (e.g. employment, education, family reunification). • Holds party/meetings to symbolize transfer of care

Assertive Community Treatment (ACT)

Multidisciplinary teams (e.g. psychiatrist, nurse, social worker) that are available 24/7 to offer support, treatment and rehab services.

Characteristics of ACT Teams

- A multi-disciplinary team of professionals that provides wrap-around service directly to the client.

- The team members are available 24/7 and provide real-time support.

- The staff to client ration is generally 1 ACT team per 10 clients.

- The program components are informed by client choice, peer support and a recovery-orientation.

- Services are offered on a time-unlimited basis, with planned transfers to lower intensity services for stable clients.

Intensive Case Management

Assessment, goal setting, high-quality service coordination to help enhance and improve a client's wellbeing and ability to function. Designed for enhancing life skills, addressing health and mental health needs, engaging in meaningful activities and building social and community relations. It is designed for clients with lower acuity, but who are identified as needing intensive support for a shorter and time-delineated period.

Characteristics of Intensive Case Management

- One-on-one case manager to client relationship using a recovery-oriented approach (the team of case managers many include Housing and Support Workers).

- The case manager brokers access to mainstream services that the client identifies as needed to attain his or her goals.

- The case manager often accompanies clients to meetings and appointments in support of their goals/needs.

Characteristics of Intensive Case Management

- Case managers are available on a regular schedule; caseloads are often shared to assure coverage of 7 days per week/12 hours a day.

- The staff to client ratio is generally 1 case manager per 20 clients.

- The duration of the service is determined by the needs of the client, with the goal of transitioning to mainstream services as soon as possible.

Adapted from the Homeless Hub

Excerpted from Housing First in Canada: Supporting Communities to End Homelessness.

Progressive Engagement

Progressive engagement is a person-centered approach to ending someone's homelessness. It is based on tailoring assistance to each individual or household's needs and assessing what works best for them, with their specific strengths, and in their specific situation.
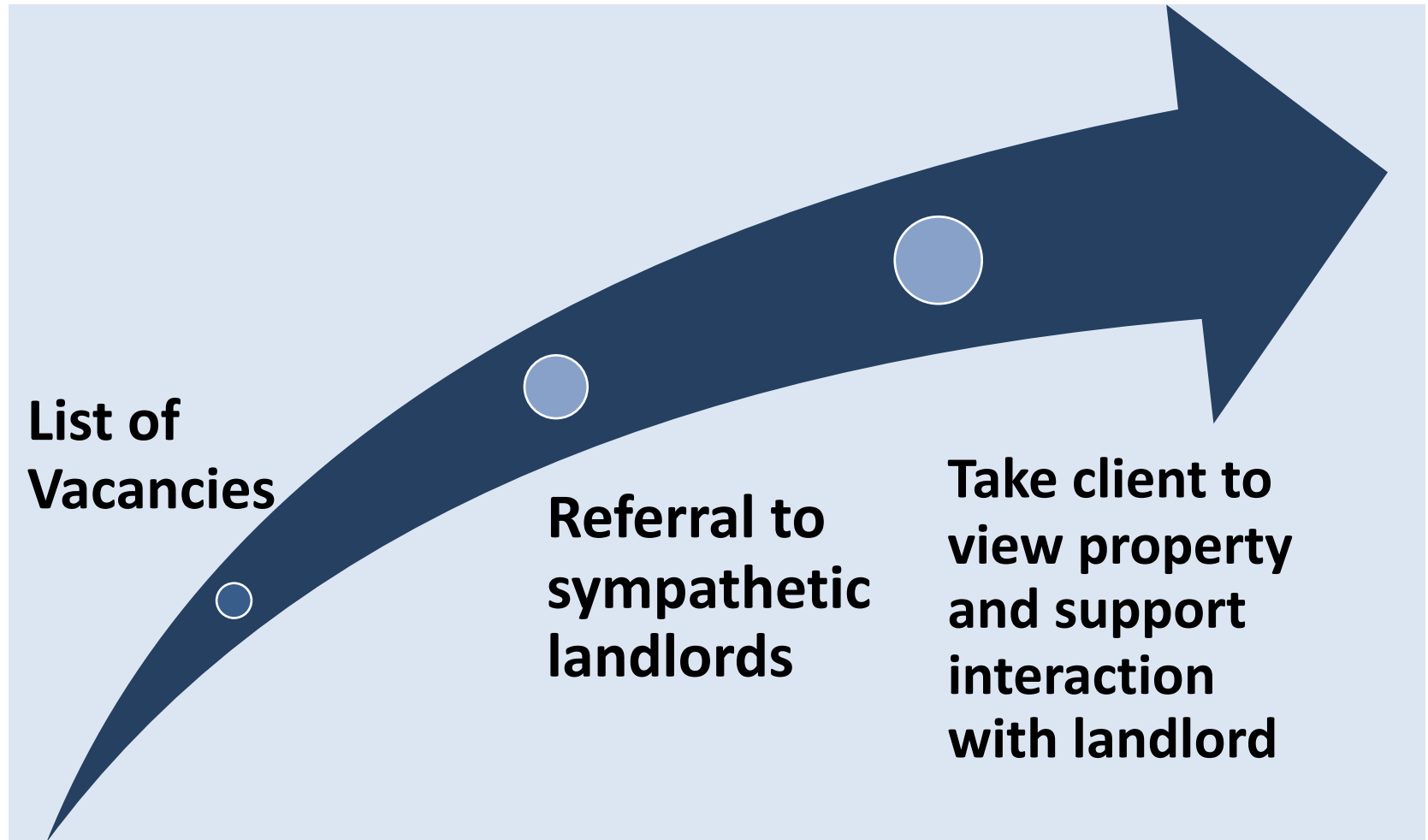
What is Progressive Engagement?

- An approach to ending homelessness

- Focus primarily on housing

- Calculation of the minimum resources needed to gain a successful outcome

- Flexibility to add resources

- Partnership with the person / family experiencing homelessness

- A recognition that every person / family has differing needs

Progressive Engagement and Housing Search

List of Vacancies

Referral to sympathetic landlords

Take client to view property and support interaction with landlord

Progressive Engagement and Financial Assistance

Initial month rent / move in costs

Rental Subsidy for 90 days

Long term financial assistance
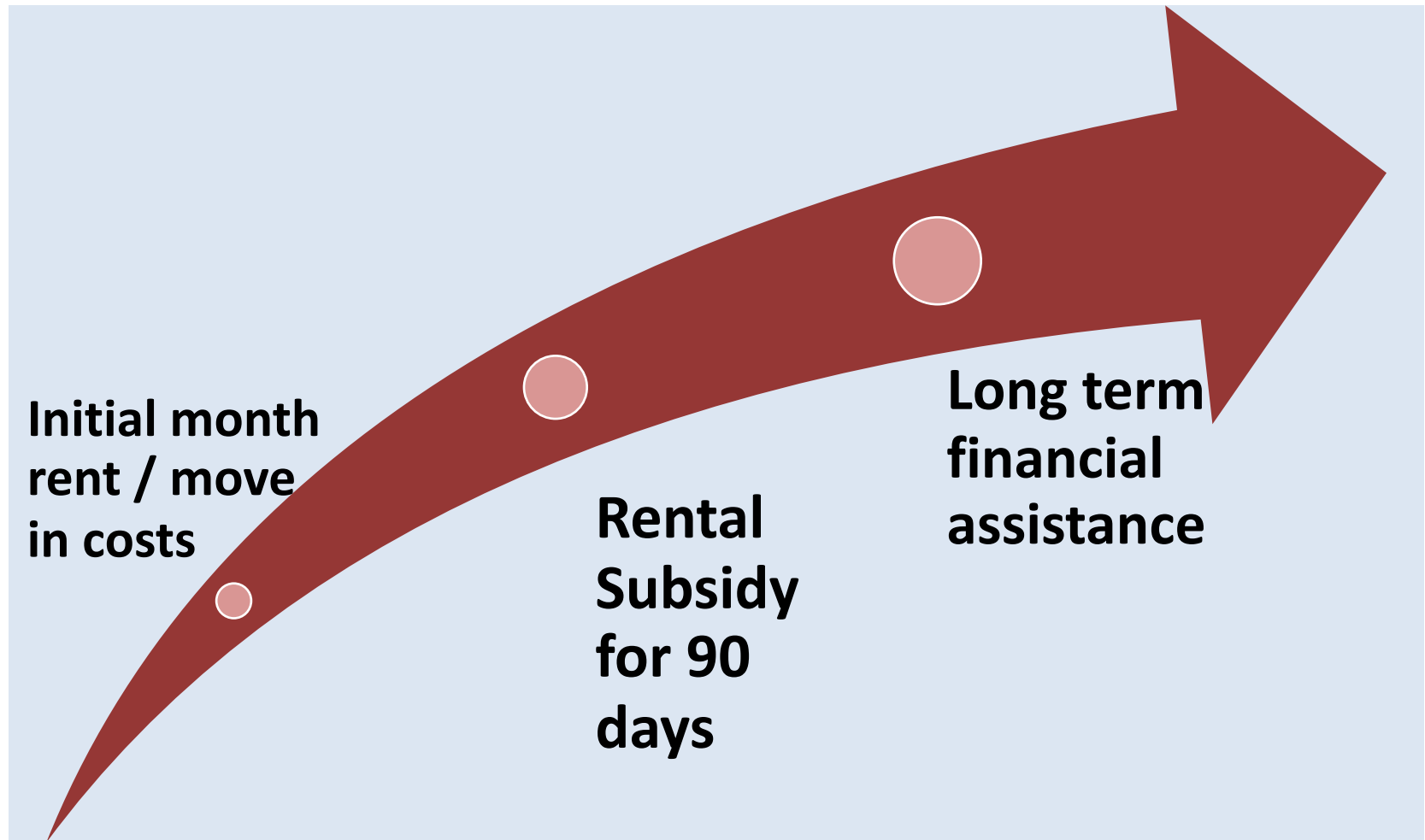
Reassessment

- Evaluation of the progress made by your client

- Use a strengths based approach

- Opportunity to increase resources as needed

- Critical to the success of your rapid re-housing intervention

When Does Progressive Engagement Fail?

- When supportive services are not top notch.
- When communication lags.
- When landlords are not treated as partners.
- When funding ends.
- When there is no plan for long term supports.

Speaking of Long-Term Supports…

- Even with high quality RRH services there will likely be some high acuity households will not be able to live independently

- ESG-CV resources provide for temporary rental assistance

- Those with high acuity needs can be housed with these resources as long as services match the individual or families needs as communities develop permanent housing with appropriate levels of services

- REMEMBER: Households in RRH maintain their homelessness status to qualify for PSH or other housing resources

Necessary Considerations for Transitions

DO NOT:

• Assume that all program participants will need PSH or deeper interventions and lead them in that direction without the explicit want and need expressed by the participant themselves

• Prioritize the work of planning for a transition or applying for subsidized housing opportunities until the participant's immediate needs have been met

Necessary Considerations for Transitions

DO address process questions at the CoC-level:

- How do case managers assess the need for long-term subsidy and or services?

- How are those in need of long-term subsidy referred to and integrated into CE systems and prioritization?

- How will the CoC regularly reassess the changing landscape of available resources including EHVs, new CoC projects, etc.?

- Is the necessary long-term support based on financial challenges, the need for intensive services or both? The answer may determine the appropriate trajectory

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Rapid Re-Housing & Progressive Engagement

Cleveland/Cuyahoga County Continuum of Care

What is Progressive Engagement?

- *An approach to helping households end their homelessness rapidly by providing a minimal amount of assistance and support based upon their individualized barriers and needs*

Key Concepts of Progressive Engagement

- ▶ Focus on resolving homelessness
- ▶ Housing First: Rapid Re-Housing Without Conditions….Screen in vs Screen Out
- ▶ Individualized Services
- ▶ Ongoing Assessments: *Determine barriers, not predict services*
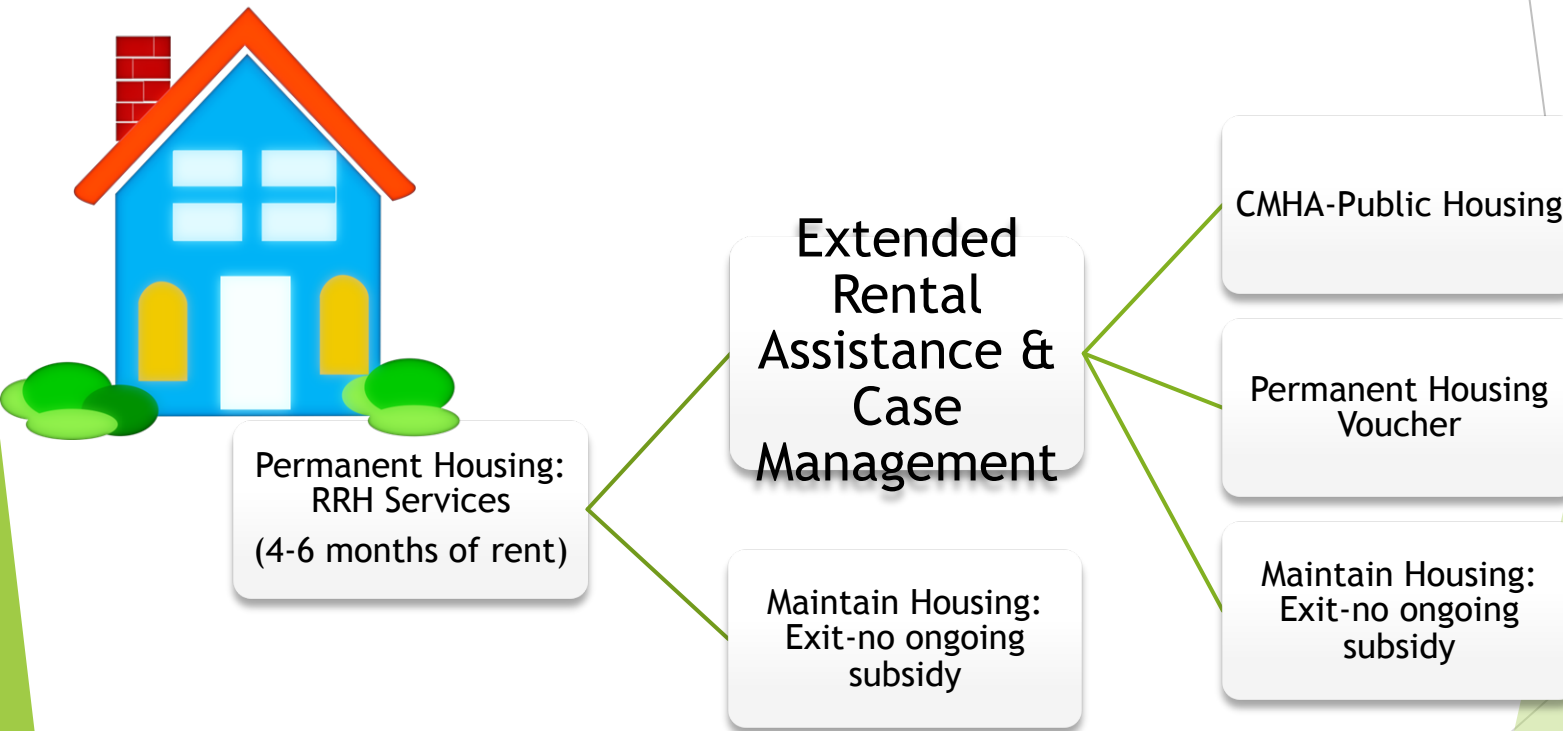- ▶ Start with the minimal amount of assistance and increase if needed

Coordinated Intake and Progressive Engagement

Diversion

Assessment of Barriers (if unable to divert)

Shelter Placement for literally homeless

Housing Plan: Rapid Re-Housing for Most

Rapid Exit to Housing

Progressive Engagement & Rapid Re-Housing

Initially Provide the Minimal Amount of Assistance to Stabilize Housing

Ongoing Assessment of Barriers and path to Maintaining Housing Independently

Determine Whether Able to Exit and Maintain or to Extend Assistance

Continue to Extend Assistance with Case Management; Tailor Assistance to Needs of Household

Determine When Another Long-Term Housing Intervention is Needed: PSH, Local Housing Authority, Etc.

Rapid Re-Housing Progressive Engagement Model in Cleveland:

Permanent Housing: RRH Services

(4-6 months of rent)

Extended Rental Assistance & Case Management

CMHA-Public Housing

Permanent Housing Voucher

Maintain Housing: Exit-no ongoing subsidy

Maintain Housing: Exit-no ongoing subsidy

Questions?

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Poll: What's the main thing that is stopping you from moving to serve high acuity folks in rapid rehousing?

Resources

- https://files.hudexchange.info/course-content/best-practices-for-serving-populations-with-high-acuity-needs/SNAPS-COVID-19-Webinar-Best-Practices-for-Serving-Populations-with-High-Acuity-Needs-October-20-2020-Slides.pdf

- https://files.hudexchange.info/resources/documents/COVID-19-Homeless-System-Response-High-Acuity-Transition-from-Short-term-to-Long-term-Subsidy.pdf

- https://www.homelesshub.ca/sites/default/files/HousingFirstInCanada.pdf

- https://files.hudexchange.info/resources/documents/CriticalTimeIntervention.pdf

- https://letsendhomelessness.org/wp-content/uploads/formidable/31/COVID-19-Homeless-System-Response-Primer-on-Serving-People-with-High-Acuity-Needs.pdf