HCH2024 Conference and Symposium
Cluster Care in Safe Havens: ADL Support in Low-Barrier Shelter

Handout Excerpts From:

Cluster Care Planning Report and Program Design Plan

March 2022

Supported in part by a grant from the Fan Fox and Leslie R. Samuels Foundation, Inc.

"The good news is that while difficult, successfully alleviating the supportive service needs of frail elder tenants is possible. Even modest efforts produce positive outcomes. Importantly, not just older residents in need will benefit. Building morale will be higher, incidence of fires and accidents will decrease, … and fewer housekeeping and repair problems will erupt"

(Golant, 2000)

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Acknowledgements

Breaking Ground wishes to acknowledge the time and contributions of the Cluster Care Planning Committee, which was tasked with developing a Cluster Care program plan that could meet the needs of our Safe Haven clients. Planning Committee members are:

Wale Adegbenle, LCSW, Director, Aging Services, Breaking Ground
John Betts, LMSW, Assistant Vice President, Program Development & Innovation, Breaking Ground
Lee Isaacsohn, MD, Assistant Medical Director, Breaking Ground (Janian Medical Care)
Erin Madden, LCSW, Vice President, Programs, Breaking Ground
Jill Maddox, MD, Medical Director, Breaking Ground (Janian Medical Care)
Bonnie Mohan, Executive Director, The Health & Housing Consortium, Inc.
Keona Serrano, LCSW, Assistant Vice President, Breaking Ground
Roberta Solomon, LMSW, Deputy Vice President, Breaking Ground
Tess Sommer, Program Manager, The Health & Housing Consortium, Inc.

We also want to thank the hospital staff and Breaking Ground program directors of our Safe Haven and homeless outreach programs who conducted the needs assessments that informed the design of the proposed program described in this paper.

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Appendices

Appendix A. Needs Assessment Questions

Healthcare Providers Cluster Care Needs Assessment

1. Have you ever referred a patient to a homeless shelter, but the shelter or the Department of Homeless Services said the patient was inappropriate for shelter due to medical needs?
2. If yes, what is your estimate of the average number of patients that you work with in any given month who are referred to shelter but not able to go/return due to their medical needs?
3. If yes, what are the most common reasons that are given for the person not being able to go to/return to shelter due to medical needs?
4. If the answer to question 2 is "ADLs" or something similar, which are the most common ADLs that prevent the person from going to/returning to shelter?
5. In your opinion, would long-term Home Health Aide services at the shelter have allowed some of these people to go to/return to shelter safely?
6. Have you ever had to refer someone to a SKILLED NURSING FACILITY simply because long-term home health aide or similar services were not available at the shelter where they were living?
7. Have you ever had to keep someone IN THE HOSPITAL simply because long-term home health aide or similar services were not available at the shelter where they were living?
8. If yes, what were the needs that required them to stay in the hospital?
9. Any other comments you would like to add?

Breaking Ground Safe Haven Programs Needs Assessment

1. Has the program ever had to discharge (or not accept back) someone because they were no longer appropriate for a Safe Haven level of care?
2. If yes, approximately how many times in the past year has this happened? Where did these people end up going (if you know) after discharge?
3. Of these individuals, how many might have been appropriate to remain at a Safe Haven if they had long-term home health aide support who could assist with bathing, toileting, and other ADLs?
4. In the past year, have staff ever had to clean up a condition created by someone who was unable to care for themselves on an ongoing basis (e.g., repeated incontinence, incontinence due to alcohol)
5. If yes, how frequently does this happen on average?
6. What are the most common issues that create this situation?

7. In the past year, has your program site sustained any physical plant damage requiring more than just simple housekeeping due to a condition created by someone who was unable to care for themselves?
8. If yes, how frequently does this happen on average?
9. If yes, what was the damage and what was/were the condition(s) that created it?
10. If you know approximately how much the repair cost, please indicate.
11. How frequently does a client go to an emergency room to address an ADL or other medical issue created by an inability to care for oneself?
12. What are the most common issues that create the need for these emergency room visits? How many clients could benefit from additional, regular support around ADLs?

Appendix B. Cluster Care Referral Form

Client Name:

Client DOB:

Room Number:

Safe Haven Admission Date:

Case Manager:

Describe reason for referral in 1-2 sentences:

Describe examples of assistance needed/suggested:

Is need episodic or chronic (e.g., only when intoxicated or every day)?

Current Housing Package Status: ( ) Active package ( ) Missing Documents ( ) Linked/Awaiting Move Out

( ) Undocumented/Ineligible ( ) Other_____

Current Housing Plan: ( ) Permanent Supportive Housing ( ) Gen Pop ( ) Subsidy/Voucher ( ) Assisted Living/Nursing Home ( ) Other_____

Barthel Scale Score (*Attach Barthel scale and/or other assessment instruments*)

Is client on Medication Monitoring?

Has client been engaged about Cluster Care and, if so, is client interested?

Is client actively using substances? If yes, what?

Has client completed a medical assessment with Janian or another provider? (*Conditions or assistance for strictly medical issues—e.g., wound care—are not appropriate for cluster care*)

Appendix C. Prospective Job Descriptions

ADL Team Leader

Reporting to Assistant Director of Operations the ADL Team Leader provides supervisory oversight of the ADL Coaches and the day-to-day operations of Cluster Care services and acts as ADL Coach for particularly complex clients and/or as needed. Cluster Care services provide staffing support and maintain program stability by providing client support, assistance, and monitoring through frequent, positive interactions to increase independence and self-sufficiency, improve client overall quality of life, and support clients in preparing to transition to permanent housing.
This position has a 35-hour work week, onsite.

ESSENTIAL DUTIES

- Supervise a staff of 2 ADL Coaches providing direct support services to clients.
- Provide training to ADL Coaches
- Develop and administer Cluster Care schedule, including development of work plans, schedules, and assignments.
- Collaborate with Clinical Supervisors onsite to ensure smooth, coordinated service delivery.
- Review ADL Coaches' service documentation and reports, make service adjustments as necessary, and provide reports about service delivery to onsite Clinical staff and/or others upon request.
- Act as ADL Coach for particularly complex clients and/or as needed, including:
    - Providing reminders, guidance, and coaching to clients to improve their daily living skills. (e.g., showering, grooming, housekeeping, medication adherence, eating/grocery shopping, laundry, decluttering, delousing, adhering to bed bug protocol, toileting).
    - Facilitating onsite laundry, housekeeping, and shower resources for clients
    - Supporting clients in transition planning and skills practice, including consultation with Clinical staff about potential supports needed upon move into independent housing (e.g., HHA or MLTC).
    - Providing engagement to increase participation in case management, medical and psychiatric appointments, and other housing-related appointments, including providing reminders and escorts to appointments as necessary.
    - Using company vehicle or mass transit to escort clients to and from appointments in the community and as necessary.
    - Documenting daily client interactions, progress towards goals (including use of short functional assessments), and case conferences.
    - Reporting and documenting incidents, crisis interventions, and communicate with on-call management team
- Perform other related duties as assigned

MINIMUM QUALIFICATIONS

- Minimum 5 yrs. experience working with homeless or disabled populations, and minimum 3 yrs. of supervisory or leadership experience
- Excellent clinical and assessment skills, creative, person-centered problem solving, ability to delegate and motivate. Ability to communicate and work with diverse populations. Detailed oriented and can manage team tasks
- Strong organizational skills
- Proficiency with Microsoft Office Suite
- Advanced training/experience in occupational therapy, home care, congregate care milieus, nursing home, etc. strongly preferred
- Preferred: Valid NY driver's license with driving record that is in good standing
- CPR and First Aid certifications a plus
- Experience or familiarity with Motivational Interviewing, Primary Caregiver Support Training, Harm Reduction, Housekeeping/Operations Training, Safe Transfers, and/or De-escalation is preferred.
- Bilingual or Multilingual preferred

ADL Coach

Reporting to the ADL Team Leader, the ADL Coach assists in enhancing client independent living skills. The ADL Coach provides staffing support and maintains program stability by providing client support, assistance, and monitoring through frequent, positive interactions to increase independence and self-sufficiency. The ADL Coach is expected to engage with individuals experiencing homelessness to improve their overall quality of life and support them in preparing to transition to permanent housing.
This position has a 35-hour work week, onsite.

ESSENTIAL DUTIES

- Provide reminders, guidance, and coaching to clients to improve their daily living skills. (e.g., showering, grooming, housekeeping, medication adherence, eating/grocery shopping, laundry, decluttering, delousing, adhering to bed bug protocol, toileting).
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- Provide engagement to increase participation in case management, medical and psychiatric appointments, and other housing-related appointments, including providing reminders and escorts to appointments as necessary.
- Use company vehicle or mass transit to escort clients to and from appointments in the community and as necessary
- Document daily client interactions, progress towards goals (including use of short functional assessments), and case conferences.
- Report and document incidents, crisis interventions, and communicate with on-call management team
- Provide additional client support and advocacy as needed.

- Perform other related duties as assigned

MINIMUM QUALIFICATIONS

- One to two years of related experience
- Proficiency with Microsoft Office Suite
- High School Diploma or GED, Associates degree preferred
- CPR and First Aid certifications a plus
- Preferred: Valid driver's license with driving record that is in good standing
- Experience working with individuals experiencing homelessness and/or mental health or substance use issues is a plus
- Experience or familiarity with Motivational Interviewing, Primary Caregiver Support Training, Harm Reduction, Housekeeping/Operations Training, Safe Transfers, and/or De-escalation is preferred.

Appendix E. Additional Information Regarding the Barthel Index

Shah Version of the Barthel Index

The Barthel Index has been modified and adapted in different ways. For the purposes of our initial needs assessment, we used the Shah version of the Barthel Index. The full assessment with scoring metric and descriptions can be found here: http://functionalpathways.com/intranet-files/Modifiet_Barthel_Index.pdf

Interpreting Barthel Index Scores

There is very little guidance on how to interpret Barthel scores, but the following is one potential resource: https://www.elitelearning.com/resource-center/rehabilitation-therapy/the-original-barthel-index-of-adls/

Relevant excerpt on interpreting scores:

> "Several authors have proposed guidelines for interpreting Barthel scores. Shah et al. suggested that scores of 0-20 indicate "total" dependency, 21-60 indicate "severe" dependency, 61-90 indicate "moderate" dependency, and 91-99 indicates "slight" dependency. Most studies apply the 60/61 cutting point, with the stipulation that the Barthel Index should not be used alone for predicting outcomes.
>
> Modifications to the Barthel Index include a variation of the 10-item version by Collin and Wade, that reordered the original 10 items, clarified the rating instructions, and modified the scores for each item based on a three point scoring system with a total score range from 0 to 20.
>
> Generally speaking, a score of 14 indicates some disability, usually compatible with the level of support found in the home, a score of 10 is compatible with discharge home, provided there is maximum support and a caretaker in attendance."

Another option within Barthel is a different scoring method. The following is an example of Barthel using a 0–20-point scale, with instructions on how to score. This scoring method could be simpler for the staff completing it, though it does limit the sensitivity to capture more variation in ability.
https://www.albertahealthservices.ca/assets/about/scn/ahs-scn-bjh-hf-barthel-index-of-adls.pdf

Alternatives to the Barthel Index

One critique of the Barthel Index is that it doesn't lend itself well to demonstrating progress or change in ability. A possible alternative to Barthel is the Functional Impairment Measurement (FIM), which has a 0-7 score on 18 items related to ADLs as well as social cognition (total score 18-126). Here is another resource about it, which gives some helpful guidance on translating FIM scores into hours of assistance needed per day:

> "...according to the Uniform Data System for Medical Rehabilitation organization, a total FIM score of 60 can equate to approximately four hours daily of assistance needed while a score of 80 equates to about two hours daily. People with a total FIM score between 100 and 110 require minimal assistance with their day-to-day activities. Additionally, the difference between your initial FIM score and your score at discharge is also a good indicator of progress you've made during your rehabilitation period."

Considerations in Scoring Assessments

An excerpt from another resource that warns against using an aggregate score alone:

> "A final summed score is created and ranges from 18 – 126, where 18 represents complete dependence/total assistance and 126 represents complete independence. The single summed raw score may be misleading as it gives the appearance of a continuous scale. However, intervals between scores are not equal in terms of level of difficulty and cannot provide more than ordinal level information"

This is an important consideration regardless of which tool is used because someone may have an overall high score but score very low on one or two activities measured, indicating significant support is still needed.