Planning for Partnerships, Contracts, and Subcontracts
Medi-Cal Academy Team Brainstorm

Part 1: Articulating your services and service alignment with Community Supports

Directions: Circle the services that your agency currently provides; star the services your agency plans to provide:

1. Housing Navigation & Transition Services

a. Tenant screening and housing assessment that identifies the member's preferences and barriers related to successful tenancy.

b. Development of individualized housing support plan

c. Searching for housing and presenting options

d. Assisting in securing housing, including the completion of housing applications and securing required documentation

e. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process.

f. Identifying and securing available resources to assist with subsidizing rent

g. Identifying and securing resources to cover expenses, such as security deposit, moving costs, adaptive aids, environmental modifications, moving costs, and other one-time expenses.

h. Assisting with requests for reasonable accommodation, if necessary

i. Landlord education and engagement

j. Ensuring that the living environment is safe and ready for move-in.

k. Communicating and advocating on behalf of the Member with landlords.

l. Assisting in arranging for and supporting the details of the move.

m. Establishing procedures and contacts to retain housing, including developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.

n. Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist Members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move in day.

o. Identifying, coordinating, securing, or funding environmental modifications to install necessary accommodations for accessibility (see Environmental Accessibility Adaptations Community Support).

p. Coordination with other entities to ensure the individual has access to supports needed for successful tenancy

q. Coordination with local Coordinated Entry Systems, homeless services authorities, public housing authorities, and other operators of local rental subsidies

2. Housing & Tenancy Sustaining Services

a. Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment, hoarding, substance use, and other lease violations.

b. Education and training on the role, rights, and responsibilities of the tenant and landlord.

c. Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy.

d. Coordination with the landlord and case management provider to address identified issues that could impact housing stability.

e. Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action including developing a repayment plan or identifying funding in situations in which the Member owes back rent or payment for damage to the unit.

f. Advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized.

g. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset.

h. Assistance with the annual housing recertification process.

i. Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.

j. Continuing assistance with lease compliance, including ongoing support with activities related to household management.

k. Health and safety visits, including unit habitability inspections9.

l. Other prevention and early intervention services identified in the crisis plan that are activated when housing is jeopardized (e.g., assisting with reasonable accommodation requests that were not initially required upon move-in).

m. Providing independent living and life skills including assistance with and training on budgeting, including financial literacy and connection to community resources.

n. Coordination with other entities to ensure the individual has access to supports needed to maintain successful tenancy

3. Housing Deposits

a. Assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute room and board, such as:

i. Security deposits required to obtain a lease on an apartment or home.

ii. Set-up fees/deposits for utilities or service access and utility arrearages.

iii. First month coverage of tilities, including but not limited to telephone, gas, electricity, heating, and water.

iv. First month's and last month's rent as required by landlord for occupancy.

v. Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy.

vi. Goods such as an air conditioner or heater, and other medically-necessary adaptive aids and services, designed to preserve an individuals' health and safety in the home such as hospital beds, Hoyer lifts, air filters, specialized cleaning or pest control supplies etc., that are necessary to ensure access and safety for the individual upon move-in to the home.

4. General Support Services

a. Street outreach

b. Hospital, shelter, and institutional in-reach for screening and assessment

c. New tenant orientation/move-in assistance

b. Tenant's rights education/tenants council

c. Housing Case management or service coordination

d. Psychosocial assessments

e. Individualized service planning

f. Individual counseling and support

g. Referrals to other services and programs

h. Crisis intervention

i. Peer mentoring

j. Support groups

k. Recreational/ socialization opportunities

l. Legal assistance

m. Non-medical Transportation

n. Nutritional services

o. Meals

p. Emergency financial assistance

q. Furnishings

5. Independent Living Skills

a. Communication skills

b. Conflict resolution/mediation training

c. Personal financial management and budgeting

d. Credit counseling

e. Representative payee

f. Entitlement assistance/benefits counseling

g. Training in cooking/meal preparation

h. Training in personal hygiene and self-care

i. Training in housekeeping

j. Training in use of public transportation

k. Assistance with activities of daily living

6. Health/Medical Services

a. Routine medical care

b. Medication management or monitoring

c. Health and wellness education

d. Nursing/visiting nurse care

e. Home health aide services

f. Personal care

g. HIV/AIDS services

h. Pain management

i. Recuperative Care/Medical Respite for unhoused neighbors

j. Community Health Workers

k. Street Medicine

6. Mental Health Services

e. Peer mentoring/support (describe below)

g. Education about mental wellness and illness management

h. Education about psychotropic medication

i. Psychiatric services

j. Coordination with psychiatrist

k. Psychiatric Nurse

7. Substance Abuse Services

a. Recovery readiness services (tenants with active addictions)

b. Relapse prevention and recovery planning

c. Substance use counseling (individual)

d. Substance use counseling (group)

e. Methadone maintenance

f. Harm-reduction services (specify)

g. AA/NA/CA

h. Substance use case management

i. Sober recreational activities

8. Employment Services

a. Job skills training

b. Education

c. Job readiness training — resumes, interviewing skills

d. Job retention services — support, coaching

e. Job development/job placement services

f. Opportunities for tenants to volunteer

9. Services for Families

a. Support group for parents

b. Support group for children

c. Support group for families

d. Parenting classes

e. Classes on child development

f. Child care or day care

g. After-school care

h. Children's services (specify)

i. Domestic violence services

j. Child care in the event of parent illness/hospitalization/detox

k. Family advocacy (specify)

l. Family reunification (specify)

m. Assistance with accessing services for children (specify)

n. Assistance with accessing entitlements/benefits

Part 2: Articulating how services lead to health-related outcomes

1. **In the chart provided on page six, list the outcomes that your current and future services can and may contribute to. How do you define and measure success? (**You may pull from the list below and add your own.)

Outcomes examples from Medicaid Triple Aim and CalAIM:

- Improvement in the individual experience of care
- Improvement in health outcomes (like A1c levels for clients with diabetes)
- Housing placement rates and average placement timeframe
- Housing retention rates at 12 and 18 months, return to homelessness rates
- The number of individuals authorized for service who were housed for more than 6 consecutive months
- Reduction in the per person (per capita) costs of care for populations
- Reduction in unnecessary emergency department visits
- Reduction in avoidable overnight hospital stays
- Improvement in rate of screening for social drivers of health
- Improvement in rate of screening for substance use
- Documenting ways services "Allow Members to obtain care in the least restrictive setting possible and to keep them in the community as medically appropriate." (Key goal of CS, from DHCS CS Policy Guide, page 4)
- Tracking referrals, assessments, care coordination and services delivered timeframes to "Demonstrate and ensure seamless service to Members experiencing homelessness entering the Housing Transition Navigation Services Community Support" (DHCS CS Policy Guide, page 9)

2. **What Medi-Cal contracting agencies (MCPs, ECM providers, County Departments, nearby hospitals, FQHCs) are also working toward these same outcomes for your target population?**

OUTCOMES WE ACHIEVE & HOW WE MEASURE THEM CURRENTLY	AGENCIES WHO SHARE OUR OUTCOMES AS GOALS-
OUTCOMES WE CAN REACH & HOW WE'LL MEASURE/TRACK PROGRESS	AGENCIES WHO SHARE OUR OUTCOMES AS GOALS

Part 3: Utilizing DUAs to track outcomes from external data systems and share housing-related data to health partners

What Data Use Agreements do you currently have in place with partners who may track individual and population health and housing outcomes that your services contribute to?

What Data Use Agreements and Sharing Methods might you need to put in place to better understand and articulate the outcomes your services contribute to?