Bridge to Health & Housing Project

Background

In November 2015, **Partnership HealthPlan of California (PHC)** released a social innovation grant to address social determinants of health, with the primary aim of removing barriers that prevent access to quality health care.

The Yolo County Health and Human Services Agency (HHSA) submitted a proposal to improve the health and well-being of medically vulnerable people experiencing homelessness through the **Bridge to Health & Housing Project**.

In March 2016, HHSA received **$499,125** to fund the two-year project.

Target Population

Medically Vulnerable

Homeless persons who have an acute or chronic health condition and/or substance use disorder.

Frequent Emergency Room Utilizers

Homeless persons who have visited the emergency room four or more times within the last six months.

Project Goals

The project aims to accomplish the following three goals:

Goal 1

- Identifying the most medically vulnerable people experiencing homeless in Yolo County.

Goal 2

- Diverting people experiencing homelessness with medical issues from the local emergency rooms into appropriate primary care settings.

Goal 3

- Improving the overall well-being a medically vulnerable people experiencing homeless by targeting four social determinants of health: housing stability; physical health; behavioral health; and self-sufficiency.

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Project Description

The project includes three components aimed at better serving the medically vulnerable including (1) identification, assessment and triage, (2) case management, and (3) housing navigation.

Project Staffing

- 3 full-time Outreach Workers/Case Managers
- 1 full-time housing navigator
- 24 hour on-call response

1. Identification, Assessment and Triage

The outreach triage component of the project will utilize two full-time Outreach Workers/Case Managers to assist with identifying, assessing, and providing services to the target population.

Identification: Workers will conduct outreach to identify the target population, including:

- Street Outreach
- Provider Outreach
- 24-Hour Emergency Room Response in cases involving high utilizers

Assessment: Workers will use the Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT) to assess the vulnerability of all homeless persons that they identify.

Triage: Workers will provider case management services to the most vulnerable individuals, and clients with lower levels of vulnerability will be linked with services from partner agencies.

2. Case Management

The case management component of the project will provide intensive services and emphasize whole person care by focusing on strengthening four target areas for each client, including (1) housing stability, (2) physical health, (3) behavioral health, and (4) self-sufficiency.

3. Housing Navigation

The Housing Navigation component of the project will provide assistance with permanent housing placements for clients on the case management caseload. The Navigator will consider the medical needs of each client when securing placements, such as proximity to medical care, presence of service dogs and mobility requirements.

Project Partners

- **Fourth & Hope** will operate the outreach, case management, and 24-hour on-call response components of the project.
- **Yolo Community Care Continuum (YCCC)** will operate the housing component of the project.
- **Sutter Davis** and **Woodland Memorial Hospital** will partner with the project by contacting the on-call project staff when an individual in the target population is accessing emergency room services.
- **CommuniCare Health Centers, Elica Health Centers, Northern Valley Indian Health, Winters Healthcare Medical Clinics,** and **Woodland Clinic** will act as the primary care providers for clients of the project.
- **Yolo County Health and Human Services Agency (HHSA)** will serve as the project's lead. HHSA will be responsible for project management and reporting outcomes to PHC.