

People We Serve: Guidelines

August 30, 2018

Introduction

As a FQHC serving a homeless population, we operate under the broad HHS definition of homelessness so that we can serve those who are most vulnerable. The HHS definition focuses on housing instability as the key marker of homelessness. The HUD definition is narrower and more proscriptive but generally only applies to our housing programs

Individual staff, disciplines and sites have subtly different interpretations of homelessness and these differences surface when determining who is eligible for our services, how to manage changes in housing situation while receiving care, and who is ready to transition to community providers.

To address this, Health Care for the Homeless convened a workgroup to identify the “People We Serve”. This workgroup was charged with developing:

- A clear guideline that staff can use in determining who is eligible for services
- Procedures to manage those who are not eligible for services
- Processes to transition clients who no longer need agency services to other providers

These resources were developed to assist providers and staff in caring for our clients and are not a replacement for clinical judgment.

Process

The “People We Serve” workgroup was composed of staff from multiple locations and disciplines across the organization, clients and board members:

Staff

- Lilian Amaya
- La Keesha Arrington Vega
- Leonard Croft
- Sherry Golden
- Amelia Jackson
- Veronica Johnson
- Nilesh Kalyanaraman
- Laura Wolff

Clients

- James Barnes
- Paul Behler
- Dorsheena Hagler

Board member

- Elena Marcuss

The workgroup met on May 17, June 7, and July 5. A staff feedback session took place on May 10, a client feedback session took place on May 11, and the Health Equity Committee provided feedback on August 2.

Guidelines

Below are the most common situations that cause confusion about client eligibility for our services, based on staff and client feedback, as well as guidelines for how to resolve them. **These guidelines do not replace your clinical judgment and are not meant to restrict access to services.** Instead, they are meant to help us more consistently provide high quality care to our clients.

What homelessness looks like

When asked, “where did you stay last night,” the most common answers provided by people experiencing homelessness are:

- On the street
- In a shelter
- In transitional housing
- In a motel
- In a vehicle
- In an abandoned building
- With a friend/relative (“doubling up” or “couch surfing”)
- In a room (through an SRO as part of a housing program)
- In a place where they are paying rent, but their name is not on the lease

People living in permanent supportive housing (PSH)

People in PSH require and receive ongoing services to stay housed and, as such, are a core part of the population we serve. We provide the full range of services to these individuals, whether they are receiving PSH services through our housing program or through a community program.

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People who are “doubling up”

Doubling up is when a person is staying with a family member or friend. We consider this living situation a form of homelessness. Doubling up is a marker of instability, but there are a handful of situations where someone who is doubling up may be considered stable. A person can be considered stably housed when they meet all 3 of the following criteria:

1. have been staying in the same place for over a year,
2. are secure with no threat of being displaced, and
3. are safe.

As a matter of course, we assess both the security and safety of the client as part of our social determinants of health screenings.

In consultation with the client, staff may consider, but are not required to, referring the client to a community provider (if they are new to care) or transitioning them to a mainstream provider if the clinical situation warrants.

People who are paying rent, but are not on the lease

This situation is very similar to doubling up because of the instability of not being on a lease. Staff should follow the guidelines for doubling up.

Both “doubling up” and paying rent, but not being on a lease, are forms of homelessness.

People who are addressing financial and social factors other than homelessness

Whether an individual is homeless will determine the services and assistance we can provide. We refer individuals who do not meet our criteria to other FQHCs and agencies that can assist them. As a reminder, FQHCs and many primary care practices have case management services available for their clients.

Factor	If they are homeless	If they are housed
<i>Receive primary care elsewhere, but want lower cost services and/or medications</i>	Refer back to PCP or transition to our services	Refer back to PCP and provide community resources
<i>Referred by ER for “free care”</i>	Refer back to PCP or transition to our services	Refer back to PCP and provide community resources
<i>Has Medicare but can’t afford co-pays, deductibles, etc.</i>	Refer back to PCP or transition to our services	Refer back to PCP and provide community resources
<i>Seeks case management only</i>	Engage and transition to our services or if engaged in services elsewhere, evaluate and refer to other agencies focused on case management	Refer to other agencies focused on case management
<i>Seeks dental care only</i>	Internally refer to our dental clinic at Our Daily Bread	Refer to community dental resources
<i>Is undocumented</i>	Eligible for our services	Refer to culturally and linguistically appropriate community resources
<i>Has pending eviction or foreclosure</i>	n/a	Same day internal referral to case management

People with insurance issues

People with the following health insurance are able to receive services here, but their insurance status complicates what we can provide. When in doubt, please refer to the Benefits team for further assistance.

- **Veteran's Benefits:** We serve anyone experiencing homelessness, including veterans. We encourage people with VA benefits to get their care at the VA as they have a supportive housing program and are able to provide a wide range of services. However, we will provide comprehensive care if that is their preference. For those who wish to get their care with us, we will determine their eligibility for Medicaid/Medicare and enroll them as appropriate.
- **Private Insurance:** We are able to see these clients as an out-of-network provider, but we will not get paid an FQHC rate. For these individuals, we need to be clear that referrals or lab tests will be billed to them and these issues need to be addressed prior to providing services.
- **Kaiser MCO:** We ask people to change their MCO, as we cannot get reimbursed at our FQHC rate and we are unable to refer them to other services. If they want to remain on the Kaiser MCO, we will refer them to Kaiser for further services.
- **Other Insurance Issues:** We will see these clients. Refer them to the Benefits team to determine what services we can provide.

We can serve veterans and people with insurance issues. The Benefits team is here to help.

Transitioning clients to community care

One of the most difficult clinical questions is: *When should a client be transitioned to other community services?* The goal of transitioning is for clients to receive care in the most appropriate setting.

When a client meets the following five criteria, they can be considered for transition to a less intensive level of care:

1. Medically stable with a care plan in place
2. Behavioral health issues are stable with a care plan in place
3. Social supports in place
4. Stable income
5. Stably housed for more than 1 year (excludes those in PSH)

Clients may also be considered for transition when they need more intensive level of care (i.e., ACT team) or when they would benefit from receiving care closer to where they are staying.

Transitioning a client requires these five steps:

1. Discuss with the client to identify their thoughts and/or concerns. The client must agree with transitioning to continue.
2. Discuss with the client's care team, including the client's feedback as part of the process.
3. Develop a transition plan as a partnership between the client and care team.
4. Identify community providers for the client.
5. Designate a member of the care team to provide support after the transition to help with any issues that arise.

It is important to recognize that the transition may not work and that the client may return to care here.