One Community's Collaborative Approach: A Spotlight on Yakima, Washington

Some communities have made tremendous strides to effectively align homelessness services and MRC programs. This spotlight interview includes the housing, CoC, and MRC leaders in Yakima, Washington. They describe their MRC program, how it fits within their community's response to homelessness, their collective approaches to racial equity, and specific ways they have strengthened their system through their collaboration. Finally, they offer four bits of advice for others who are looking to align their homelessness and MRC programs. All communities—large and small—can make improvements in their systems of care.

Spotlight on Yakima, Washington

Yakima is an agricultural community in the central region of Washington State. In September 2021, leaders of the Yakima CoC, the housing authority, and the federally qualified health center (FQHC) that operates the medical respite care (MRC) program convened to discuss their effective collaboration together:

- **Esther Magasis, Director, Department of Human Services.** As a part of the Balance of State CoC, this agency coordinates the CoC activities in Yakima County. The 2020 Point in Time report counted 663 people in 524 households, and homeless services is tracked on a public dashboard.
- **Lowel Krueger, Executive Director, Yakima Housing Authority**; which is tasked with providing safe, decent, and sanitary housing for low- and moderate-income residents of the City of Yakima.
- **Rhonda Hauff, CEO, and Annette Rodriguez, Director of Homeless Services**, Yakima Neighborhood Health Services (YNHS). As a large FQHC offering primary care, behavioral health, and support services—as well as operating an MRC program—YNHS served 2,633 people experiencing homelessness in 2020.

Medical Respite Care

Provides acute and post-acute medical care for people who are homeless and too ill to be on the street/in shelter, but not ill enough for hospital-level care.

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Purpose of this Spotlight Profile: People experiencing homelessness need space to recover safely from illnesses or injuries, and receive support to access care. This "spotlight" interview illustrates how one community forged an effective partnership between its CoC, its public housing authority, and its FQHC-operated MRC program. It serves to complement the issue brief, Expanding Options for Health Care Within Homelessness Services: CoC Partnerships with Medical Respite Care Programs, by providing an example other communities might replicate in order to increase their own collaborations with health care partners.

Can you describe Yakima's Medical Respite Care program and the services it offers?

Yakima Neighborhood Health Services (YNHS), an FQHC, operates the MRC program. The program currently has three locations—"The 101 House," a wheel-chair accessible residence with five, single-occupancy rooms, and "The Bonlender House," a three-bedroom house nearby that can accommodate up to five people (two rooms are double-occupancy). In order to accommodate greater client needs and to conduct more infection control during the COVID-19 response, YNHS contracted with the Department of Human Services to add 10 "COVID" rooms at a nearby motel using CDBG funding [Community Development Block Grant]. However, the contract was flexible enough to expand capacity according to need; hence, YNHS was able to shelter and care for as many as 26 COVID-19 respite patients at one time in the motel. Between all three sites, the MRC program in Yakima has served up to 40 people at any given time. Referrals to the program can come from either hospital discharge staff or YNHS providers. YNHS nurses at the MRC program evaluate referrals to ensure each patient is appropriate for the program.

Services: Daily case management and nursing visits, behavioral health care visits (if needed), medication management, care coordination to specialty care and other services, connections to a housing specialist, enrollment in benefits such as health insurance, transportation to medical appointments, three meals a day, laundry, and housekeeping. Each client is screened for an assessment of social determinants of health, and a client-centered care plan is developed. The program focuses on support services and connections to care; most medical care is provided separately at YNHS (as an FQHC).

Staff: YNHS dedicates a registered nurse, a behavioral health specialist, an outreach worker, a medical case manager (who is a certified medical assistant), and a housing specialist to staff the MRC program.

How does your MRC program fit within your community's response to homelessness?

The MRC program is a critical part of the county-wide homelessness system response, especially during COVID-19, because it brings the health care lens to the entire continuum. Our MRC program is considered an "emergency shelter" so enrollments and transfers to other homelessness assistance programs are seamless.

The Yakima Housing Authority (YHA) has dedicated more than 100 housing vouchers to people experiencing homelessness, and has been a significant partner for the MRC program in order to house clients directly upon discharge from the program. These YHA vouchers,

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combined with YNHS's support services, help provide supportive housing and supported employment to improve the health status and income status of our shared clients. One of MRC's goals is to identify a housing option prior to discharge, but this is only able to happen for approximately 25% of clients due to the lack of available, affordable housing units.

Importantly, the CoC's collaboration with the MRC helps improve CoC outcome measures. In Yakima County's 5-year Plan to Address Homelessness, the MRC helps most directly with Goal 1 (identify and engage PEH) and Goal 2 (prioritize housing for people with the greatest need). Not only does the MRC receive referrals from hospitals and coordinate needed care using a warm hand-off, but once people are connected to the MRC program, they have a chance to recover, be assessed through the CE, and connect with a case manager and a primary care provider. Offering greater supports and medical care in addition to a bed and a meal has brought greater dignity to those who are genuinely suffering.

How are you addressing issues of racial equity within your efforts?

More young adults (age 18-24) with behavioral health conditions are being housed, but we want to ensure that BIPOC and LGBTQ youth have equitable access to those housing opportunities. To that end, we are surveying our community so we know how best to reach this population. To help stretch housing opportunities and assist a greater number of youth, our CoC is also offering more diversion training in order to avoid longer-term involvement with the homeless services system.

To better serve the Native population, the Yakima County Department of Human Services met with the Yakama Nation Tribal Council to discuss the large group of Tribal members living outside in a field. Now all three of our coordinated entry access point agencies are building stronger relationships with Village of Hope, a family shelter for the Yakama Nation. This will help better connect those living unsheltered to housing and health care services.

How have you strengthened your system and collaboration?

Four systemic changes our community has made to help further our collaboration include:

Resumed MRC funding and reassigned as emergency shelter: The MRC received CoC funding back in 2010, but that ended after several years because the CoC didn't consider the program a low-barrier emergency shelter. The CoC evaluation committee at the time believed the eligibility criteria of requiring an acute medical condition was a barrier to accessing a traditional "shelter." Just before the pandemic, however, a re-constituted CoC resumed funding MRC to cover the beds, meals, and support services because of its low-barrier approach, and reclassified the MRC beds to emergency shelter.

Increased capacity to respond to COVID-19: The CoC allocated additional COVID-19 funding to expand MRC beds and staff capacity. The additional funds allowed the MRC program to expand beyond 10 additional beds to using motel rooms to accommodate greater client needs and to conduct more infection control. The extra funding allowed the MRC program to add more clinical staff

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(to include night and weekend coverage), which increased the capacity to conduct more outreach at shelters and encampments to address outbreaks and provide public health education. Separate facilities are available for COVID and non-COVID patients.

Revised assessment tool: The CoC is revising its CE assessment tool to be more equitable and better prioritize those who are most vulnerable, especially BIPOC and LGBTQ clients. The Statewide Diversity, Equity and Inclusion Council reviewed and approved the new tool. Staff from YNHS chair the CE Committee, where providers meet twice a month to discuss the needs of clients who have not yet been housed, and ensure they are connected to a case manager and/or a health care provider, as needed.

Added health information: Care coordinators at YNHS conduct a PRISM assessment (Predictive Risk Intelligence SysteM), which is a modeling system developed by the WA State Medicaid program. PRISM predicts the type, intensity, and costs of future health care services as well as likely barriers to care and assigns a score. While this type of assessment is new to housing providers, the health care sector is more familiar with this process. There is now additional information to add to the CE determination because PRISM scores are considered along with the score from the new prioritization tool to better determine vulnerability.

"Health care risk factors should drive more housing decisions."

– **Annette Rodriguez,** Director of Homeless Services, Yakima Neighborhood Health Services (YNHS)

Because the health center is both the health care provider and the CE coordinator, there's more information about the health status of clients.

What advice do you have for other communities?

- Integrate MRC in a way that's not a stand-alone medical program, but an integral part of your homelessness response system that can take and make CE referrals. Discuss how and why MRC qualifies as emergency shelter for the housing inventory count (HIC).

"Many communities just involve housing providers in their CoC, but here in Yakima, we've included housing AND health care, which is unique. As a housing provider, you need to build relationships with your health care providers because it's difficult for clients to navigate both systems—they need help from us, and we need to be good partners for them."

– **Annette Rodriguez,** Director of Homeless Services, Yakima Neighborhood Health Services (YNHS)

- Build partnerships with other shelters and housing providers to conduct CE intakes, provide warm hand-offs to needed services, and discharge clients to permanent housing as often as possible.

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- Be responsive to one another when there's an urgent need to get clients into care.

"One of the great things about being in a medium-size town is that you know people and you know if you pick up the phone, they will likely help you—even at 6:00 on a Friday night."

– **Esther Magasis**, Director, Department of Human Services

- Set realistic boundaries, but be flexible enough to occasionally cross them. For example, we often say we are not a nursing home or a skilled nursing facility, yet sometimes we accept someone we otherwise would not.

Examples of How MRC Programs Respond Quickly to Medical Needs (September 2021):

The hospital called our MRC to report a very fragile, terminally ill patient had just left AMA (against medical advice). When we found her on the street, she was very weak, but desperately did not want to be in the hospital. We got her into an MRC unit immediately, helped meet her dietary needs, and scheduled hospice services to help care for her. She regained her strength and is currently staying with friends for further recuperation (thus diverting her from the homelessness services system).

The church called because someone was resting in their yard and needed help. Our team found him malnourished and with a bad wound. He hadn't slept or ate in three days. We delivered urgent care and admitted him to the MRC program. We coordinated wound care for him and he is currently still healing in our program.