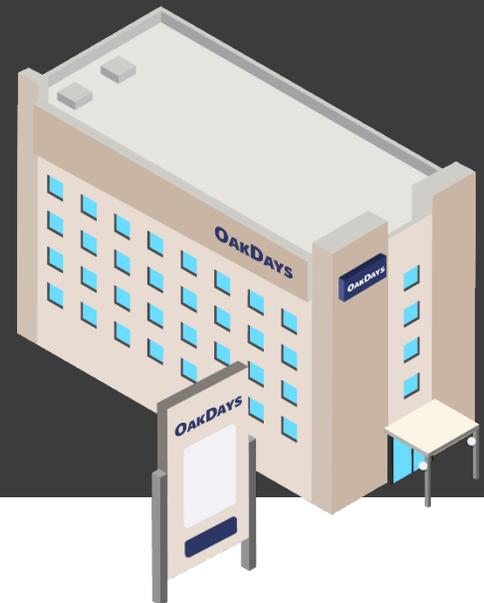


OakDays: A Case Study

Permanent Affordable Housing with Healthcare and Home- and Community-Based Services for Unhoused Disabled People

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THE HELLER SCHOOL
FOR SOCIAL POLICY
AND MANAGEMENT
Lurie Institute
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Executive Summary

In 2020, in response to the COVID-19 pandemic, Alameda County, in Northern California, purchased a former Oakland hotel where approximately 130 people who were unhoused could quarantine and shelter safely in place. At the same time, public-health leaders launched a novel pilot project for 40 residents with severe and complex chronic illnesses, significant functional limitations, and mental-health, substance use, and behavioral-health disorders. They seized the opportunity to offer permanent housing and to build culturally aware and sustainable healthcare that met individual residents' "whole person" needs across personal, health, economic, and social domains. They planned to convert the hotel, referred to as OakDays, to Permanent Supportive Housing (PSH) after the pandemic waned. They offered on-site healthcare to all residents and provided or arranged for home- and community-based services (HCBS), including personal care for the smaller subset of residents with complex illnesses and disabilities.

The pilot aimed to help them regain their health, avoid cycling frequently through fragmented care systems and unwanted institutionalization, and live successfully in the community. Immediate objectives included reducing mortality by stabilizing residents' health and supportive services needs while establishing connections with community services. The pilot was launched with combined Medicaid waiver funding, federal COVID-19 relief aid, and seed money from Alameda County. Philosophically, the pilot was grounded in harm reduction and Housing First principles and respected residents' personal preferences, values, and goals. Residents reported satisfaction with housing and HCBS, but some thought the COVID-19 quarantine restrictions were too restrictive. Stable housing and hands-on clinical and HCBS stabilized most residents' chronic health conditions. Compared with the previous six months, all residents' healthcare utilization during the first six months of the pilot revealed a substantial reduction in emergency-department visits, in-patient admissions, and use of emergency psychiatric services. Healthcare utilization by the 40 pilot participants was even lower for the same six-month period. At the time of the study, all but three of the initial 40 residents with significant health problems and disabilities planned to remain at OakDays after the site became PSH.

Case-Study Introduction

“*And seeing people come in off the street was just unbelievable. Just the level of acute medical and mental health needs. We had people coming in who couldn't walk and didn't have wheelchairs. Right? And we had people who had no way of moving. We had people who hadn't showered in years because they didn't have*

access to a [shower] bench. Or had incontinence, but had no supplies and just all these things that you're like, how did this happen? Let's not even talk about consistent medication access or storing your insulin So the lack of access to consistent basic medical services for unhoused people is significant ... and you're wondering, how did this person get here? How are they alive?

— A senior program administrator

The COVID-19 pandemic laid bare the systemic inequities and health dangers for people who were experiencing homelessness and could not safely shelter in place, quarantine, or access healthcare. In response, in 2020, Alameda County, situated in Northern California, purchased two former Oakland hotels where people who were unhoused could quarantine and shelter safely in place. One hundred and thirty people were housed at one of the hotels, referred to as **OakDays**. At the same time, public-health officials launched a novel pilot project at OakDays that aimed to support a subset of this larger group. **Project Roomkey** initially identified approximately 40 participants among the large group of unhoused individuals who had moved from encampments and shelters to emergency housing. Project Roomkey was a temporary FEMA- and state-supported COVID-19 response program that provided non-congregate shelter.¹ (The pilot program has since expanded in 2022 to serve 60 residents at OakDays and has launched an additional program at the second Oakland hotel location serving 30 individuals.) To qualify for the pilot, individuals must have met “medical frailty criteria,” which included need for institutional level of care, frequent use of healthcare services, significant functional limitations, and complex chronic illness that would worsen without ongoing care. (See [Appendix A](#) for a description of medical frailty criteria.)

Many of these individuals had been cycling frequently through emergency departments and nursing facilities and experiencing high rates of illness and death. The pilot aimed to stabilize and improve their health, prevent deaths, and avoid institutionalization. At the outset, the leaders conceptualized operating the pilot from a “whole person” perspective. On-site healthcare was offered to all 130 residents and home- and community-based services (HCBS), including personal care, case management, home health aides, and skilled nursing, were offered to the 40 pilot participants.² The aim was to support residents so they could live healthy lives in their own homes with opportunities for community engagement as their needs changed over time. Healthcare and HCBS were provided in a culturally aware, trauma-informed environment that valued and honored harm reduction and “Housing First” principles.^{3, 4, 5} Practically speaking, residents’ participation in any services being offered was entirely voluntary and interactions with them acknowledged and deferred to their personal preferences, values, and goals.

After the pandemic, OakDays would be converted to Permanent Supportive Housing (PSH) where residents could remain in apartments with leases if they wished. PSH is a model that supports people who are unhoused or unstably housed, face many barriers to housing, and find it difficult to maintain housing stability without supportive services. PSH typically pairs ongoing rental assistance with in-house services, such as social workers and substance-use-disorder counselors.⁶ The OakDays model differed from most PSH in that residents would continue to receive on-site healthcare as needed as well as emergency personal care and other HCBS that they required to maintain stability and live successfully in the community.

The federal 2020 Coronavirus Aid, Relief, and Economic Security Act funded the hotel purchase, thus making housing readily available. Braided funding from the Alameda County Whole Person Care pilot, a Medicaid (called Medi-Cal in California) waiver program intended to promote integrated care for vulnerable groups, and other Medicaid-waiver funding supported healthcare and HCBS provided for OakDays residents.^{7, 8, 9} Pandemic services included necessities such as meals, transportation, and site security. The clinical care and HCBS aspects of the model relied on established, sustainable funding available in all states that opted into the Affordable Care Act's Medicaid expansion and could potentially be replicated across California and beyond.¹⁰

Even before the pandemic, unhoused people with complex chronic illnesses, mental- and behavioral-health disabilities, substance use disorders, and functional-mobility limitations were at high risk of severe illness and institutionalization. Long-term lack of stable housing made managing their illnesses and mobility limitations difficult or impossible. Living in encampments made it virtually impossible to acquire or retain health insurance and HCBS such as personal-care assistance, attend to hygiene needs, or prepare adequate meals. Even with health-insurance coverage, they faced hostile community and healthcare-provider attitudes and daily logistical, financial, and emotional barriers to visiting a healthcare provider, getting medications prescribed and filling prescriptions, managing diabetes or mental-health symptoms, maintaining wheelchairs or other devices, or getting help with wound care.

Background

OakDays leaders launched the pilot against increasing homelessness in the United States and, in particular, in California. Estimates suggest that 174,000 people did not have a place to live in California in 2022.¹¹ In the San Francisco Bay Area alone, 35,000 people were unhoused at any given time. In spring 2022, an estimated 9,750 people were unhoused in Alameda County. That point-in-time survey revealed that about 7,100 of these individuals were unsheltered, and about 2,600 were temporarily sheltered, mostly in congregate

facilities.¹² The survey also revealed that 69 percent of unhoused people in the county were people of color. The racial group most disproportionately affected by lack of housing were people identifying as Black or African American (43 percent), followed by those identifying as white (39 percent) and those identifying as Hispanic/Latinx (25 percent).^{13, 14} The over-representation of people of color among those experiencing homelessness reflected the effects of historic structural racism across multiple systems.¹⁵

Disability prevalence was also high among people who are unsheltered in Alameda County. Mental- and behavioral-health conditions were among the highest reported disabilities (41 percent), followed by chronic health problems (36 percent) and post-traumatic stress disorder (PTSD) (29 percent). Physical/mobility disability ranked fourth (27 percent), followed by substance use disorder (26 percent) and traumatic brain injury (10 percent). Around 18 percent of unhoused people reported three or more disabilities, and 43 percent received Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI). However, data on the intersection of race, ethnicity, and disability among unhoused people were not available.¹⁶ OakDays leaders estimated that about 200 unhoused people were eligible for institutional level of care when the pilot was launched.¹⁷

Recent research showed that housing vacancy rates and high rental costs, which contribute to housing scarcity, are the highest predictor of homelessness.¹⁸ Housing vacancy rates were considered low in the San Francisco Bay Area in 2022. However, tens of thousands of housing units in several cities, including Oakland and San Francisco,

Resident Profile

Jorge

Jorge, a 31-year-old man with high weight, estimated to be about 700 lbs., an enlarged heart, and incontinence, arrived at OakDays with significant mobility limitations and other problems related to his weight. He has been hospitalized many times and sent to a nursing home following discharges because he did not have a home and he required help with personal care. The clinical staff at OakDays worked with him to find creative solutions for managing his incontinence, which improved his chronic skin ulcers. They also assisted him with obtaining a bariatric walker and bed, which improved his mobility. His health improved with stable housing, adequate personal care, appropriate equipment, and clinical support. He began doing daily exercise and walking to a sunny bench in front of the OakDays building. He told staff that he felt his life had promise and was eager to continue working towards better physical and mental health. When he felt he was ready, OakDays staff helped him move to an apartment, although fewer healthcare services were available.

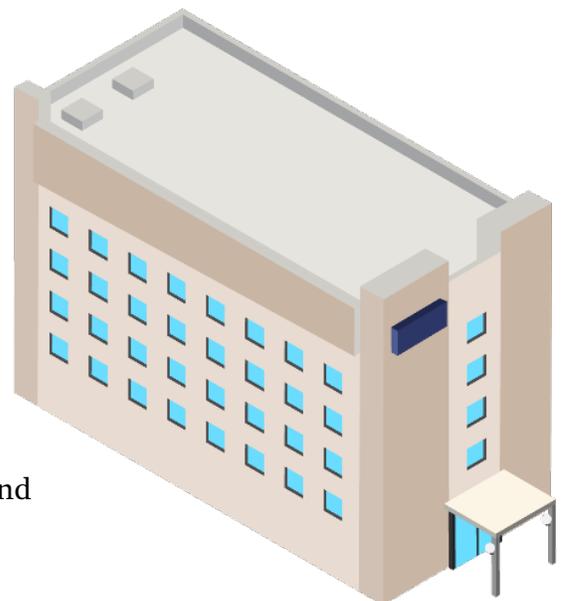
remained vacant for more than six months, spurring some cities to propose laws that imposed substantial fines on landowners if properties remained empty for more than six months. Municipal leaders intended these fines to motivate housing owners to place their units back on the rental market to ease the housing shortage and increase housing availability for unhoused individuals in the area. Fines would subsidize rents for lower-income renters.^{19, 20} Moreover, there had been a 932 percent rise in housing prices in San Francisco since the 1980s, over 326 percent more than wage increases. The purchase prices of existing homes ranged from two to four times the cost of building comparable new homes. Price was a rough proxy for extra costs driven by restrictions on new construction and zoning favoring single-family homes.²¹ These building restrictions effectively priced lower-income people out of the commercial housing market.

Alameda County estimated that it needed 25 affordable units for every 100 very low-income households, yet these units were not available. The county needed 54,000 more affordable units to meet demand. SSI payments covered less than half of the fair market rate (FMR) for a one-bedroom apartment in this market. Statewide, 700,000 people were wait-listed for U.S. Department of Housing and Urban Development (HUD) rental vouchers, twice the number available.²² Moreover, few units were accessible to people who used mobility devices. In 2011, HUD estimated that only about 0.2 percent of U.S. housing was fully accessible to wheelchair users, and less than 1 percent of units inhabited by wheelchair users were accessible.²³ Commenting on the failure of housing policy for people with lower incomes, one former county official said:

“ We’ve learned that concentrating poor people in widget style housing complexes doesn’t make sense. But the problem is we disinvested without a commensurate reinvestment in scattered site or other models, particularly supportive housing.... [W]e didn’t replace them with anything. We replaced them with mass incarceration. We put people in jail. That’s literally what happened.

Research Methods

The OakDays pilot was one of only two similar pandemic-related programs in California. The second, in Los Angeles, brought clinical care to people living in the Project Roomkey hotels.^{24, 25} We wanted to learn how public-health leaders convinced county administrators to invest in OakDays. We also explored how the pilot’s leaders had envisioned braiding together Medicaid waiver funding to pay for clinical care and



HCBS and built buy-in from stakeholders. We conducted a literature review to identify the strengths and challenges of housing intended for specific demographic groups, especially from residents' perspectives. Our investigation also included research about PSH models. We also conducted extensive personal interviews, by telephone and videoconference, with 18 key informants, including OakDays residents, Alameda County healthcare, mental-health, and housing officials, and former county healthcare administrators. Interviews were also conducted with staff and administrators from Five Keys, the group that managed the OakDays location, and East Bay Innovations (EBI), which oversaw and provided case management. Executive staff from Cardea Health participated in interviews early in the research and again later as we followed up on the pilot's progress. That organization's leaders initially proposed combining Medicaid funding streams to pay for healthcare and HCBS at the OakDays location and provided on-site clinical, home-health, and personal-care staffing. The Brandeis University Institutional Review Board approved the project.²⁶

Program Description

Remarking on the people the OakDays pilot served, a Cardea Health executive noted that some people in the care-delivery system referred to them as "Impossibles."

“*It's a very loaded term because that's the label that the delivery system imposes on them. Really, they highlight an epic failure of our delivery system to support individuals who have this particular set of needs. I would contend, nobody is impossible, we're all just human. We bring our own whatever, unique set of conditions. It's simply that the system is so shockingly ill-equipped to provide for individuals with this particular set of needs.*

Another OakDays partner observed:

“*And the nursing facilities also do not want them. They're not cut out to take care of people who have decades long history of trauma and substance abuse and mental health challenges. I mean, we [OakDays] house a handful of people who have basically been barred from every nursing facility in Alameda County*

Vision and goals

“I saw where we were failing a number of the people at the Roomkey sites who were super-sick and really functionally compromised and wanted to have a solution that wasn't just a band-aid.... Let's design something that really works for this group and see maybe if it can be a COVID silver lining to have something that is sustainable, enduring, and successful [that] come(s) out of this COVID response.

— Cardea Health executive

The OakDays pilot envisioned providing permanent, stable housing, clinical care, and HCBS for individuals coming out of homelessness who had complex, chronic physical or mental- and behavioral-health conditions, substance use disorders, and significant functional limitations. The goal was to stabilize their health and secure on-going HCBS so they could live with dignity in the community and avoid cycling through fragmented care systems and unwanted institutionalization. The pilot also aimed to reduce severe illness and death among residents as their needs changed over time.

“And we have to really maintain humility because when we're working with people who have so little agency in a system that has never served them, it's not our choice to make. We really need to recognize that

— Five Keys staff person

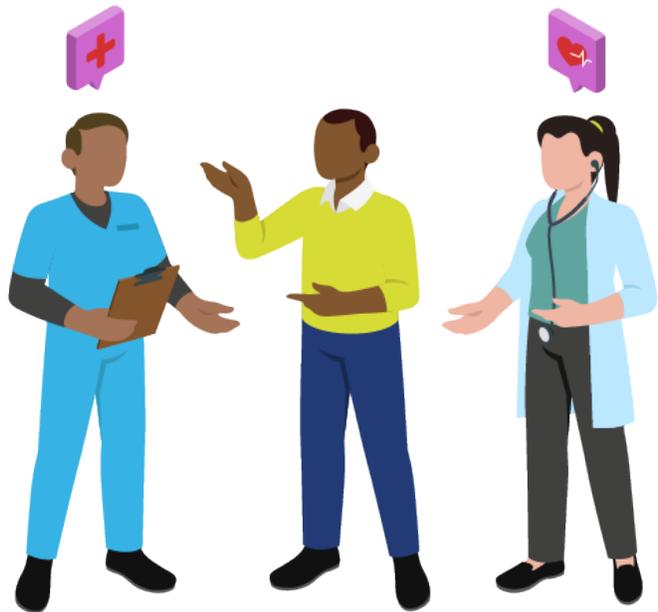
Objectives

The pilot envisioned interrupting the churn between siloed and fragmented care-systems that residents inevitably experienced. Objectives included:

- Stabilizing the health of residents and helping them establish connections with healthcare services in the community;
- Providing immediate HCBS, including personal care, and helping residents establish eligibility for state Medicaid programs;
- Creating a model grounded in harm-reduction and Housing First principles, and in residents' personal preferences, values, and goals;
- Combining Medicaid funding to establish comprehensive, on-site healthcare and HCBS.

Health stabilization

Many people came to OakDays from temporary encampments or after recently leaving institutional settings such as nursing facilities or hospitals, some without medical approval. As new arrivals, most people did not have health insurance, a primary-care provider, mental-health support, needed medications, personal-care services, or skilled care to assist, for example, with wound care or dialysis. The pilot set out to stabilize the HCBS and health needs of residents until permanent services and benefits could be established. Residents who required HCBS that exceeded those available through standard Medi-Cal were enrolled in Medicaid waiver programs that provided, for instance, supplemental personal care, home healthcare, and nursing services. Once permanent benefits were in place, additional flexible services tailored to residents' preferences and needs were also provided that allowed them to remain at OakDays even as their care needs changed.



“ *We see people blossoming and flourishing. They become more future-focused in their thinking. We see their personalities emerge as they kind of move out of crisis mode.*

— Cardea Health executive

Resident autonomy and personal decision-making

OakDays residents had access and control over their living units and could come and go as they pleased, with some exceptions required by the COVID-19 Homekey program.²⁷ For instance, before leaving the residence, guests were required to leave the keys to their unit with the “ambassador,” a Five Keys staff person assigned to their floor who served as both security personnel and liaison between residents and other staff. Visitors were also restricted in order to ward off the spread of the coronavirus. The OakDays hotel site reduced these limitations once the county eased the COVID-related restrictions. In the future, when the hotel site converts to PSH, residents will sign leases and have complete legal control of their units. Residents who used wheelchairs or other mobility devices were

given wheelchair-accessible units that were compliant with the Americans with Disabilities Act (ADA). During the duration of the Homekey program, Five Keys served three meals a day, which were delivered to residents in their rooms. Pets were allowed, and a pet-relief station was available on a grassy area adjoining the residence. OakDays provided transportation to medical appointments.

The pilot also worked with any resident who did not wish to remain at OakDays to transition to other permanent housing with as many supports as possible, even though fewer supports might be available than OakDays provided. When the research was being conducted, staff were helping three people move to apartments.

““ *The way we’ve approached that, when somebody is really invested in that, we support that. Again, even if we assess them as being likely to have pretty significant unmet needs, we’re nobody’s jailer, it’s their decision whether they want to move. Usually, the way we approach that conversation is to say our experience working with you is that these are the things that have really helped to stabilize you medically. And to try and develop shared goals around what they might want to have in place to feel like they would really be likely to be successful somewhere else. It might be around making sure they have a stable IHSS provider or some other way to meet the needs that we’ve been meeting.*

– Cardea Health executive

Even though skilled medical care was available on-site, residents could determine the amount and type of care they would accept. The staff respected residents’ right to live their lives consistent with their preferences, values, and goals. OakDays provided on-site personal care as a gap service even after residents had secured permanent services through the various Medicaid waiver programs. The pilot also arranged hospice care for those residents at end-of-life.²⁸ A Five Keys manager said:

““ *[We] process a little on a very human level of, again, people’s medical choices are their own, their life choices are their own We want to be supportive, and we want to be thoughtful ... It’s their choice, right? But it’s not our choice what people decide to do and most of our folks that had agency taken away from them, their entire lives. And so, I think the most important thing is just, can we have a conversation with them about it, right? Can we genuinely ask them, what do you want? And help them to see maybe pieces that they’re not seeing, without being the judge.*

Partnerships and staffing

Four primary partners played roles in founding and operating OakDays: Cardea Health, East Bay Innovations, Five Keys, and the County of Alameda.

Cardea Health

Oakland-based Cardea Health was a nonprofit healthcare organization founded to connect marginalized populations to the clinical and supportive services they need to improve their health, remain in stable housing in their community, and age in place. Cardea Health provided personal-care services, skilled nursing, home healthcare, and primary care. Filling a critical gap in care systems, the organization's leaders first envisioned the OakDays pilot and the combined Medicaid funding structure that supported most of the on-site services and care. Cardea Health arranged and managed skilled nursing services when residents needed wound care or dialysis management, for instance. Primary care was also available when residents needed prescriptions refilled or other essential care until a permanent primary-care doctor or medical home had accepted them. Cardea Health also provided personal-care assistance with showering, dressing, toileting, and other activities of daily living until residents qualified for In-Home Supportive Services (IHSS) and hired regular workers. Cardea Health worked in close partnership with East Bay Innovations (described below), the organization that carried out resident assessments for services, provided case management, and helped residents recruit and hire personal-care workers.

Five Keys

Founded in San Francisco in 2003, Five Keys invested in individuals living on the margins so that they could change their lives. The organization focused on education, employment, social justice, housing, and revitalizing communities. It operated shelters for individuals previously living in encampments, an outgrowth of the COVID-19 pandemic, and was becoming a leader in transitional housing solutions for unsheltered people. The organization served 30,000 Californians annually at 120 teaching sites, including 25 county jails across 14 counties. Most Five Keys employees were formerly justice-involved.

In Alameda County, Five Keys operated the OakDays site on behalf of the County Health Care Services Agency's Office of Homeless Care and Coordination (OHCC). Five Keys arranged and provided meal service, housekeeping, and transportation, and facilitated on-site visits by clinical, personal-care, and other staff. Two staff members were stationed on each residence floor during the day. They provided security and served as ambassadors who bridged communication with all residents.

““ *And [the] ambassadors, I get along with all of them. They pretty well take care of you. They reasonable. They don't cuss you out. They respectful. They always dress right. My health ain't too good, but I'm here, so. I'm just taking care of that day-by-day. And they're real good. They help you. As far as the living arrangements, it's okay. It's good.*

— OakDays resident

Floater also helped residents who were seriously ill or unable to leave their rooms with other needs, such as picking up mail or getting items such as ice, juice, and toilet paper. Five Keys staff also conducted wellness checks once a day for very self-sufficient people and more frequently for people who had more serious functional, medical, or mental-health issues or who were heavy substance users.

They also fulfilled an important role as cultural liaisons with residents because many of the ambassadors and Five Keys staff also had experienced substance use disorders or homelessness or had been justice-involved.

““ *You can imagine many people would choose the streets if they feel like their freedoms and practices are really jeopardized. So you have to be super-flexible as a housing provider and you're balancing accepting somebody with whatever issues they have [W]e accept this person. There's almost a parallel person-centered process to being a property management company in a situation like this.*

““ *The big nonprofit housing providers, they wouldn't know how to deal with a lot of the issues that come up with the homeless population that we're seeing. It's a "Housing First" scenario, where there's very few they won't tolerate there. They really take an individualized approach, try to build a relationship, but good boundaries too. They won't accept b*****t, but they're also not rigid at all.*

— East Bay Innovations senior staff member

East Bay Innovations (EBI)

East Bay Innovations, located in Alameda County, California, arranges and provides personalized support that enables disabled people to live in their own homes, work in jobs of their choice, and fully participate in their communities. In 2022, EBI provided supportive services for about 600 people with diverse disabilities. Since its founding, EBI has created affordable, accessible housing in Alameda County and assisted people with disabilities to move from institutions, such as nursing homes and unstable or inadequate

housing, to permanent homes in the community with the services and support they required to live independently.

In partnership with Cardea Health, EBI provided case-management services for OakDays residents beginning with comprehensive assessments that identify person-centered needs and goals and eligibility for various Medicaid waiver services. Depending on individual desires and preferences, EBI worked with residents to recruit and hire IHSS workers and coordinate healthcare and other supportive services.

Alameda County

Alameda County served as a partner, funder, and administrator of the OakDays site and the pilot program. The county used Project Homekey funding to purchase the hotel where OakDays operated and the second hotel in Oakland. The county intended to convert both buildings to PSH when the pandemic emergency waned. At the time of the study, Alameda County used Whole Person Care (WPC) funding to pay for interim on-site clinical care until Medicaid waivers were approved and residents had sources of primary care. WPC also hired Five Keys to operate the OakDays site on behalf of the County Health Care Services Agency's OHCC. A Cardea Health executive commented on the County of Alameda's initial reaction to the idea for the pilot:

“ *Our very first conversation with the county about this, [a senior county leader] ... basically said those people just eventually end up in a nursing home and that's housing. That really stuck with me. That's not housing.*

Eventually, however, county officials played a central role in creating the pilot and strongly supported the program's vision and goals.

Funding

The OakDays healthcare and HCBS funding model relied on braiding together two primary Medicaid sources: 1) standard Medi-Cal, which included clinical care, some home-health nursing, and up to 283 hours per month of personal care, referred to as IHSS, and 2) Home- and Community-Based Alternatives (HCBA) Waiver services, which provided up to 24 hours a day of personal-care and skilled-nursing services. OakDays residents were enrolled in HCBA waiver services when skilled care needs exceeded allowable limits through standard Medi-Cal benefits. (For instance, eligible people who live at home and use ventilators use HCBA services, including home-health nursing.)

These funding sources, along with seed funding from the county, paid for residents' ongoing clinical and supportive services over time. They could remain at OakDays, if they

wished, irrespective of changes in health, personal-care, and other HCBS needs. One project partner said:

“ I think one of the benefits we’ve had here is the flexible funding to float things while everything’s coming into place.

(See [Appendix B](#) for additional information on funding.)

Oversight and evaluation

Ethics panel

Cardea Health executives observed that a hierarchical approach to decision-making characterized healthcare systems and it assumed that patients would value and follow care instructions. However, OakDays’ foundational philosophy rested on principles of individual choice and personal decision-making wherein residents could refuse care if they chose. Sometimes, such refusal of care could be life-threatening, raising ethical concerns for the OakDays healthcare providers. In response, Cardea Health formed an ethics panel made up of a nurse practitioner, a physician, and an attorney who had extensive experience working with people who had experienced homelessness. Cardea Health also participated as panel members. The panel met once every two weeks or so initially and as needed after that when situations arose that raised ethical or staff safety concerns. In these instances, Cardea Health brought the situation to the attention of the ethics panel. Members would explore further if other options were available that might benefit the resident without undermining personal choice and, in some instances, provide additional validation of the commitment to personal decision-making and harm-reduction principles. Cardea Health described a situation involving a spinal cord-injured wheelchair user that spurred the ethics panel to meet for the first time:

“ [A resident] has been paralyzed from the waist down due to a gunshot wound for the last 15 years. So, he has extensive and really profound decubitus wounds on his backside all the way down to the bone essentially, unstageable, that extend all the way down to his toes. They recommended amputation due to chronic osteomyelitis. He’s refused the amputation, he has constant urosepsis, because he’s incontinent ... and he’s got a Foley. He’s got a pretty profound substance use disorder, recently overdosed in the hotel and it took three rounds of Narcan to bring him back to life.

In this instance, the ethics panel recognized that if clinical staff tried to force unwanted care on the individual, he would leave OakDays and return to life on the streets, which would accelerate his health problems and further shorten his life. They also recognized that no other place would accept him, and he would not agree to move to another location. Consequently, OakDays supported him most effectively by providing stable housing, limited medical support such as dressing changes, and non-medical services including meals and personal care.



Evaluation

Cardea Health planned to evaluate the OakDays pilot based on quality-of-life measures and healthcare utilization. At the time of the study, the program had collected and analyzed preliminary data on utilization, which the staff considered a reasonable proxy for the assessment of health stability. Quality of life measurement had yet to begin. However, according to Cardea Health and EBI, residents had informally reported that the program’s emphasis on improving health “had provided a lifeline, particularly for [residents] whose only other immediate options were a skilled nursing facility or an encampment.” An analysis of healthcare utilization for all residents during the six-month period after they had been housed and received the pilot’s services compared with the previous six months revealed a substantial reduction in healthcare use overall. It showed reductions in emergency department visits (72 percent), inpatient admissions (71 percent), nursing facility admissions (84 percent), and use of emergency psychiatric services (89 percent). Utilization for the same period by those participating in the pilot had been even further reduced.²⁹

Resident input during COVID-19

Several interviewees said that during the COVID-19 pandemic, OakDays residents could raise issues and provide feedback on the site’s operation during regular town-hall meetings that Five Keys organized. During these sessions, residents raised concerns about food quality, parking restrictions, and visitor policies. They could also bring interpersonal issues

to the town-hall sessions, including any conflicts or problems they perceived that had arisen between residents, staff, medical-care providers, and others with on-site responsibilities for the day-to-day operation of the residence. Pilot leaders explained that Five Keys organized these sessions short-term to enable residents to discuss the implementation of the COVID-19 shelter-in-place rules. Once the location became PSH, residents would become tenants with rights and responsibilities and no longer subject to system-wide rules like those in place during the pandemic. Therefore, there would be no purpose or mechanism for continuing town-hall-type meetings.

Impact

“ ... *I've seen people put on collared shirts, put on belts, when before they were out, pants hanging off... before living on the street, now they wearing socks. They gained sophistication being here, they get nutritious meals, and they get the proper stuff that they didn't have, they start to feel like a human again.*

— OakDays resident

Resident perceptions and satisfaction

We interviewed OakDays residents during the second year of the COVID-19 pandemic, in 2021, when the site was operating as an emergency shelter. Several factors influenced residents' perceptions of the site and the pilot program. Regional shelters throughout the San Francisco Bay Area, including those to be converted to PSH units, followed state and federal COVID-19 public-health guidance to avoid the spread of the coronavirus. For instance, visitors were not allowed in residents' rooms. However, as the pandemic began to subside, they could meet friends and family members in outdoor sitting areas. Residents were also required to give their room keys to the Five Keys ambassador on their floor if they left the premises. The residence also enforced a 10:00 p.m. curfew. Interviews with residents revealed that they understood the restrictions safeguarded against the spread of COVID-19, although some thought they were overly limiting. Residents also observed that they and others benefitted from the healthcare and other services the pilot offered. For instance, one woman commented:

“ ... *[T]his is like having my own place because, it is just me and I haven't been in a room by myself... in a long time.*

Another resident remarked:

““ *They [other residents] got wounds. They going to come take care of them. Oh, they help. As far as your health and stuff like that, they are good. They be here around the clock. They take good care of you.*

A man said:

““ *They help you get your birth certificate, your social security cards ... they revamp you into a new life. They take you from where you were and they upgrade you.*

An older woman stated:

““ *If they convert it into an apartment building, yes. I would love to stay here.*

Remarking on the COVID-19 emergency shelter curfew rule, one resident said:

““ *You know? And it all worked out. Then they had that little curfew thing going on. And I'm like, "Wow! I'm almost 60 years old. How you going ... You're going to tell me I have to be in the house at this time." Do you know what I mean?*

Staff perceptions

Representatives from the OakDays pilot agencies observed that residents had become more medically stable and had reacted positively to the program's core harm-reduction philosophy and commitment to personal decision-making. One Cardea Health executive said:

““ *I would say, clinically, people thrive. It's pretty amazing. We have better and better systematized approaches to diabetes management, hypertension management, more just really gaining steam around chronic disease management. We're seeing a lot of successes in all those areas.*

A Five Keys staff member said:

““ *My sense is, from the conversations, interactions that I've had is that people are really relieved to have a place where they are getting the care that they need and aren't being forced or shamed during that process. Because if your whole life you're accessing a system that is full of institutional racism and trauma-reinforcing practices, then of course you're not going to want to go to the hospital. No one ... ever wants to go to the hospital. That's the scariest thing in the world because they get treated like trash. And so, I feel like people just feel really relieved to not have to go through that process.*

Various pilot partners observed that residents had moved from medical crisis to medical crisis to managing their health conditions effectively and were no longer cycling through the emergency department with significant health events. As residents' health improved, the staff observed that other life needs began to emerge.

““ *We have a gentleman that came from another site and he was like, “Oh, my God, I feel so welcomed here. Nobody yells at me. Nobody’s mean Now, ... he’s doing better, he’s gaining weight, he’s going outside with his wheelchair. You know what I mean? He’s starting to perk up*

— Five Keys staff member

Capacity-building playbook

Cardea Health executives documented the creation of the OakDays pilot so other locales interested in launching a similar program could benefit from the pilot's lessons. They actively created a “Playbook” by capturing in real time what they were doing operationally. The goal was to create a document that presented the overarching philosophical framework, program goals and objectives, and all the required resources and institutional commitments other locales would need to re-create the program. While each locale would have to adapt the model to their specific situation, the playbook set out the specific elements as guideposts.

Challenges

Limited mental-health and substance-use-disorder treatment

Cardea Health reported a significant unmet need for psychiatric support, mental-health services, and substance-use-disorder treatment among OakDays residents. The County of Alameda, rather than the Medicaid managed-care organizations (MCOs), was responsible for providing behavioral-health and substance-use-disorder treatment through its services for individuals who experienced homelessness. However, these services were limited and had come under sustained criticism for failing to meet the community's needs. An Alameda County Grand Jury report, issued in 2022, observed that the system was fragmented and unresponsive. It also noted that:

““ *The mental health system is supposed to provide a safety net for the thousands of homeless and near-homeless residents of Alameda County who struggle with serious mental illnesses. The current approach is missing the mark.³⁰*

One significant barrier to providing adequate mental-health support was the shortage of practitioners. Another barrier was the unwillingness of some practitioners to work with people who had been unhoused for long periods of time and who had co-occurring mental-health and substance use disorders. Licensed mental health professionals in the county system typically only met with clients in their offices, leading one OakDays partner to observe that the mental-health system had not yet found a way to operate “out-of-the-box.” One former county official observed that to build a meaningful coordinated-care system in the future, MCOs must play a central role in providing mental-health services.

When we conducted the study, the OakDays pilot leaders planned to add a mental-health and substance-use-disorder provider to their clinical team. This person would offer voluntary services to residents, on-site at the OakDays location.

A Cardea Health executive said:

“*In the same way that the folks we serve are not likely to turn up for scheduled appointments and various other things. But if you come to their door, they’ll probably talk to you There’s nothing different about substance-use-disorder treatment or mental-health issues. We’re really looking to apply that site-based model across these other domains*

Financing and policy barriers

Wages and staffing

At the outset, the OakDays pilot found it challenging to identify a home healthcare agency partner. Those few licensed homecare agencies operating in the county willing to provide care to OakDays residents experienced severe shortages of certified home-health aides, licensed vocational nurses, and registered nurses. These shortages were primarily because the HCBA-waiver program reimbursement rates were far too low to be competitive. A Cardea Health executive commented on the rate barrier:

“*Oh, and I think the barrier to this working broadly is the rates, it’s the waiver, the rates are terrible. Medi-Cal rates are in no way commensurate with market rate wages across the state, but particularly in some of the higher wage areas like the [San Francisco] Bay Area. So, yes, there already is a differential for HCBA-authorized nursing services, but it still doesn’t quite close the gap between reimbursements and actual costs of providing care. So, you have to be fearless to make this work.*

Cardea Health executives also reported that it was relatively easy to get state approval to enroll OakDays residents into the HCBA waiver. However, the skilled nursing and home-health services the waiver covered were not readily available. These factors made it virtually impossible for the pilot to secure home-health services through a local agency. They said:

“ *But now we’re at this sort of crossroad where we are having a ton of trouble finding an agency that is willing, because of the very low reimbursement. And even if they are willing, they don’t have the staff. The reimbursement is just so low, and agencies really can’t profit at all, or even break even on that kind of margin.*

Eventually, Alameda County funded the acquisition of a home-health agency, which Cardea Health incorporated into its nonprofit organization. This administrative arrangement permitted Cardea Health to reduce some costs that for-profit home-care agencies had to bear and conduct staff recruitment. One Cardea Health executive said:

“ *I really want to shout from the rooftops how creative and progressive Alameda County was on this. We were up against a real barrier there and naively, I thought we would find a partner and we just did not.*

Cardea Health also said that other counties interested in offering services like those provided at OakDays could use their home-health licensure if the county did not have the independent capacity to provide home healthcare.

Historically, low wages, limited employee benefits and advancement opportunities, and, in some cases, demanding working environments also have made recruitment and retention of personal-care workers challenging in California’s IHSS program. COVID-19 heightened these problems, which continued even after the pandemic waned, because unemployment was low. Many industries were recruiting entry-level workers at the same or higher hourly rates than personal-care workers earned. OakDays partners and residents who qualified for IHSS also reported significant difficulty recruiting and retaining workers. While the pilot provided stop-gap on-site personal care, the medium-term goal was for residents who required ongoing, daily assistance with activities of daily living such as toileting, bathing, and dressing to hire and retain their workers and supervise them independently. EBI and Cardea Health helped residents advertise for workers, screen candidates, and interview prospects. However, some residents’ high care needs and behaviors, along with labor market dynamics in the San Francisco area, made the process challenging. A Cardea Health executive noted:

“ *So, an amount of the caregiver needs will be met by the onsite caregiver staff, which is such a huge component at the moment. So, we are seeing ... difficulty*

finding and retaining IHSS providers, particularly if your needs are high. I think it's just even more challenging. And I think the other thing is considering the population we're serving, there's different challenges there as well

Permanent Supportive Housing (PSH) conversion

When project interviews concluded in late summer 2022, Cardea Health observed that conversion of the OakDays site to PSH would likely take longer than conversion of the second site, which had been operating for less time. The main difference between the two sites was that the second site's housing organization had longstanding experience and the required infrastructure to complete the process efficiently. In contrast, the OakDays site operator was relatively new to housing and had less expertise in obtaining PSH approvals.

Replication challenges

OakDays partners noted that one barrier to opening a similar site elsewhere or adopting the OakDays model would be a lack of staff with lived or adjacent experiences similar to those of residents. Staffed by people who had experienced substance use disorders, homelessness, or justice involvement, Five Keys helped bridge cultural differences between clinical and personal-care staff and residents. EBI also had extensive experience working with people who had multiple health conditions and disabilities and followed harm-reduction and Housing First principles. Moreover, OakDays founders had worked in international refugee camps. They had deep experience with the physical and mental-health effects of being displaced, unhoused, economically destitute, and existing outside social systems such as healthcare that typically serve as safety nets. One Cardea Health executive said that, for example, not every organization could walk into the room of a person with severe pressure ulcers from hip to toe that caused a foul odor “and not just close shop and move to the next county.” Of Five Keys and EBI, the executive stated:

“ *They've just been incredible working partners. They're really an instrumental part of making it possible and developing some of the cultural aspects of the program*

Several people observed that another barrier to replicating the OakDays pilot was a combination of clinician shortages and their limited willingness to work with people with complex physical and mental-health conditions and substance use disorders arising from long-term systemic failures. In addition, these interviewees noted that it was uncommon for clinicians to voluntarily take up strategic leadership roles in settings that respect the right of individuals to make health and life choices, especially when these choices sometimes ran against medical advice. A Cardea Health executive observed:

“ [Residents] take up a significant amount of everyone’s time and energy and ... from a sustainability issue, that’s tough. And I also worry about when we do try to turn this over to partners, will they be tolerant of that? Will they have the capacity and want to manage their time that way?

One OakDays partner observed that the behaviors of some residents contributed to staff burnout and even trauma that required specific interventions to lessen these effects. For instance, one resident with a significant mental-health condition, spinal cord injury, and quadriplegia, was sexually aggressive with the staff. Cardea Health said they trained staff to respond to behavioral issues and set boundaries to fortify resilience. They also made efforts to give staff regular breaks by arranging respite with the resident’s MCO:

“ I think of it as a contest between his behaviors and our staff’s resilience. We’ve tried to fortify the resilience side to the extent possible.

Resident Profile

Jessie

Jessie, a 48-year-old transgender woman, lost her home to a fire. Following the fire, she lived in a van with her partner and their dog. Jessie had uncontrolled seizures and high blood pressure for many years and, in 2018, she became partially paralyzed due to a stroke. Since then, she has needed personal-care assistance with bathing, toileting, dressing, and transferring to her wheelchair. She was admitted to the hospital 12 times in two years following the stroke. After each admission, the hospital discharged her to a nursing home; one nursing home stay lasted a year. Jessie frequently left the nursing home because she missed her partner and dog. She would live briefly in the van with her partner, who would attempt to care for her. Eventually, though, Jessie would return to the hospital after a seizure or a fall, and her partner, who had advanced heart failure, would not be able to care for her. She moved to OakDays in late 2020 from another COVID-19 shelter. Jessie did not have a hospital or nursing-home stay during the eight months following her move to OakDays when staff first reported the program’s impacts to the County of Alameda. During that period, she qualified for In-Home Supportive Services benefits and hired personal-care workers. Jessie also applied to enroll in the HCBA waiver program that would pay for 24-hour personal care. Until that application was approved, OakDays provided the additional personal care she required. During this time, she gained weight and reported being happier than she had been in years. She began planning for gender-reassignment surgery, and her primary-care provider reported that Jessie was flourishing in a way that she had not been able to achieve since her stroke.

Opportunities

Services for other locales

Cardea Health hoped to offer a menu of services other locales could engage if they wanted to replicate the OakDays pilot. For instance, if an available service provider was not licensed as a home-health agency or needed a more robust billing infrastructure, the agency could offer bridge services. They could also consult on program design and funding. Moreover, Cardea Health’s “Playbook,” described previously, sets out the philosophical framework, goals, objectives, and required resources and institutional commitments that locales would need to replicate the pilot.

County investment in bricks and mortar housing

The OakDays project was feasible because the county purchased vacant hotels with COVID-19 funding, which provided move-in-ready housing while the pilot provided healthcare and HCBS for unhoused people with serious chronic illnesses and disabilities. However, looking ahead, Alameda County and the San Francisco Bay Area will continue to face severe low-income housing shortages that present a practical hurdle to ensuring that unhoused individuals will have access to permanent, stable homes. Moreover, too few federal low-income tenant-based housing vouchers made it challenging for people coming out of homelessness to afford commercial rent. Even with low-income tax credits and other incentives, commercial and nonprofit builders faced complex hurdles in constructing low-income housing. Several partners suggested ways counties and private funders could speed up the acquisition and construction process.



One former county health official observed that counties should play a more significant role in acquiring and building low-income housing, as Alameda and other California counties did during the COVID-19 pandemic. They noted that counties often raise money for these acquisitions, primarily through obligation bonds, and act as managers for properties they either purchase or build from the ground up. They also noted that corporate and private donors and philanthropies should increase support for purchasing existing properties or new construction because they can avoid some financing and administrative hurdles that commercial and nonprofit developers face. This person said:

“ I think there’s a future where local government will simply pre-pay the cost of a development project and do it so fast and so cheap that it will make new unit construction a viable strategy. If you ask me, what am I hopeful about, it’s blending private contracting timelines and practices with modular construction with the access to capital that local government has through bond authority.

Applying the OakDays model in other settings

OakDays leaders envisioned bringing healthcare and HCBS to community-based independent-living settings other than PSHs. These locations could include senior housing or housing for lower-income individuals, where there likely would be a strong correlation between income, poor health, and disability. It could also support residents living in larger commercial complexes where lower income, and possibly poorer health, were unifying factors.³¹ They also envisioned deploying the services in situations other than single sites. For instance, the locus could be a geographic area of a few square blocks where intergenerational poverty is highly concentrated and residents likely experienced disability, health and healthcare disparities, and unmet HCBS needs. Research has confirmed the positive association between adverse neighborhood features and a higher proportion of residents reporting disabilities affecting activities of daily living and, potentially, unmet HCBS needs. Applying the OakDays model in these situations could ward off institutionalization and lower any risk of homelessness.³² The California Healthy Places Index (CHPI) might be a starting point for identifying these areas. The CHPI explored local factors that predicted health and life expectancy and compared community conditions across the state.³³

Differences and Similarities With Other Models

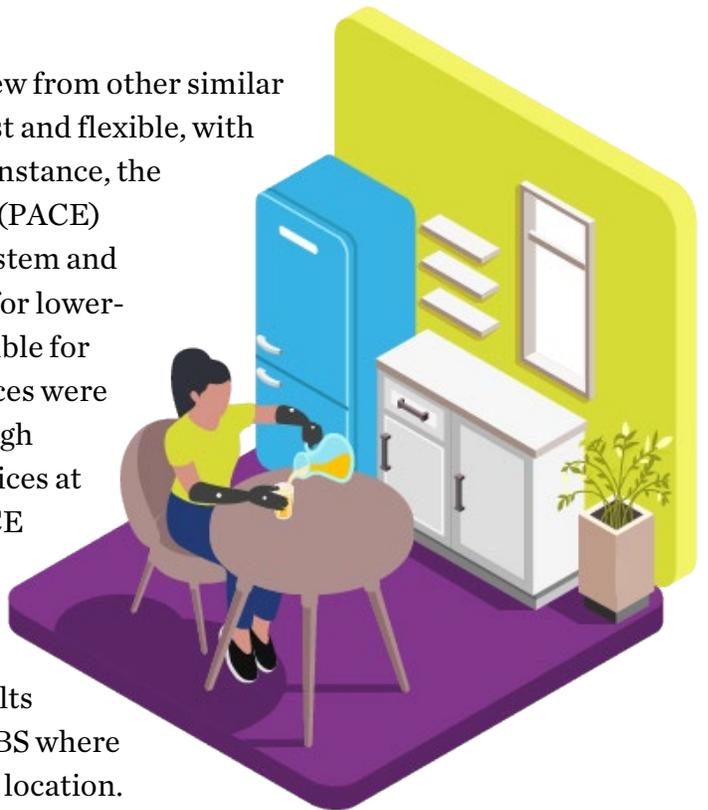
Viewed as a whole, the OakDays hotel site and the pilot were unique in several important ways when it launched during the early days of the COVID-19 pandemic. First, it made available emergency shelter that would become permanent, affordable housing as the pandemic eased. The speed with which the county purchased the COVID-19 hotel sites was

unprecedented and at a scale that showed the housing crisis for unhoused individuals could be partially solved with political will and federal government funding. Second, it provided both on-site healthcare and HCBS that made it possible for people with complex health conditions and disabilities to improve their health and avoid institutionalization. Reliable and ongoing personal care was especially important for residents who required help with daily activities including toileting, bathing, and dressing. Moreover, as residents' health and personal care needs stabilized, new opportunities for independent living in the community opened for them, including moving to apartments if they chose not to live at OakDays when it became PSH. Third, the pilot's leaders were committed to supporting the whole person by working with residents across multiple personal, health, economic, and social domains. Other COVID-19 emergency housing sites typically focused on a few specific short-term solutions, such as providing safe, temporary shelter and nutrition. OakDays, on the other hand, seized the opportunity to build permanent and sustainable healthcare and HCBS solutions for each individual who participated in the pilot so that they would not be forced to return to encampments or enter into institutional care when the pandemic waned.

The OakDays pilot leaders also specifically recognized that staff, medical personnel, personal-care workers, and others site-wide must be culturally sensitive to the experiences of people who had lived in encampments long-term. Moreover, they understood that residents must be agents of their own futures and that the pilot must observe and respect their decisions and preferences. This commitment emanated from an understanding that such individuals had inevitably experienced multiple traumas and social stigma. Many likely had endured demeaning and disrespectful interactions with healthcare providers and others in social service networks. Successful healing and reentry depended on how they were treated and the extent to which they trusted the people they encountered daily. Cultural competence therefore became a hallmark of the pilot and differentiated it from some other Medicaid programs that aimed to prevent institutionalization.

OakDays leaders also planned to convert the former hotel to PSH as the pandemic eased. However, their vision for the OakDays PSH departed from the way such sites typically operated. For instance, PSH sites often provided voluntary substance-use and mental-health counseling on site. However, as a rule, they did not provide hands-on clinical or personal care, which were essential for the OakDays pilot residents and would continue to be available when the site converted to PSH. Healthcare and HCBS made it possible for people with complex physical and mental-health conditions and disabilities who required daily support to maintain their health and live independently and successfully in the community.

The OakDays healthcare and HCBS model drew from other similar publicly funded programs but was more robust and flexible, with fewer eligibility and service restrictions. For instance, the Program of All-Inclusive Care for the Elderly (PACE) featured a comprehensive service-delivery system and integrated Medicare and Medicaid financing for lower-income people aged 55 or older who were eligible for institutional care. Healthcare and other services were delivered primarily at “PACE centers,” although participants sometimes received specific services at home.³⁴ The OakDays pilot differed from PACE in that it stressed staff cultural awareness and combined healthcare and HCBS to meet the multiple, complex needs of the whole person. Moreover, OakDays served adults of all ages and provided complex care and HCBS where people lived rather than primarily at a central location.



The OakDays pilot also had some eligibility and service elements in common with the Multipurpose Senior Services Program (MSSP) waiver, which provided HCBS to individuals eligible for Medi-Cal who were 65 years or older and disabled, as an alternative to nursing-facility placement. However, MSSP typically did not provide services for people who were unhoused, and cultural competence was not baked into its operation. Most MSSP participants received IHSS and care coordination; however, MSSP coordinated referrals to other community services and healthcare providers rather than providing them directly. Like PACE, MSSP also had age restrictions. Furthermore, helping formerly unhoused people transition from COVID-19 housing to PSH or other permanent housing was not a component of the program.

Community health workers sometimes worked with people living in encampments and facilitated case management and referrals to other community services, but they did not provide either clinical or personal care.³⁵ “Street Medicine” teams made up of social workers, physicians, nurses, and community health workers provided primary care, care coordination, social services, and housing referrals for unhoused people living in urban encampments.³⁶ Similar to OakDays, these programs emphasized meeting people where they were, in their own homes, in encampments, or in shelters. However, the OakDays pilot differed in several important ways. It provided critical services on-site, including HCBS and individualized clinical services not typically provided in the home. For instance, OakDays provided home dialysis when a resident would not seek treatment at a dialysis center. Moreover, the pilot’s emphasis on cultural awareness also helped reduce some

emotional barriers to care and even care-aversion that many people experienced who had been unhoused long-term. These and other differences tip the scales toward this integrated and culturally competent housing-with-services model and increases the likelihood that residents would become healthier, live longer, and enjoy an improved quality of life.

Conclusion

Public-health leaders in Alameda County created the OakDays pilot during the unusual convergence of COVID-19 public-health concerns and the rapid availability of federal government relief funding. Together, these factors helped local governments secure permanent homes in former hotels for people who were unhoused and who had been living in encampments or shelters for months or years. At the OakDays location, the pilot program offered healthcare to all residents and HCBS, including personal care, to a subset of people with significant physical and mental-health conditions and disabilities who were eligible for institutional care. The pilot aimed to improve their health, reduce mortality, and prevent institutionalization. The culturally aware, “whole person” services model, built on harm-reduction and Housing First principles, respected residents’ agency and personal goals and values. The pilot tailored healthcare and HCBS to individual needs and provided ongoing emergency and gap services when they were needed, even when residents qualified for permanent ones. Moreover, OakDays implemented creative methods to support people whom more conventional systems of service had abandoned. More research is needed to understand the long-term impact and sustainability of the program. However, OakDays’ service and funding innovations, along with very low-income permanent housing, appeared to have forged a new path to health and independent living for some formerly unsheltered disabled people who had been left behind or forgotten.

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Appendices

Appendix A: OakDays medical frailty criteria

| | |
|-------------------------------|---|
| Medical complexity | <p>Defined as positive if resident had chronic illness requiring significant ongoing management, resulting in a high risk for deterioration if inadequately managed.</p> <p>Data sources: Diagnosis in health record, nursing assessment (diagnosis and medications), and site-level trackers (durable medical equipment use, medical needs, e.g., oxygen dependent or requires transportation to dialysis).</p> <p>Additional clarification: Diabetes, high blood pressure and other common medical diagnoses were not viewed as qualifiers unless accompanied by additional co-morbidities. For example, an older adult with chronic heart failure, chronic obstructive pulmonary disease, and high weight who was taking medications indicating advanced heart failure would qualify as medically frail.</p> |
| Functional status | <p>Defined as positive for functional impairment if resident used a walker or wheelchair for mobility. Use of near-daily IHSS services was also a qualifier for functional impairment. Using a cane or needing a shower chair alone was not considered an indicator of impaired functional status.</p> <p>Data sources: Site-level census trackers, Salesforce nursing intakes.</p> |
| Healthcare utilization | <p>Defined as positive if a resident had 8 or more ER visits, or 3 or more inpatient admissions in the prior 12 months.</p> <p>Data source: Medical record</p> |
| ACG score | <p>Defined as positive if the Johns Hopkins ACG score is “yes” (ACG indicator is a proprietary validated methodology for predicting healthcare utilization)</p> |
| Source: | <p>“OakDays Homekey Site: Piloting Use of Integrated Medi-Cal Waiver Programs in the Permanent Supportive Housing Setting to Stabilize Homeless Individuals at Risk for Institutional Placement.” Prepared for Alameda County [California] as a deliverable for the Project Room Key/Project Home Key (PRK/PHK) clinical services contract. Cardea Health and East Bay Innovations. July 2021.</p> |

Summation of scores:

- Medical complexity, impaired functional status, and ER-utilization were each scored “1” if positive
- ACG was scored as 0.5 if positive (weighted to reflect assessment of ACG validity for this application)
- Score range is 0–3.5

Defining medical frailty:

For the purposes of qualifying for OakDays, residents were defined as medically frail if their medical frailty (MF) score was 3 or higher.

Appendix B: Medicaid (Medi-Cal in California)

California’s Medicaid program, referred to as Medi-Cal, is a public health-insurance program that [provides healthcare services](#) for low-income families with children; seniors; persons with disabilities; those in foster care; pregnant women; and low-income people with specific diseases such as tuberculosis, breast cancer, or HIV/AIDS. Medi-Cal currently provides a core set of health benefits, including doctor visits, hospital care, immunization, pregnancy-related services and long-term services and supports, including home- and community-based services, personal-care services, and nursing-home care.³⁷

Medi-Cal In-Home Supportive Services (IHSS)

The In-Home Supportive Services (IHSS) program provides in-home assistance to eligible older, disabled, and blind individuals and enables recipients to remain safely in their own homes. The administration of IHSS is a partnership that includes beneficiaries, the California Department of Social Services, Department of Health Care Services (DHCS), counties, public authorities, program advocates, providers, and employee unions. Assessments are completed during home visits. Recipients may request a reassessment at any time if their needs or circumstances change. IHSS social workers complete a needs assessment for each applicant or recipient using the following criteria: the Functional Index Rankings, the Annotated Assessment Criteria, and the Hourly Task Guidelines. They also determine service authorizations during the needs assessment. A maximum of 183 personal-care service hours are available for qualified individuals.³⁸

Medi-Cal Home and Community-Based Alternatives (HCBA) Waiver

The HCBA waiver provides care-management services to persons at risk for nursing-home or institutional placement. The care-management services are provided by a multidisciplinary care team comprised of a nurse and social worker. The care-management team coordinates waiver and state plan services (e.g., medical, behavioral health, in-home

supportive services, etc.), and arranges for other long-term services and supports available in the local community. Care-management and waiver services are provided in the person's community-based residence. This residence can be privately owned, secured through a tenant lease arrangement, or the residence of a participant's family member.³⁹

Responsibility for administration of the waiver has been delegated to nine waiver Agencies serving different geographic locations. Centers for Elders' Independence is the waiver agency in Alameda County. Applicants for the waiver submit their applications to the waiver agency serving their location. Waiver agencies process applications, assess applicants, develop a plan of treatment, and submit that plan of treatment to DHCS for approval. Once a person is approved for HCBA waiver services, the waiver agency provides monthly comprehensive care-management to ensure all services on the plan of treatment are being delivered.

Services available under the waiver include:

- Facility respite, family/caregiver training
- Medical-equipment operating expense
- Personal Emergency Response System—installation and testing
- Private duty nursing including home-health and shared services
- Transitional case-management for medically fragile and technology-dependent individuals of any age
- Case management/coordination
- Habilitation
- Home respite
- Waiver Personal Care Services
- Community transition
- Continuous nursing and supportive services
- Environmental accessibility adaptations⁴⁰

According to Cardea Health, OakDays residents who needed skilled care that exceeded the allowable limits through standard Medi-Cal were enrolled in the HCBA waiver. HCBA services authorized for OakDays residents were used in aggregate to fund a site-level care team that included Home Health Aides and nurses. Cardea Health noted that using HCBA

funding for a site-level team generally required that a minimum of 20 people be enrolled in the program to be financially viable and that waiver slots are readily available in California. While OakDays aggregated individually authorized HCBA services to fund a site-level team, billing was complex, and the Home Health Agency charged with invoicing required a high level of familiarity with Medi-Cal billing. Moreover, payment was also frequently delayed so the Home Health Agency should have 12 months of operating costs in reserve. In addition to OakDays, one other COVID-19 housing site located in Los Angeles used HCBA to bring clinical care to people living in COVID-19 hotels.⁴¹ An additional site, a HUD 811 apartment in Alameda County, also used HCBA services to support a few residents.^{42, 43}

Notes

¹ California Health Care Foundation. (2023, June 24). *Project Roomkey: A statewide evaluation*. <https://www.chcf.org/project/project-roomkey-statewide-evaluation/#related-links-and-downloads>

“Project Roomkey was partly funded through the federal CARES (Coronavirus Aid, Relief, and Economic Security) Act, which authorizes using FEMA [Federal Emergency Management Agency] funds to protect people experiencing homelessness from COVID-19. The California state legislature also initially earmarked \$150 million for emergency homelessness aid, which has been used to support local governments in identifying hotels and negotiating and executing contracts with hotel operators Project Roomkey represented a more than 50% increase in the number of people sheltered in California and demonstrates the ability for local systems of care to quickly expand capacity and partnerships to house and serve a highly vulnerable population.”

² California Department of Health Care Services. (2023). *1915(c) home and community-based services waivers*. <https://www.dhcs.ca.gov/services/Pages/HCBSWaiver.aspx>

“Home and Community-Based Services (HCBS) Waivers allow states that participate in Medicaid, known as Medi-Cal in California, to develop creative alternatives for individuals who would otherwise require care in a nursing facility or hospital. Medi-Cal has an agreement with the Federal Government, which allows for waiver services to be offered in either a home or community setting. The services offered under the waiver must cost no more than the alternative institutional level of care. Recipients of HCBS Waivers must have full-scope Medi-Cal eligibility.”

³ National Harm Reduction Coalition. (2020). *Principles of harm reduction*. <https://harmreduction.org/about-us/principles-of-harm-reduction/>

“Harm reduction is a set of principles focused on reducing negative consequences related to substance use. Harm reduction is also a social justice movement, built upon the respect for the rights of people who use substances such as drugs and alcohol.”

⁴ Corporation for Supportive Housing. (n.d.). Fact Sheet, *Housing First*. <https://www.hcd.ca.gov/grants-funding/active-funding/docs/housing-first-fact-sheet.pdf>

“Housing First” acknowledges that care coordination and social services are necessary elements of housing stability.

⁵ Trauma-Informed Care Implementation Resource Center. (2021). *What is trauma-informed care?* <https://www.traumainformedcare.chcs.org/what-is-trauma-informed-care/>

“A trauma-informed approach to care acknowledges that health care organizations and care teams need to have a complete picture of a patient’s life situation—past and present—in order to provide effective health care services with a healing orientation.”

⁶ National Health Care for the Homeless Council. (2023). *Permanent supportive housing.* <https://nhchc.org/clinical-practice/homeless-services/permanent-supportive-housing/>

⁷ Coronavirus Aid, Relief, and Economic Security Act. (2020). Pub. L. No. 116-136, (2020), 134 Stat. 281. <https://www.congress.gov/bill/116th-congress/house-bill/748>

⁸ California Department of Health Care Services. (2023). *Whole Person Care Pilots.* <https://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx>

“Whole Person Care Pilots provided an option to a county, a city and county, a health or hospital authority, or a consortium of any of the above entities serving a county or region consisting of more than one county, or a health authority, to receive support to integrate care for a particularly vulnerable group of Medi-Cal beneficiaries who have been identified as high users of multiple systems and continue to have poor health outcomes.”

⁹ California Department of Health Care Services. (2023). *Medi-Cal waivers.* <https://www.dhcs.ca.gov/services/Pages/Medi-CalWaivers.aspx>

“Medi-Cal waivers are programs that provide additional services to specific groups of individuals, limit services to specific geographic areas of the state, and provide medical coverage to individuals who may not otherwise be eligible under traditional Medicaid rules.”

¹⁰ KFF. (2022, November 9). *Status of state Medicaid expansion decisions.* <https://www.kff.org/medicaid/issue-brief/status-of-state-medicare-expansion-decisions-interactive-map/>

¹¹ Tobias, M. (2022, October 6). *California homeless population grew by 22,000 over pandemic.* CalMatters. <https://calmatters.org/housing/2022/10/california-homeless-crisis-latinos/>

¹² Burbank, K. (2022, May 22). *Leaders call for more housing as county homelessness rises 22%.* Bay City News Service. <https://www.pleasantonweekly.com/news/2022/05/22/leaders-call-for-more-housing-as-county-homelessness-rises-22>

¹³ Burr, J. (2022, September 22). *2022 Alameda County homeless count and survey comprehensive report*. Applied Survey Research. https://everyonehome.org/wp-content/uploads/2022/10/2022-Alameda-County-PIT-Report_9.22.22-FINAL-3.pdf

¹⁴ California Health Care Foundation. (2023). *Homelessness and health care*. <https://www.chcf.org/topic/homelessness-health-care/>

“People who live on the streets die an average 20 years earlier than people who are housed.”

¹⁵ Paul, D. W., Jr., Knight, K. R., Olsen, P., Weeks, J., Yen, I. H., & Kushel, M. B. (2019, December 18). Racial discrimination in the life course of older adults experiencing homelessness: Results from the HOPE HOME study. *Journal of Social Distress and the Homeless*, 29(2), 184–193. <https://doi.org/10.1080/10530789.2019.1702248>

¹⁶ Abbott, K. (2022, November 17). Personal communication.

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¹⁷ OakDays leaders also observed that a significant number of people residing long-term in skilled nursing facilities would prefer to live in a community-based setting if they were supported by enhanced clinical services. In their opinion, county-level planning should consider implementation of an OakDays-type care model in other PSH settings to increase capacity for serving unsheltered individuals at risk for institutionalization.

¹⁸ Colburn, G. & Aldern, C. P. (2022). *Homelessness is a housing problem: How structural factors explain U.S. patterns*. University of California Press.

¹⁹ City of Oakland. (2019, June 7). *Measure W authorizes a tax to be imposed on vacant property beginning July 1, 2020 for property deemed vacant in 2019*. <https://www.oaklandca.gov/news/2019/measure-w-outreach-and-civic-engagement-forums>

²⁰ Dineen, J. K. (2022, October 20). *Are S.F. landlords sitting on tens of thousands of empty homes? Vacancy tax could put debate to rest*. San Francisco Chronicle. <https://www.sfchronicle.com/bayarea/article/Are-S-F-landlords-sitting-on-tens-of-thousands-17522816.php>

²¹ Bowman, S., Myers, J., & Southwood, B. (2021, September 14). The housing theory of everything. *Works in Progress*, 5. <https://www.worksinprogress.co/issue/the-housing-theory-of-everything/>

²² Morales, L. (2019). *The 2019–2020 budget: Considerations for the governor’s housing plan*. Legislative Analyst’s Office, Sacramento, CA.

²³ Bo'sher, L., Chan, S. Ellen, I. G., Karfunkel, B. & Liao, H-L. (2015). *Accessibility of America's housing stock: Analysis of the 2011 American Housing Survey (AHS)*. Office of Policy Development and Research, U.S. Department of Housing and Urban Development, Washington, DC. <https://www.huduser.gov/portal/publications/mdrt/accessibility-america-housingStock.html>

²⁴ Boyd-Barrett, C. (2022, June 9). "House calls" for people experiencing homelessness. California Healthcare Foundation Blog. <https://www.chcf.org/blog/house-calls-people-experiencing-homelessness/>

"This unprecedented rapid action to move people into shelters gave health care providers a unique opportunity. Under a \$2.3 million grant program called [Health Pathways Expansion \(HPE\)](#), developed by the United Way of Greater Los Angeles, 16 local health care organizations and clinics tested an unusual strategy. Instead of waiting for people to come to a clinic or searching the streets for them, the health care providers brought the medical services directly to people staying at Project Roomkey hotels."

²⁵ East Bay Innovations executive staff member. (2021, November). Interview.

One 811 housing site in Alameda County, California uses HCBA waiver funding to support several individuals. (Through the Section 811 Supportive Housing for Persons with Disabilities program, HUD provides funding to develop and subsidize rental housing with the availability of supportive services for very low- and extremely low-income adults with disabilities.) https://www.hud.gov/program_offices/housing/mfh/progdesc/disab811.

²⁶ Brandeis University, Committee for Protection of Human Subjects. (2019, November 8). "IRB Protocol #20048R-E Caldwell: Understanding Barriers and Facilitators to Increasing Affordable Housing for People with Disabilities."

²⁷ Homekey was a California program that aimed to sustain and rapidly expand housing for persons experiencing homelessness or at risk of homelessness, and who were especially impacted by COVID-19. <https://www.hcd.ca.gov/grants-and-funding/homekey>

²⁸ Cardea Health executive. (2022, December 1). Personal (written) communication.

OakDays provided service connections for hospice when indicated, but the hospice care was covered by Medi-Cal and was not included in the OakDays care model.

²⁹ Cardea Health and East Bay Innovations. (2021, July). *OakDays Homekey site: Piloting use of integrated Medi-Cal waiver programs in the permanent supportive housing setting to stabilize homeless individuals at risk for institutional placement*. [Prepared for Alameda

County as a deliverable for the Project Room Key/Project Home Key (PRK/PHK) clinical services contract.]

³⁰ Alameda County Grand Jury. (2022). Final Report 2021–2022.

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³¹ Public Health Alliance of Southern California. (n.d.). California Healthy Places Index. Community Commons. <https://www.communitycommons.org/entities/03ccca83-37c3-44ca-a9c4-eb389e7d1c54>

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³⁵ Health Care Access Now. (2020, April 15). *What is a community health worker?* <https://healthcareaccessnow.org/what-is-a-community-health-worker/>

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³⁷ California Department of Health Care Services. (2023). *Medi-Cal*. https://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-Cal_EHB_Benefits.aspx

³⁸ California Department of Social Services. (2023). *In-Home Supportive Services (IHSS) Program*. <https://www.cdss.ca.gov/inforesources/ihss>

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⁴⁰ California Department of Health Care Services, “*Home and Community-Based Alternatives Waiver*.” [https://www.dhcs.ca.gov/services/ltc/Pages/Home-and-Community-Based-\(HCB\)-Alternatives-Waiver.aspx](https://www.dhcs.ca.gov/services/ltc/Pages/Home-and-Community-Based-(HCB)-Alternatives-Waiver.aspx)

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⁴² Cardea Health and East Bay Innovations, “OakDays Homekey Site: Piloting Use of Integrated Medi-Cal Waiver Programs in the Permanent Supportive Housing Setting.”

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One 811 housing site in Alameda County, California used HCBA waiver funding to support several individuals. (Through the Section 811 Supportive Housing for Persons with Disabilities program, HUD provides funding to develop and subsidize rental housing with the availability of supportive services for very low- and extremely low-income adults with disabilities: https://www.hud.gov/program_offices/housing/mfh/progdesc/disab811.)