Washington State Department of Social and Health Services

Transforming Lives

REPORT TO THE LEGISLATURE

Personal Care in Homeless Shelter Pilot

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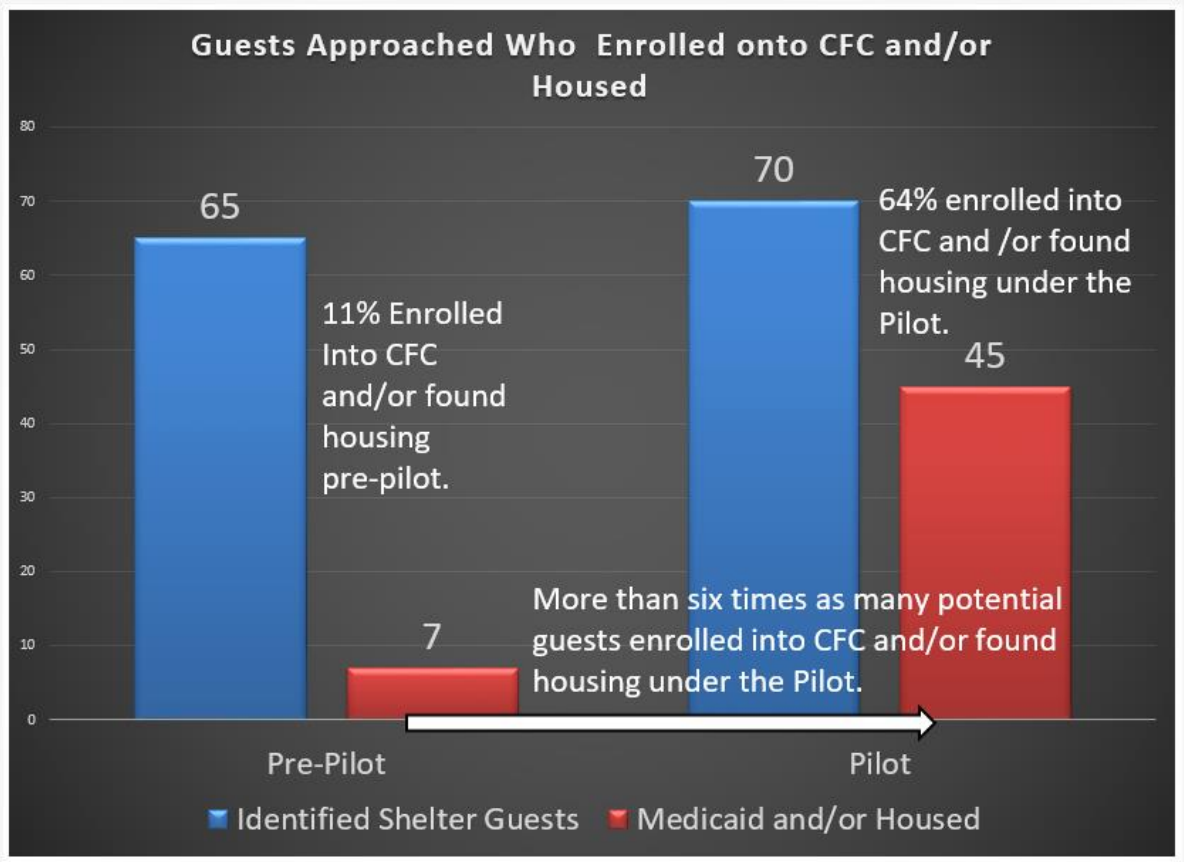
Summary

Beginning in 2017 (pre-pilot), the Department of Social and Health Services (DSHS) and Catholic Community Services (CCS) partnered to target Medicaid personal care services to seniors and people with disabilities at Nativity House Homeless Shelter in Tacoma, Washington. DSHS stationed a social worker there part time. The outcomes were very positive and many individuals served transitioned out of homelessness and continued successfully into housing.

Historically, the Medicaid Long-Term Services and Supports (LTSS) rules and requirements were identified as a barrier to most people who needed care. To address this, the state Legislature funded a pilot program to provide personal care services immediately when individuals present with a need, without waiting for the federally-required steps necessary to determine eligibility and authorize Medicaid-funded LTSS. The pilot, which started July 2019 and is funded through State Fiscal Year 2021, is to test whether: 1) more people can be served, 2) engagement with services happens more quickly; and 3) the same positive housing outcomes can be achieved. This report looks at the data collected from the first 15 months of the pilot program (July 2019-September 2020) and compares it to results from the previous 15 months of "pre-pilot" when personal care services were not offered absent completed Medicaid eligibility.

In the first 15 months of the pilot project, 68 out of 70 individuals accepted services that were offered. 45 of the 68 enrolled in Medicaid and/or acquired housing: 33 of the 45 have successfully enrolled into the Medicaid Community First Choice (CFC) program, which provides personal care and other supportive services, and 30 of the 45, acquired housing. These numbers are significantly higher than the outcomes under the pre-pilot program at the shelter (identified by the red bars, below).



Source: Catholic Community Services pilot data.

Background

Homeless shelters began seeing a significant increase in older adults and people with disabilities after the Great Recession of 2009. In addition to presenting with cognitive impairment, assistance is often needed with walking, transferring, toileting, showering, and other personal care tasks. There is also a need for transportation to medical, pharmacy, and other appointments.

CCS and DSHS started working together in 2017 in an attempt to bring CFC personal care services to qualified individuals at the Nativity House Homeless Shelter in Tacoma, Washington. The original effort attempted to assist frail elders and people with disabilities by using the rules and processes required under Medicaid. This meant that all individuals had to go through an extensive assessment and financial review before services could be provided.

A DSHS social worker was assigned to the shelter and kept office hours onsite. Shelter staff encouraged individuals who were likely eligible to work with the DSHS social worker in an effort to become eligible for CFC personal care services. Once the individual qualified, they could choose personal care provided by the CCS Home Care program.

This had never been attempted before. While it was felt there were many individuals who could qualify, only those who were able to successfully go through the functional and financial eligibility process ultimately could be served through Medicaid funded LTSS.

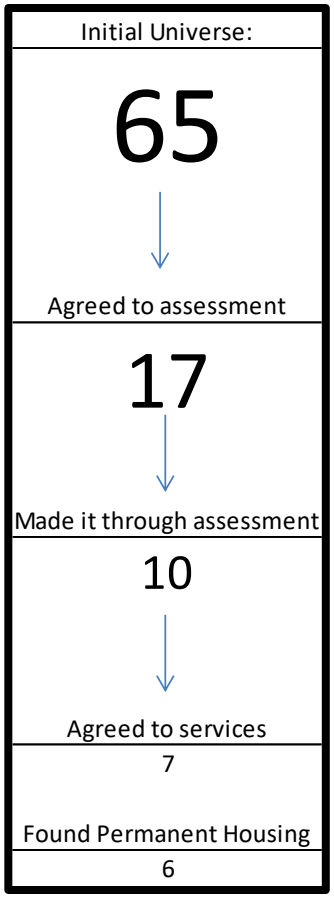
Homelessness is a barrier to access

Given the complexities of federal rules surrounding Medicaid personal care, and the complexity of factors impacting individuals in shelters and the shelter environment, it is very challenging to administer the assessment in a shelter setting.

In the initial pre-pilot effort, shelter staff were provided training as to what personal care services were allowed under CFC as well as what functional limitations qualified a person for services. Using this information, shelter staff identified 65 individuals who they felt were in need of care and would qualify for services.

Individuals were approached and services and eligibility were explained. Of those who were approached, only 17 agreed to go through the assessment process. Seven did not complete the process, and three more decided against services although they were found eligible. A total of seven were served in the initial cohort. Six of the seven did find housing.

While the outcomes in the initial effort were good, the concern centered on the majority of people who could/should receive services but declined them. The process of going through a comprehensive assessment while being a guest at a shelter was the largest barrier identified.



Program Design of the Pilot

Staff working on this project felt that many more seniors and people with disabilities who are experiencing homelessness would benefit from personal care services, and perhaps obtain similar outcomes, if the care was provided when the individual first arrived or needed it, rather than waiting for enrollment onto the Medicaid program, which can take weeks, even if the individual is motivated.

Pilot Funding by State Legislature

To that end, the Legislature funded care for homeless shelter guests that would be provided immediately. $94,000 per year was contracted to Catholic Community Services to fund two 30-hour per hour week caregivers who would provide the same personal care service as one would receive under Medicaid.

The legislative intent was to do the following:

- Determine if people would accept services if personal care was offered at the beginning of a shelter stay– would the pilot engage more individuals?
- Determine the barriers to eligible individuals being enrolled into Medicaid at a faster rate than was currently occurring.
- Determine if the same positive housing outcomes would occur.

Results

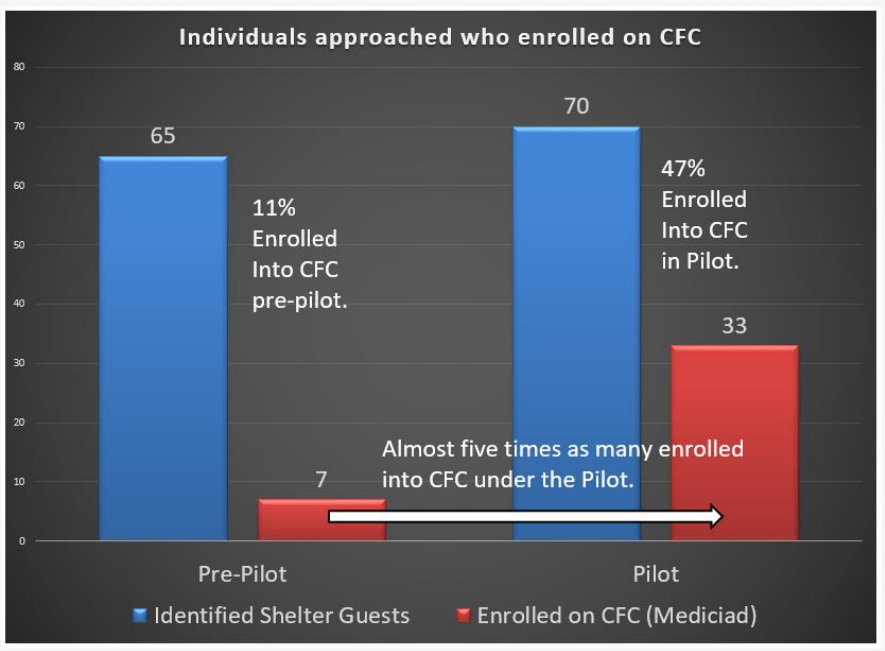
Based on the data of the pilot, it appears all three questions have been answered in the affirmative:

Seventy individuals were offered services and 68 accepted and received care during the 15 months. This compares to only seven out of 65 individuals in the initial program who would have had to be willing to participate in a functional and financial eligibility process prior to receiving services. The outcome flipped, from 90 percent of individuals declining assistance to 90 percent accepting assistance. Nearly ten times as many individuals were assisted:

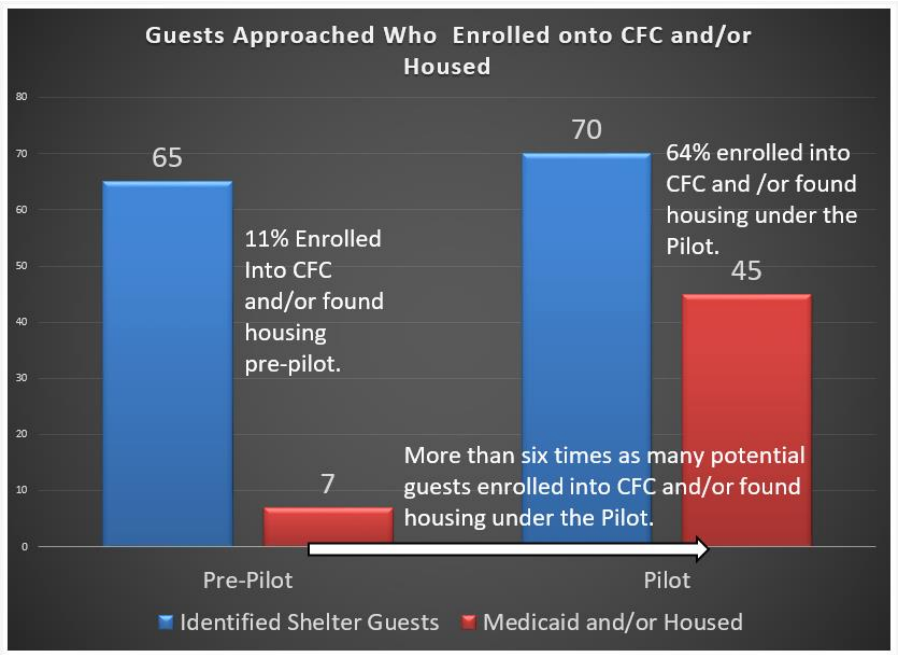
Source: Catholic Community Services pilot data.

Thirty-three people successfully enrolled into the Medicaid personal care program. Providing the services while guiding people through the enrollment process had a significantly better outcome.

In the first 15 months of the pre-pilot effort, seven individuals were enrolled in Medicaid out of a total of 65 potential individuals, or 11% acceptance. In the same length of time for the pilot, 33 of the 70 individuals approached successfully enrolled in Medicaid, equating to 47% or almost five times the successful enrollments of the pre-pilot effort. This does not include nine individuals from the pilot period who are enrolled in the pilot, but who have not yet enrolled in CFC.



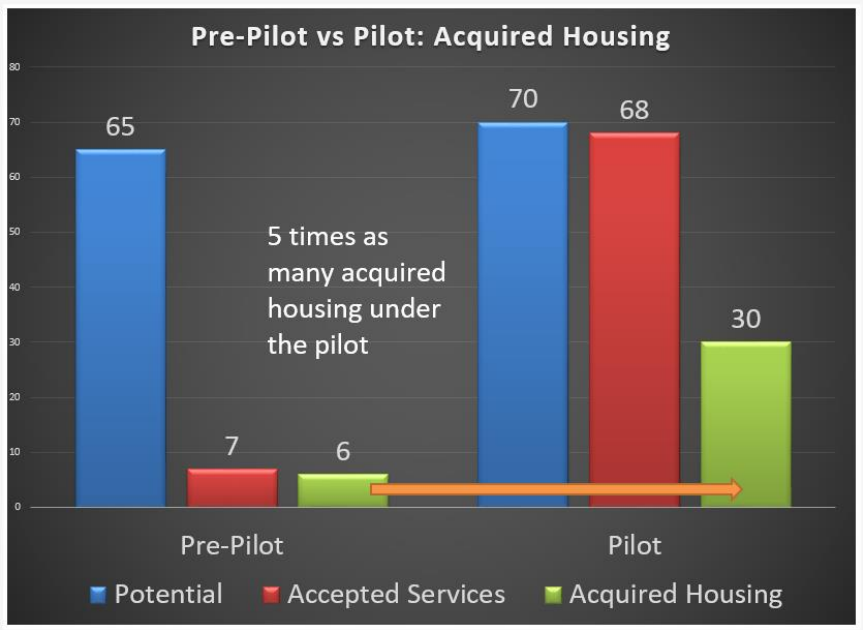
We believe this dramatic increase strongly correlates to the trust individuals develop with the personal care providers who are embedded in the staffing at a homeless shelter. It is also important to note that an additional 12 individuals who accepted services found housing without getting onto CFC. When you add these 12 to the comparison, the outcomes are even greater, with 45 vs 7 or 64% vs 11% success:



Source: Catholic Community Services pilot data.

Successful Transitions

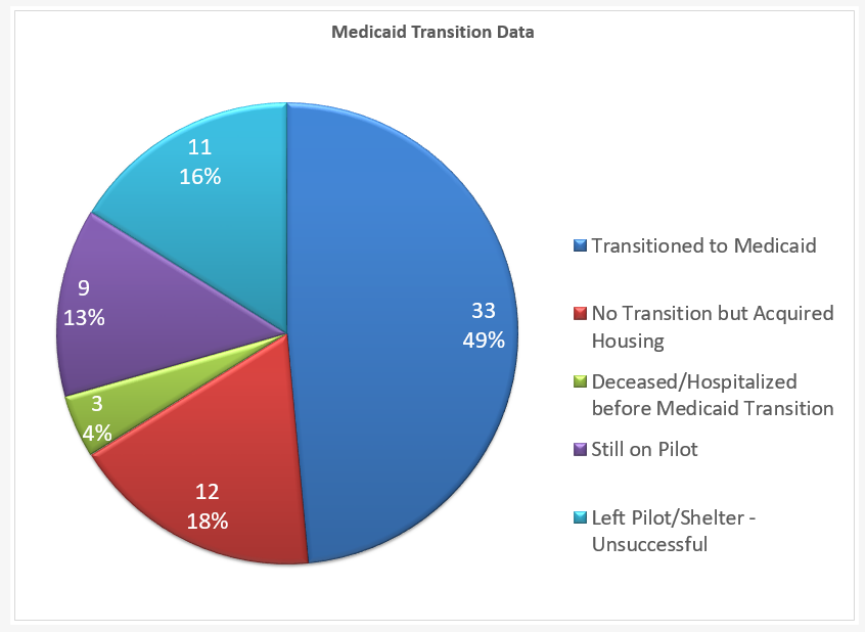
Thirty individuals have transitioned out of homelessness into housing. Five times as many individuals were housed under the pilot program than in the pre-pilot program. Many of the individuals who found housing met the definition of 'chronic homelessness'. Within the pilot project group, 18 individuals are still in the process of looking for housing and are either on Medicaid or receiving personal care services through the pilot; all 18 are still residing in the shelter.



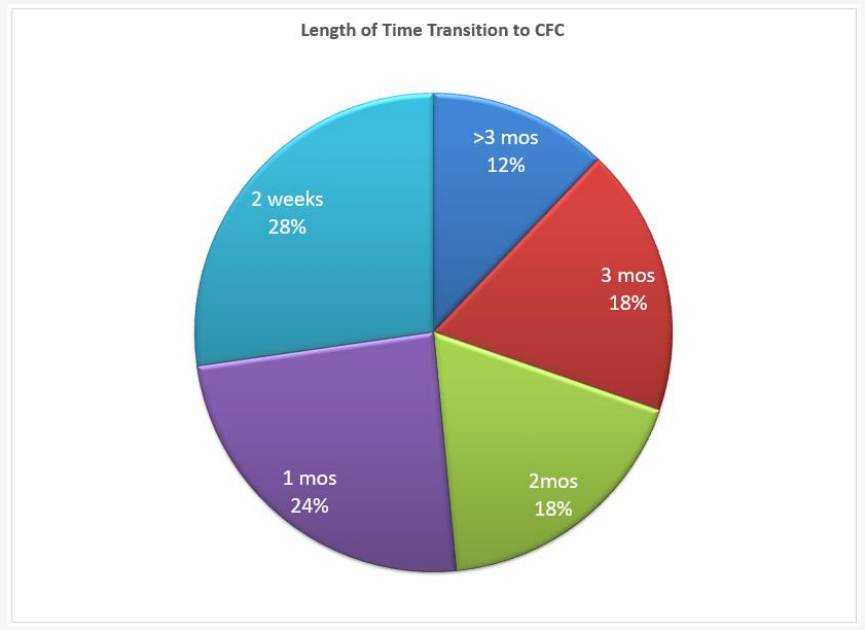
Source: Catholic Community Services pilot data.

Of the 30 individuals who found housing in the 15 months of the pilot thus far, 18 first transitioned onto Medicaid and then found housing – these individuals spent an average of 41 days enrolled in the pilot. Twelve individuals went from the pilot straight to housing without transitioning onto Medicaid – they spent an average of 71 days enrolled in the pilot.

This means that 40 percent of those who found housing were not enrolled into Medicaid. These individuals were served by the pilot, were stabilized, and subsequently found housing without first getting onto Medicaid. This may speak to the value having these services before eligibility is established. This program not only increased the number those who found housing, but appears to be diversionary to Medicaid. This was a surprise and potentially identifies significant savings within the pilot that could be expanded should the program become permanent.



The percentage of individuals who transitioned to Medicaid is significant. Starting with the universe of 68 people served and subtracting those who did not transition but acquired housing (12), those who are deceased or were hospitalized (3), and those who were actively enrolled in the pilot but have not yet transitioned (9), you are left with 44 total individuals, 33 of which (or 75 percent) have successfully transitioned to Medicaid.



More than half of individuals who transitioned to Medicaid did so within one month. 82 percent enrolled into Medicaid within two months. This is remarkably fast, especially for a population which often is resistant.

When individuals have support with personal care and have navigators assisting them with appointments and paperwork, they are more successful accessing needed services that can help them avoid costly institutionalization and they can begin receiving Medicaid services more quickly.

Source: Catholic Community Services pilot data.

Without the encouragement and assistance of the pilot personal care staff, it is doubtful if these individuals would be enrolled into Medicaid as quickly and at such large numbers due to the complexity of issues facing individuals who are homeless and in the shelter environment. Again, the transition to Medicaid is only part of the success story. Twelve individuals so far have gone from the pilot to housing without first getting onto Medicaid. This points to the notion that housing stabilizes well-being and lessens the need for Medicaid LTSS. It is also doubtful that this could have been achieved without the benefit of the pilot services.

Pilot Enrollment and Services Provided

We used a simple intake and consent form to enroll individuals into the pilot. Part of this process is to explain the services (tasks) we are able to provide. Individuals determine what supports they may need, the frequency and level.

As we followed all home care agency licensing requirements, we kept detailed notes as to what tasks were provided with each visit. Using a special form for the pilot, individuals initialed after each visit and signed at the end of the period, signifying agreement with the time spent and task provided, as well as any mileage associated with the visit. The results for all individuals are as follows, showing the percentage of those who received each task:

Task:	%
Ambulation	87%
Medication	75%
Housework	73%
Standby Assistance/cueing	68%
Travel to Medical	60%
Shopping	51%
Personal Hygiene	24%
Meal Prep	17%
Bathing	10%
Telephone	8%
Dressing	5%
Assistance with Eating	2%
Advanced Care*	40%

*Bathing, Toilet Use, Transfers

The tasks accepted were very consistent with the pre-pilot program and leaned towards needing support that would make one eligible for Nursing Facility Level of Care (NFLOC) required to receive most Medicaid LTSS.

By far, the most used support was ambulation. Almost all people served needed help with walking and had either a walker, wheelchair, or other assistive device. The second most needed task was medication assistance. Three out of four individuals needed assistance with medication management. Needing support with these two tasks illustrates the fragility of this population.

We also looked at the percentage of individuals who needed 'advanced care'. We defined this as needing help with bathing, toilet use, and transfers. Forty percent of those we served fit this category. Needing these supports while being homeless put these people in a very vulnerable position. Note: all but two individuals who needed transfer and/or toileting supports have found housing and/or are on the Medicaid program now.

Direct Service Hours vs. Billed Hours

The pilot was set up with two caregivers working 30 hours per week. We tracked the 'direct service hours' as a percent of the total hours worked by the caregivers. There were several months when the hours worked exceeded the amount of hours available to be billed. The amount of hours of direct service versus billed ranged from 95% to 106%. Overall, 99.6% of the total hours billed were direct service hours.

We were surprised by this number. We believed there would be more 'down time' when staff were not directly working with an individual. This number speaks to the need for this service, as the need of the individuals served kept staff time completely filled.

Cost and associated data

Cost through 15 months:	$115,518
Cost/individual/month	$540
Cost/Individual w/ housing (30 to date)	$3,851
Hours/individual/month	17.3
Shift/individual/month	7.9
Hrs/shift	2.2
% shifts w/travel	41%
Ave miles/travel shift	6.7
Ave miles/individual/month	22
Travel miles/served hour:	1.3

- Our current Medicaid caseload averages $1800 per month compared to the pilot cost per individual per month of $540.
- The average hours per visit is twice as much for current Medicaid clients versus individuals enrolled in the pilot.
- The average hours/individuals/month is significantly lower than that of current Medicaid clients.
- Conversely, pilot enrollees use travel to medical appointments and errands at a much higher rate than CFC clients, but the overall monthly miles are lower.

COVID-19 Impacts

Services continued throughout the pandemic, despite challenges. Staff were exposed to the virus, having to quarantine numerous times. Two staff were infected with COVID-19, but fully recovered and no known exposures occurred due to strong infection control procedures in place. A hotel was secured for those enrolled in the pilot over age 60 and those with compromised health issues. While all individuals enrolled in the pilot fell into this category, some chose not to move to the hotel. The addition of the hotel did mean that the pilot program had two locations to work from, which slowed progress. The pandemic also slowed progress in other ways, as reported by staff:

"This is a team effort. Peers and case managers who are instrumental in assisting clients reverted to working from home, making it more challenging to be hands-on and seeing clients to gather information to proceed with housing. "

"With some of the individuals moving to the hotel, they were so appreciative to have that setting and settled for that instead of continuing to push for housing of their own."

"Due to the pandemic, housing was slowed down when apartments and shared housing were not allowing new tenants."

Thoughts from Direct Service Staff

The ability of caregivers to take individuals to medical and housing related appointments, as well as provide assistance with activities of daily living, has much to do with helping them reweave the social networks and contacts needed to successfully transition out of homelessness. This program provides the structure and stability many people have lost through the trauma of homelessness.

The success of the program has much more to do with the simple act of human kindness. Caregivers report most individuals are reluctant at first, not feeling worthy; feeling society has looked through them and past them for years. The first connection between the caregiver and the individual is usually a simple act of offering a steady hand while the unsteady individual walks or helping clean up an individual's small sleeping space, or bringing a tray of food when the individual is too weary.

The simple acts quickly build trust which allows not only caregivers but other members of the team to help individuals reconnect. Caregivers at the shelter do not work in a vacuum. They are part of a team which includes mental health professionals and support staff. In many ways, the caregivers are the missing piece for some individuals. For some, the first person with whom they could rely on for years is their caregiver. The structure and stability a caregiver brings allows the individual to accept care from others.

The trust built by the care begets more trust and allows for further weaving the individual back into the fabric of our community. The program in many ways provides individuals with the emotional support and encouragement needed to be part of the community again.

Case Studies (as prepared by staff – all names changed)

Case Study #1 (A couple) Mary & Charlie were homeless since 9/1/2017, both entered the pilot program on 7/2/2019. This program provided each of them with a caregiver to meet their daily care needs. Nativity House Case Managers assisted both to get the proper documents needed and become eligible for the CFC program. This program provides a caregiver to assist with their daily needs. After being on CFC it was discovered that Charlie was a veteran and was assisted to reach out to the VA for assistance with housing. The couple obtained housing 3/12/2020.

Case Study #2 Senor' was a rookie football player for the Cowboys years ago, was caught in the fast life and found himself from pillar to post and ultimately homeless on 12/8/2018. With assistance from the pilot program, he was able to obtain housing on 8/30/2019 and receive CFC services. Senor' said that he is very thankful to have this service because it helped him get on his feet, regain a sense of independence, feel human and a part of society again.

Case Study #3 Frank became homeless on 10/20/2018. Frank was labeled as a grumpy old man but with the encouragement of the caregivers and explaining the tasks they could assist him with, Frank finally accepted the pilot program. Frank did not enroll in CFC, but from the assistance with care through the pilot program and Nativity House Case Manager, Frank was able to find shared housing, and on 5/13/2020 he moved and is independent.

Case Study #4 Roy became homeless on 6/1/2016. With memory loss and no family he was aware of, he was in and out of shelters until he found Nativity House shelter. The pilot program was offered, he accepted and was enrolled. He then transitioned to the CFC program. Roy moved out of the shelter and into housing on 8/7/2020 with a friend he met at the shelter.

Case Study #5 Leon became homeless on 9/26/2018. He had been frustrated, battling depression, drug addiction and living on the streets until he was able to find shelter at Nativity House. His voice was a whisper due to a tracheostomy. Lacking an amplified device, he could not be easily heard. Pilot caregivers were able to communicate with him, get him into the pilot program, and assist him with receiving CFC and housing on 11/4/2019. He continues to receive CFC services. Soon he will receive a microphone so he will be able to be heard again!

Recommendations

This pilot program has demonstrated that an initial modest investment of state-funded services was instrumental in engaging vulnerable individuals to improve their lives. As reported, thirty people enrolled in this pilot found stable housing. That's 44% compared with 9% during the pre-pilot period, a very significant increase. Thirty-three people enrolled onto Medicaid. Two-thirds of the people who enrolled in the pilot either graduated to stable housing and/or were enrolled into the CFC/COPES programs. Bringing these people out of chronic homelessness and providing personal care likely saves the state hundreds of thousands of dollars in 911 calls and emergency room visits. Homeless service leaders in Seattle and Spokane find these results extraordinary.

A Medicaid skilled nursing facility bed is estimated to cost the state approximately $98,000 annually. Hospital care, 911 calls, or potential incarceration is more costly and can be prevented. One could reasonably assume that even if 10

percent of the 30 people who were diverted to housing eventually would instead transition into a nursing facility or other institutional setting, the cost could be $300,000 per year. One could make the same argument for those served on the pilot who have not yet transitioned into housing. We estimate this pilot has already shown return on investment, in addition to helping people reconnect with society.

DSHS and advocates would like to see this program continue and expand. At an annual cost of $94,000 for one site, results show it gives the state a significant return for its dollars invested. We recommend this pilot expands into two to three more urban counties, with at least one site on the east side of the state. We know there are elders and people with disabilities who are frail and homeless and could use the supports and stability the program brings. The state would benefit from cost savings as these individuals will have improved quality of life for a modest, short-term investment and may avoid more costly settings in the future.

Ground work has been done in several counties where DSHS and providers work to enroll homeless people onto Medicaid. The key of this pilot is to provide the care to the people first, knowing that they are then more likely to engage with life-improving services. Data shows this has worked as desired. This program could expand rapidly in additional counties and show results very quickly. This program is still filling a vital need in Pierce County and so we recommend, at the very minimum, that the funding for the current pilot site continue.