LifeLong Medical Care, Berkeley, California

LifeLong Medical Care (LMC), which currently provides a broad range of health and social services to people of all ages, began in 1976 when the Gray Panthers, a senior citizens' advocacy organization, opened the storefront Over 60 Clinic on San Pablo Avenue. In 1996, the organization merged with Berkeley Primary Care Access Clinic and rapidly grew into a community health center (CHC) with five clinic sites and a variety of special programs. LMC is known as the primary "safety net" provider of medical services to the uninsured and those with complex health needs in Berkeley, Albany, Emeryville, and parts of Oakland. LMC has been involved in permanent supportive housing since 1998.

Supportive Housing Program: The LifeLong Supportive Housing Program (SHP), also known as the Alameda County Health, Housing, and Integrated Services Network, is a collaboration of public and private agencies that provide permanent housing as well as social and health services to formerly homeless people with disabilities. SHP provides on-site, multidisciplinary support services to over 600 tenants living in eight subsidized housing sites scattered throughout Berkeley and Oakland. Services provided by SHP are optional and available to all tenants living in these housing sites. LMC does not own or operate any of the housing sites, but collaborates with several nonprofit housing development corporations which create and operate affordable housing in Alameda and Contra Costa Counties.

C.W. Dellums Apartments
Oakland

U.A. Homes, Berkeley

Intensive supportive services are provided to SHP tenants and include: outreach, intensive case management, housing stabilization and eviction prevention, benefits advocacy and money management, medical care, mental health and substance abuse services, community building and social activities, and employment/vocational support. SHP staff also provides outreach and case management services to currently homeless individuals to help them obtain and maintain permanent affordable housing.

In 2006, LMC was awarded a New Access Point Public Housing Primary Care (PHPC) Program grant by HRSA. This grant partially funds the Downtown Oakland which is in the neighborhood of most of LifeLong's SHP sites, but located in a separate building. The PHPC clinic serves LifeLong's SHP patients, other residents of supportive housing, county mental health patients who need primary medical care, frequent users of the ER, and GA recipients whom LifeLong is trying to get on SSI and Medicaid.

Project RESPECT, the Frequent Users of Health Services Initiative project in Alameda County, aims to create cost-effective and coordinated systems of care to address the overuse of medical and psychiatric emergency services, and to improve the health and psychosocial status of frequent Emergency Department users. LifeLong Medical Care, the Homeless Action Center, the Alameda County Medical Center (ACMC), and the Alameda Health Consortium are collaborating to provide intensive case management services and to participate in system change efforts to achieve this goal. Most frequent users of the emergency room have serious, chronic health conditions as well as psychosocial issues such as homelessness, substance abuse, and a lack of social support systems.

Project RESPECT's multidisciplinary team, including a social worker, case manager, nurse, attorney and psychiatrist, provides access to the following services for indigent patients who regularly use the Highland Emergency Department: primary care, housing, mental health services, benefits assistance (Medicaid, SSI, Food Stamps), substance abuse services, and transportation assistance. Services are provided through office, home and community based visits. Project RESPECT serves people who have had 10 or more visits to the Emergency Department during one year or four or more visits a year for at least two consecutive years. Services are not time limited. The Project has provided intensive case management services to more than 70 people in the past year. This model has had the following positive impact:

- 75% of clients have shown a reduction in Emergency Department visits.
- 85% of project clients have received increased primary care services.
- 50% of project clients have received advocacy services for SSI, MediCal and other benefits.
- 30% of clients are either housed or in process of receiving permanent housing

Much of this success is a result of collaboration and coordination of services across the primary care, housing, benefits advocacy, mental health, and hospital systems.

Factors to which Supportive Housing Program success is attributed:

- ***Benefits advocacy:*** Lifelong contracts with a benefits advocacy agency to provide legal representation for SSI/SSDI applicants. They have been very successful in getting clients SSI/SSDI benefits, including health insurance. Benefits advocacy has also been an important way to engage clients in services.

- ***Integrated primary and behavioral health care:*** Psychosocial and medical teams are well integrated; primary care and mental health service providers meet regularly with case management teams. Four supportive services teams—each comprised of case managers (some with BA degrees, others not), MSWs and LCSWs—provide individual case management and organize and lead a variety of groups. LCSWs serve as team leaders; they supervise case managers, provide expertise in working with seriously mentally ill clients, and are the only members of the case management team who can bill for services provided to FQHC clients. A mid-level [NP or PA] and an MD provide clinical services at 5 hotel sites. When clinic is in session, they are usually supported by a MA psychologist and a case manager who provides psychosocial referrals, support, crowd control, etc. A psychiatrist from the county mental health department serves on one of the teams for 4 hours each week. All case managers and MSWs are full-time employees; 3 of the 4 LCSWs are part-time (60% – 80%); the MD and mid-level who work at the housing sites and at the Downtown Oakland Clinic are both part-time providers (55% and 75%, respectively).

- ***Linkage with property management:*** Weekly meetings with property managers focus on pending evictions, identifying who hasn't paid rent and who is ready to move on to a better housing situation, and determining what help is needed to prevent eviction/promote readiness for better housing. Working with property managers helps keep people housed and makes the atmosphere in supportive housing buildings safer. This has taken years to achieve.

- ***Individual and group "stabilizing" interventions:*** Non-therapeutic group interventions have been particularly important to help address socialization issues; women's support groups are especially popular. Aggressive outreach to residents is necessary; a well-known case manager goes door-to-door in the housing units to invite residents to group sessions. Staff help individual clients with money management, provide vocational and transportation assistance, promote harm reduction and community involvement. These stabilizing interventions enable clients to negotiate community service systems, hook up with mental health treatment, return to school or work, and feel more connected to the broader community. Half of the groups are led by social service staff (case managers, MSWs, LCSWs), and half are led by medical providers on physical health topics.

- ***Intensive case management****:* The most intensive work is done at the point of engagement with street dwellers and during the transition from the street to housing. Many new PSH residents feel isolated and "penned in"; home visits and office visits help these clients feel more comfortable. Caseloads are 1:20 ("a bit high, but funding demands it"). Flexibility and the development of trusting relationships are important for recruitment and retention of case managers, as well as for clients. Two of the case management teams provide services exclusively at 4 hotels; the other two teams provide services out of the Downtown Oakland Clinic, through home visits (combination of Shelter + Care clients and others), at two hospital ERs, on the street, at shelters and other social service agencies and at two SROs near the clinic where full-time services are not available on site. Active outreach is provided to those sites to bring people to the clinic for primary care and to participate in group sessions.