This new strategic partnership will provide low-barrier, respite housing for homeless individuals with disabilities who are dealing with complex medical needs.
Over the past four years, Opportunity Village Marin (OVM) has served Marin’s most medically complex, homeless individuals. All of these individuals were people with multiple disabilities who were connected to either Marin Community Clinic or Ritter Center as their medical home. OVM has supported these individuals with nurse led care coordination services to support complex medical needs. The result of this intervention was that there were zero Emergency Department visits for these patients, and only one patient re-hospitalization.

AS A RESULT OF OUR COLLABORATION WE HAVE BEGUN TO:

- Provide safe shelter (local motel rooms) in conjunction with person centered, wraparound services that allow individuals to access care in a timely fashion while facilitating safe healing and recovery.
- Address the social determinants of health, especially when an individual has complex medical needs and requires surgery or intensive intervention.
- Expand OVM’s nurse-led and person-centered care coordination team that utilizes a “harm-reduction model” and meets people where they are, while providing health & housing focused support.

SERVICES & RESOURCES PROVIDED:

- Medication Compliance Support
- Transportation
- Connection to Community-Based Supports
- “Home” Visits from Nursing Students
- Extensive Chemo/Infusion Program
Participants enroll in OVM when Transition to Wellness is not an option because they are ineligible (i.e., the person is not directly discharged from hospital in Marin County) or TTW did not meet their needs (e.g., the facility is not accessible, person not able to live independently and/or share room). Reasons for seeking services with OVM included:

2 Were receiving chemotherapy.
2 Were discharged from hospital and TTW could not accommodate their special needs.
4 Needed respite before a surgery.
20 Needed medical stabilization; such as upper-respiratory infection, transition to housing, pregnancy, recent hospitalization, and recovery struggles.

Referrals come from a variety of sources and people do not qualify or are getting services through Transition to Wellness:

- 3 From Ritter Center
- 3 Through Whole Person Care
- 1 Is Self-Referral
- 4 From Additional Sources
- 5 From Marin Community Clinic
- 4 From Marin County Programs
- 3 From Marin General Hospital

1) Including Mill Street, JFCS, and St. Vincent’s; 2) non-WPC; 3) one of which was enrolled in WPC.
LENGTH OF STAY:
Maximum length of stay is 6 weeks:

- 16 people stayed under 14 days.
- 6 people stayed more than 30 days.
- 6 people stayed between 15 to 29 days.

- Approximately half OVM participants stayed 10 days or less and half stayed over 10 days.
- 16 people stayed 2 weeks or less (which is compliant with TTW maximum length of stay.
- However 12 other folks needed respite longer than 2 weeks).

HOSPITAL DAYS AVOIDED...
DOLLARS SAVED:

$1,464,000
Saved by avoided hospital stays.

$1,860
Average cost per participant for gas, food, transport, etc.

$1,832
Average cost per participant for hotel stay only.

488 Hospital days avoided; average $3,000 savings per day.
MEDICAL HOME CENSUS:
28 people in 18 weeks.

Health Insurances
• 43% Medi-Cal
• 57% Others

Medical Home
• 68% MCC
• 21% Ritter
• 7% Others
• 4% Kaiser

Staffing
Approximately 5 hours/person on average of public health nurse time.

FUNDING:
$60,000*
Funding source from the O’Keffe Grant for motel stays.

* Total costs with hotel, transportation, gas, and food equals $52,088 over 18 weeks.
EXIT TO HOUSING:

64%
Of participants exited to permanent or temporary housing.

13
Secured temporary housing (e.g. shelter, stay with a relative).

10
Remained un-housed (includes living in vehicles).

5
Secured permanent housing (3 of 5 received Section 8 voucher).

The fact that 36% of OVM participants and 27% of TTW participants exit back to streets may indicate the gaps in Marin’s medical respite system to meet the needs of people living on streets with complex medical conditions.

Since taking on fiscal sponsorship back in December, Marin Center for Independent Living (Marin CIL) has added our own person centered care coordination and housing preservation services to complement the work of OVM.
SUMMARY OF FACTS:

As a result of our collaboration we have begun to...

- Provide safe shelter (local motel rooms) in conjunction with person centered, wraparound services that allow individuals to access care in a timely fashion while facilitating safe healing and recovery.
- Address the social determinants of health, especially when an individual has complex medical needs and requires surgery or intensive intervention.
- Expand OVM’s nurse-led and person-centered care coordination team that utilizes a “harm-reduction model” and meets people where they are, while providing health & housing focused support.

Services & Resources Provided

- Medication Compliance Support
- Transportation
- Connection to Community-Based Supports
- “Home” Visits from Nursing Students
- Extensive Chemo/Infusion Program

Participants

Participants enroll in OVM when Transition to Wellness is not an option because they are ineligible (i.e. the person is not directly discharged from hospital in Marin County) or TTW did not meet their needs (e.g. the facility is not accessible, person not able to live independently and/or share room). Reasons for seeking services with OVM included:

- 2 were receiving chemotherapy.
- 2 were discharged from hospital and TTW could not accommodate their special needs.
- 4 needed respite before a surgery.
- 20 needed medical stabilization; such as upper-respiratory infection, transition to housing, pregnancy, recent hospitalization, and recovery struggles.

Referrals

Referrals come from a variety of sources and people do not qualify or are getting services through Transition to Wellness:

- 6 through Community Based Organizations
- 5 from Marin Community Clinic
- 4 from Marin County Programs
- 3 from Marin General Hospital
- 3 from Ritter Center
- 3 through Whole Person Care
- 3 is Self-Referral
- 4 from Additional Sources

1) Including Mill Street, JFCS, and St. Vincent’s; 2) non-WPC; 3) one of which was enrolled in WPC.
### Length of Stay

Maximum length of stay is 6 weeks:
- 16 stayed under 14 days.
- 6 stayed between 15 to 29 days.
- 6 stayed more than 30 days.

### Hospital Days Avoided, Dollars Saved

- $1,464,000 saved by avoided hospital days.
- $1,860 average cost per participant for gas, food, transport, etc.
- $1,832 average cost per participant for hotel stay only.
- 488 hospital days avoided; an average $3,000 savings per day.

### Medical Home Census (28 people in 18 weeks)

<table>
<thead>
<tr>
<th>Health Insurances</th>
<th>Medical Home</th>
<th>Staffing</th>
</tr>
</thead>
<tbody>
<tr>
<td>43% Medi-Cal</td>
<td>68% MCC</td>
<td></td>
</tr>
<tr>
<td>57% Others</td>
<td>21% Ritter</td>
<td></td>
</tr>
<tr>
<td>Staffing</td>
<td>7% Others</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4% Kaiser</td>
<td></td>
</tr>
</tbody>
</table>

### Funding

- $60,000* funding source from the O’Keffe Grant for motel stays (total costs with hotel, transportation, gas, and food equals $52,088 over 18 weeks.).

*Total costs with hotel, transportation, gas, and food equals $52,088 over 18 weeks.

### Exit to Housing

64% of participants exited to permanent or temporary housing:
- 13 secured temporary housing (e.g. shelter, stay with relative).
- 10 remained unhoused (includes living in vehicles).
- 5 secured permanent housing (3 of 5 received Section 8 voucher).