

# A Housing and Health Collaboration: Mount Rubidoux Manor and Inland Empire Health Plan



Case Study

# About This Case Study

---

The LeadingAge LTSS Center @UMass Boston would like to thank team members at Mount Rubidoux Manor, HumanGood, and Inland Empire Health Plan for participating in this case study and sharing their time, information, and insights about their housing and health collaboration.

The views expressed here and the interpretation of statements made by interviewees are those of the author.

## **Author:**

[Alisha Sanders](#), LeadingAge LTSS Center @UMass Boston

## **About the LTSS Center**

The LeadingAge LTSS Center @UMass Boston conducts research to help our nation address the challenges and seize the opportunities associated with a growing older population. LeadingAge and the University of Massachusetts Boston established the LTSS Center in 2017. We strive to conduct studies and evaluations that will serve as a foundation for government and provider action to improve quality of care and quality of life for the most vulnerable older Americans. The LTSS Center maintains offices in Washington DC and Boston, MA. For more information, visit [LTSSCenter.org](https://www.ltsscenter.org).



# Table of Contents

---

**Background**.....2

**Program Overview and Concept**.....3

**Program Implementation**.....4

**Initial Observations on the Housing and Health Plan Collaboration**.....9

**Early Program Evaluation**.....10

**Examples of Successful Interventions**.....11

**Next Steps**.....12

# A Housing and Health Collaboration: Mount Rubidoux Manor and Inland Empire Health Plan

## Background

Mount Rubidoux Manor is a 188-unit affordable senior housing community in Riverside, CA, managed by HumanGood. Like many subsidized housing communities, Mount Rubidoux Manor is home to an increasing number of residents with complex needs. Some of these residents are formerly homeless and/or have behavioral health concerns.

Seeking solutions to help support its residents, Mount Rubidoux Manor and HumanGood looked to a collaboration that another HumanGood community in California had developed with a managed care organization. HumanGood asked the managed care partner to help it identify a health plan that served the Riverside area and might be interested in collaborating with Mount Rubidoux Manor. The partner led HumanGood to Inland Empire Health Plan (IEHP).

Discussions between HumanGood and IEHP began in 2018. During a visit to Mount Rubidoux Manor, IEHP staff toured the housing community, met with the resident service coordinator and other housing staff, and spoke with several residents.



IEHP staff were impressed by Mount Rubidoux Manor's care for its physical property and its commitment to residents, 50% of whom were IEHP members. The health plan was intrigued by the possibility of working with the housing community because IEHP has an interest in ensuring its members receive wraparound services, such as care coordination and social supports. HumanGood and IEHP spent several months exploring a potential collaboration.

Shortly before IEHP and Mount Rubidoux Manor began their discussions, the housing community had been refinanced using low-income housing tax credits and had undergone a major renovation that resulted in some vacant apartments. By the end of 2018, the organizations agreed that Mount Rubidoux Manor would set aside six of these units, and up to 10 apartments upon resident move outs, to house health plan members who are part of IEHP's Housing Program. The set-aside apartments do not have attached rental assistance. IEHP subsidizes the rents so no resident pays over 40% of their income for housing.

Housing Program participants, who were formerly homeless or resided in a custodial care setting, receive intensive case management services from Brilliant Corners, a partnering supportive housing and case management organization. In addition, a health navigator, placed at the community by IEHP, assists all residents of the community.

## Mount Rubidoux Manor

Mount Rubidoux Manor currently houses 191 older adults and younger persons with disabilities. Four percent of residents are under age 55 and the average age is 71 years old. Almost 60% of residents are female and just under 10% report being married or in a domestic partnership. Eleven current residents were homeless prior to moving to the community. A full-time resident service coordinator has worked at Mount Rubidoux Manor for 15 years.

## Inland Empire Health Plan

IEHP is a nonprofit Medicaid health plan serving about 1.2 million members in Riverside and San Bernardino counties. The health plan offers a Medi-Cal (Medicaid) plan and a Cal MediConnect plan that serves individuals who are dually eligible for both Medi-Cal and Medicare. IEHP is one of two managed care plans in Southern California's Inland Empire region that are participating in the Cal MediConnect program. The other plan has only a small number of members living at Mount Rubidoux Manor.

In 2010, IEHP established a Health Navigator Program to help plan members address their health needs and overcome any barriers they may face in addressing those needs. Bilingual health navigators meet one-on-one with individual IEHP members in their own homes or a location of their choice.

The navigators:

- ➔ Review members' health records.
- ➔ Conduct health appraisals to better understand members' health and social circumstances.
- ➔ Help members understand their health benefits and how to use them properly.
- ➔ Educate members about the importance of accessing preventative care and avoiding unnecessary emergency care.
- ➔ Empower members to advocate for their own health and well-being.
- ➔ Help members understand and coordinate the health plan's resources, including connecting members to internal IEHP departments, such as Behavioral Health, Care Management, and Health Education.
- ➔ Help connect members with community resources to address needs associated with social determinants of health.

The health navigators are part of IEHP's Community Health Department, the mission of which is to "engage, influence, and organize efforts to create healthy communities and cultivate trusted and aligned collaborations that will empower everyone to live healthy and fulfilling lives."

IEHP recognizes that social factors can be a primary barrier to an individual's ability to manage chronic conditions and other health needs. It is difficult for a person to manage their diabetes, for example, if they encounter challenges paying for and accessing food. The Community Health Department works to help members address these social barriers and to shift IEHP's approach from "sick care" to "well care."

## Program Overview and Concept

---

The collaboration between Mount Rubidoux Manor and IEHP, which launched in March 2019, had been operational for nine months when this case study was conducted. Program elements and processes continue to evolve as the partner organizations learn to work together. IEHP is also identifying ways to adapt its member interactions to this new operating environment and the different opportunities it presents.

The program's central component is a health navigator who is on-site three days per week and works one-on-one with residents to help address their health concerns. The navigator's main role is to provide case management services, help residents understand and access their health benefits, and resolve any barriers standing in the way of that understanding and access.

IEHP also brings group programming and activities to Mount Rubidoux Manor through the Independent Living and Diversity Services (ILDS) team in the health plan's Community Health Department. The programming is designed to help residents achieve good health by addressing knowledge and resource gaps and providing health-related opportunities of interest. In particular, the programming focuses on helping create social connections and a sense of community among residents as a way to address social isolation and depression.

The dual components of one-on-one interaction and group programming allow IEHP to take a comprehensive approach to helping residents address factors within their environment that may be impacting their health.

IEHP sees its current work at Mount Rubidoux Manor as a pilot initiative designed to identify what approaches work best. After the intervention and partnership evolves, the health plan will examine the data to see if the approach is having an impact. IEHP representatives say they will not be surprised to see an initial increase in care utilization, which can be viewed as a positive sign that members are receiving important care that could prevent future health crises. The hope is that care utilization will begin to decline over time.

## Program Implementation

---

Mount Rubidoux Manor and IEHP launched their collaboration on Valentine's Day 2019 with a "Care for You" themed event. Representatives from HumanGood and IEHP, and Mount Rubidoux's resident service coordinator, spoke to residents about the new initiative and introduced the new health navigator. The partners also hosted additional town hall meetings to educate members about the initiative, and disseminated program information through fliers and newsletters.

At the Valentine's Day event, IEHP launched a short survey to get a sense of residents' interests, support networks, perceptions of their health, and feelings about whether their life had meaning. The survey was designed to help IEHP consider what kind of programs, activities, and supports it might offer residents. IEHP also asked if residents would be interested in meeting with the health navigator. Of the 43 survey respondents, 21 indicated they would like to meet with the navigator.

### Health Navigator Role

Initially, the health navigator was available on-site one day per week. Her presence quickly expanded to two days, and then three days, per week. As awareness of the health navigator spread, an increasing number of residents became interested in meeting with her.

IEHP expanded the navigator's time at Mount Rubidoux Manor in an effort to be responsive to resident interest, and to allow the navigator to build rapport with residents and complete resident health appraisals, which took longer than anticipated. These assessments revealed residents' complex health issues and the need for consistent follow-up to address those issues. Resident engagement with the health navigator increased as residents became more comfortable with the navigator and recognized the advocacy and assistance she could provide.

The health navigator engages with all residents in the building, whether or not they are IEHP plan members. When interacting with non-members, the health navigator answers questions to the best of her ability and then connects residents to their health provider or health plan, if they have one. Group activities coordinated by IEHP and its partners are also open to all residents. IEHP is willing to assist non-members as part of its mission to “organize and improve the delivery of quality, accessible, and wellness-based health care services for [the] community.”

Residents can see the health navigator on a walk-in basis. Appointments are not needed, but can be made, if desired.

The health navigator does not provide clinical services, but helps residents connect to their primary care physicians or specialists when care is needed. She also helps residents resolve issues, such as sorting out prescription mix-ups. The health navigator tries to address issues alongside residents, teaching them what to do rather than doing everything for them. The goal is to empower residents to address their own needs in the future.

IEHP health navigators, including the navigator stationed at Mount Rubidoux Manor, conduct a health appraisal with each plan member with whom they work. The assessment is designed to help identify issues that could be affecting a member’s health, and to connect individuals with resources to help address problems or fill gaps. The assessment instrument reviews social circumstances and physical and emotional health characteristics and behaviors. Mount Rubidoux Manor’s health navigator modified IEHP’s health appraisal slightly so it is appropriate for the housing community’s population and allows her to gather additional information.



The health navigator conducts a shorter health appraisal with non-plan members. The resident service coordinator also continues to conduct assessments with these residents, using an online tool developed by the American Association of Service Coordinators. All assessments are voluntary.

IEHP initially expected that the health navigator would complete about 15 resident assessments per month. However, the health plan found that residents often are not willing or are unable to complete the full assessment in one sitting. Because the health navigator is on-site, however, she is able to gather assessment information over multiple interactions at a pace that is comfortable for residents.

The health navigator encourages each resident to set goals in any area of their life they would like to improve. Goals have addressed such aspirations as being more intentional about making friends, going out for walks, or losing weight. If the resident is unable to identify goals, the health navigator will suggest possibilities based on what she has learned from the resident. For instance, the health navigator might point out that a resident said they do not know how to use their cell phone or would like to walk more. She might then suggest the resident set a corresponding goal. Being in the building regularly, the health navigator is able to check in with residents to see how they are doing with their goals, and to offer encouragement or support.

### **Health Navigator and Resident Service Coordinator Collaboration**

The resident service coordinator and health navigator at Mount Rubidoux Manor communicate and coordinate with each other extensively. Before any information-sharing about residents takes place, however, the coordinator and the navigator ask a resident if they can discuss the resident’s issues with each other. The resident must sign a consent form before any sharing can begin. Almost all residents who have been asked for permission to share their information have granted it. Currently, all sharing of information is verbal; data is not shared electronically.

When the resident service coordinator or health navigator becomes aware of a resident's need or an issue with which a resident is struggling, they talk to one another to see how they can support the resident. In addition to informal interactions, the resident service coordinator and health navigator meet formally each week to review resident issues and needs.

The resident service coordinator and health navigator work somewhat regularly with a group of about 40 residents. Several of these residents have behavioral health concerns.

With the resident's permission, the resident service coordinator and health navigator communicate with family members when it is appropriate. Frequently, the family member is the resident's caregiver. The resident service coordinator and health navigator want to ensure the family member is informed about the resident's care. They also communicate with family members when a resident's behavior is violating the rules of the housing community and their housing may be in jeopardy.

The health navigator helps address a variety of questions and issues, including queries from residents who:

- ➔ Are not sure who their insurance provider is.
- ➔ Do not have a doctor or are not happy with their doctor.
- ➔ Do not know who their case manager is, if they have one.
- ➔ Are having difficulty getting an appointment with their provider.
- ➔ Are having challenges with a referral or a prescription.

Before the health navigator was available, the resident service coordinator helped residents with these types of questions. It could take a great deal of time for the resident service coordinator to figure out where to direct various questions or how to resolve issues with health plan staff or providers. As an IEHP employee, the health navigator can answer questions and resolve issues more quickly. When a resident is not an IEHP member, the health navigator helps as much as she can by advocating for the resident with their assigned health insurance and addressing issues expressed by the resident.

This arrangement has freed up the resident service coordinator to focus on other resident needs, particularly ones that are more complex and time-intensive, such as issues involving adult protective services and lease violations.

Sometimes a resident will share a concern with the health navigator about an issue that is not health-related, such as difficulty paying rent or affording other necessities. In these cases, the health navigator will connect the resident with the resident service coordinator. Traditionally, IEHP's health navigators would help members address concerns related to the social determinants of health. To avoid duplication with the resident service coordinator, however, Mount Rubidoux Manor and IEHP clarified early in their collaboration that the health navigator would focus on medical issues and the resident service coordinator would be responsible for linking residents with non-medical resources to meet their needs.

## Programming

To help inform what types of programming to offer, the health plan's ILDS team conducted a short survey with residents asking about their interests in activities for mind, body, and health. Based on the survey responses, and feedback from the navigator's health appraisals showing resident concerns about depression and social isolation, the team identified several areas of interest, including:

- ➔ Healthy eating, weight management, and diabetes classes.
- ➔ Exercise for people with disabilities.
- ➔ A walking club.
- ➔ Meditation and healthy mind exercises.
- ➔ Emotional wellness services.



IEHP staff have conducted several classes on site, including: Diabetes 101; My Life, My Choice (Advance Care Directive); Asthma 101; and Alzheimer's 101. Additionally, the ILDS team coordinated with other community-based organizations to provide the Program to Encourage Active Rewarding Lives (PEARLS), an evidence-based depression program; the Health Insurance Counseling & Advocacy Program/Senior Medicare Patrol Program; and a self-defense workshop.

IEHP also coordinated with La Sierra University to place undergraduate social work students at the housing community as part of their degree requirement to complete a 420-hour internship in a community setting. In October 2019, two social work interns started working at the housing community for 13 hours a week.

The social work interns initially shadowed Mount Rubidoux Manor's resident service coordinator to learn what she does and the kind of issues she helps residents address. The interns observed the resident service coordinator's work, which ranges from answering basic questions to supporting a 911 call and making a report to Adult Protective Services. Interns also shadowed the health navigator while she conducted health appraisals and assisted residents.



After learning about the residents and the housing community, the interns began developing programming ideas that would be responsive to residents' needs and interests, help reduce social isolation and depression, and encourage residents to connect with neighbors, friends, and family.

For example, the interns hosted "tech hours," during which residents could have questions answered about how to use the internet, open a Facebook account, and use equipment like phones, laptops, Kindle readers, and computer apps. One consideration in choosing to implement the tech hours program was the hope that it could help engage residents who do not typically participate in social events or other programming, but might come out of their apartments to gain assistance with their computers or other tech gadgets.

The interns also created Coffee with a Purpose, a walking club, and a cooking class that one resident leads.

The health navigator and resident service coordinator communicate and coordinate with the social work interns. They alert interns to the needs or interests they are hearing about from residents so the interns can consider these ideas when planning programs and activities. The resident service coordinator meets weekly with the interns to review the students' plans for the week. The housing community's manager joins this meeting once a month.

### **Interaction with Property Management Team**

The resident service coordinator and health navigator also engage with the housing community's management team. These staff members serve as valuable "eyes and ears" around the community. For example, a maintenance person working in an apartment may observe something potentially concerning, such as a resident who is not keeping their apartment as clean as usual or a resident who is struggling to move around. That team member can let the resident service coordinator know about their concern so the resident service coordinator can follow up with that resident.

Mount Rubidoux Manor's entire team meets every morning to discuss what is going on at the community, including any resident concerns. The resident service coordinator participates in this daily meeting and the health navigator joins in on days she is at the housing community. During all discussions involving residents, the team maintains resident privacy appropriately. The resident service coordinator and health navigator do not share residents' personal or health information, and only note that they are assisting residents with concerns so that the housing community team is aware that issues are being addressed.

A growing number of residents with behavioral health concerns live at Mount Rubidoux Manor. Housing community team members were experiencing difficult interactions with residents, such as outbursts and false accusations, and team members did not have the skills to respond. In an effort to help build the capacity of team members, HumanGood asked a community partner organization to provide all housing community team members with a full-day training to help them understand mental health issues and respond to individuals exhibiting mental health-related behaviors.

Mount Rubidoux Manor also implemented a process of sharing lease violation notices with the resident service coordinator so she can attempt to help residents address violations and prevent further action from being taken against them. Depending on the situation, the resident service coordinator will reach out to the resident, family members, a case manager (if the resident has one), or other relevant service providers to help address the violation. The goal is to help the resident maintain their housing or transition to a safe setting if they are not able to stay at the housing community.

### Collaboration During the COVID-19 Pandemic

IEHP and HumanGood temporarily altered program activities in response to COVID-19. The health navigator was pulled off-site and her interactions with residents are now conducted by phone. The health navigator continues to follow up with any residents whose cases she is managing, reach out to new residents who are referred to her, and hold weekly check-in calls with the resident service coordinator. The resident service coordinator continues to work on-site, assessing resident needs and helping to address ongoing challenges and new needs created by the pandemic.

The LaSierra University interns launched a friendly-caller program called “Staying Connected” to help address social isolation and check on residents. Interns were provided training and informational materials so they could refer residents directly to appropriate resources and so they would know when to refer a resident to the health navigator or resident service coordinator.

IEHP also provided Mount Rubidoux Manor with supplies of hand sanitizer and personal protective equipment, including masks and gowns. The health plan also worked with the Riverside County public health department to make COVID-19 testing available onsite to those who wanted testing, including all residents and caregivers working in the housing community. In August 2020, IEHP began providing all Mount Rubidoux Manor residents with weekly food boxes, which include fresh produce, meat, eggs, milk, cheese, and other dairy products.



# Initial Observations on the Housing and Health Plan Collaboration

---

The resident service coordinator and health navigator found that residents were initially confused and skeptical when the health navigator first arrived at Mount Rubidoux Manor. Some residents suspected the health navigator's primary mission at the housing community was to convince them to switch their health plan membership to IEHP.

Both the resident service coordinator and the health navigator believe residents have now accepted the program. Several factors contributed to this evolution:

- ➔ **Regular Presence:** From the beginning, the health navigator had a regular presence at the housing community, beginning with one day a week and expanding to three days a week. The expanded presence increased the opportunity for the health navigator to interact with residents at events, have one-on-one meetings, be visible throughout the building, and resolve residents' questions or issues more quickly. This prompt follow-through helped build trust in the health navigator, as did residents' perception that the health navigator was knowledgeable about health care and authentic in her interactions with them.
- ➔ **Endorsements from Others:** Residents had good rapport with the resident service coordinator, which led them to trust the service coordinator's endorsement of the health navigator and IEHP's program. Residents also began referring their fellow residents to the health navigator.
- ➔ **Inclusive Communication:** The health navigator is bilingual, which allows some residents to feel comfortable connecting with her.

Some residents have joined the IEHP health plan because of the convenience of having the health navigator present in the building. These residents feel this on-site presence makes it easier for them to get questions answered or issues resolved. They appreciate not having to talk to someone on the phone, figure out who to call, or make multiple phone calls. The health navigator's connections with internal IEHP departments makes it easier for her to obtain answers to residents' questions and to facilitate warm handoffs. The health navigator also advocates for residents with outside community-based organizations, when needed.

The health navigator sees many advantages to being stationed at the housing community. Being able to see residents on a regular basis allows the health navigator to build closer connections with plan members/residents. This on-site presence also allows the health navigator to follow up with individuals more easily. She can ask residents questions when she sees them in the hall, follow up with them on tasks they are supposed to complete, or update them on issues she is helping them resolve.

# Early Program Evaluation

---

As mentioned previously, the partnership between HumanGood and IEHP was initiated as a pilot with a focus on learning how the partners could work together and how IEHP could assist housing community residents, including plan members and non-members. IEHP examined the first 13 months of the program's activities to see if the health plan had been successful in meeting its initial goals, which included:

- ➔ Conduct in-person health appraisals with IEHP members.
- ➔ Identify needs associated with the social determinants of health and link IEHP members to appropriate resources.
- ➔ Address behavioral health and care management needs through appropriate referrals.
- ➔ Address member needs related to Healthcare Effectiveness Data and Information Set (HEDIS) measures, including flu shots and screenings for breast cancer, cervical cancer, and colorectal cancer. (HEDIS is used to evaluate health plan performance on delivering service and care to plan members.)
- ➔ Promote greater socialization and interactions with others among both IEHP members and non-members.
- ➔ Provide smoking cessation referrals.
- ➔ Provide follow-up services to all residents who received outreach.

The health navigator completed 48 health appraisals with 38 IEHP members and 10 non-members during the program's first 13 months. The health navigator was able to address needs identified in the appraisals by:

- ➔ Assisting with scheduling medical care appointments.
- ➔ Making referrals to health education programs, such as blood pressure management, diabetes prevention or management, "Eat Healthy, Be Active" workshops, asthma classes, and other programs.
- ➔ Making referrals for behavioral health concerns, such as depression and anxiety, to IEHP's behavioral health department and support groups.
- ➔ Connecting residents to local community resources and IEHP programs to address concerns associated with the social determinants of health, including access to clothing, self-care items, household items, transportation, and nutrition.

The health navigator checks back with residents approximately three weeks after an initial contact, depending on the resident's circumstances. The health navigator assesses how well the resident followed through on referrals and recommendations and whether there are any outstanding needs. During these visits, IEHP found that many health plan members had followed through on the health navigator's referrals and recommendations.

The initial health appraisal also asks individuals how they rate their physical, mental, and social health. IEHP members were asked these questions again between three and 12 months after their initial appraisal. The follow-up appraisals showed a general improvement in residents' ratings across all of these aspects of their lives.

Finally, IEHP was pleased with the programming it was able to coordinate at the housing community to help address social isolation, depression, and health and wellness across the resident population. Approximately 40% of residents participated in a wide range of programming that was delivered by the LaSierra University interns, IEHP's Health Education Department, and other community organizations.



# Examples of Successful Interventions

---

The resident service coordinator and health navigator have already worked together to address some challenging issues involving residents. Here are a few examples of their successes.

## Addressing the Needs of a Disruptive Resident

A resident with alcohol misuse issues was causing disruptions at the housing community. After the resident service coordinator introduced the resident to the health navigator, the navigator worked with the resident to conduct an assessment, which helped the navigator learn about the resident's concerns. The health navigator connected the resident with care providers who could address physical and mental health concerns, and provided the resident with information about substance abuse support group meetings.

Based on the resident's expressed interests, the team also connected the resident with computer classes, provided information on local events and activities, and referred the resident to a community organization where the resident could explore employment opportunities. One of the social work interns worked with the resident, providing resources on learning how to type, develop a resume, use a laptop, and set up a Skype account.

The results of all these interventions have been promising. The resident is having positive interactions with other residents and staff, and engaging in healthy activities.

## Welcoming a Housing Program Participant

The resident service coordinator and health navigator were also able to help a new resident who moved to Mount Rubidoux Manor after living in a skilled nursing care setting for several years. The resident came to the housing community as part of the IEHP Housing Program, for which Mount Rubidoux Manor sets aside housing units. As part of this program, the resident receives case management services from a partnering community organization.

The resident service coordinator and health navigator have connected the resident with a walking club at the housing community and computer classes at a local senior center. By all reports, the resident has flourished since moving to Mount Rubidoux Manor, is active around the community, and needs limited assistance from the resident service coordinator or health navigator.

## Tapping into a Resident's Love of Cooking

Another new resident had been living in a hotel room before moving to the housing community as part of the IEHP Housing Program. While conducting a health appraisal with the resident, the health navigator discovered that the resident loves to cook. The navigator connected the resident with classes and other programs at the housing community. Before long, the resident was teaching a class that showed residents how to cook healthy meals using ingredients they receive in their commodity food boxes.

Although the resident initially did not want to move to Mount Rubidoux Manor, the team reports that the resident has become an active participant in the housing community, made many social connections, and regained purpose and dignity.

## Empowering Residents

The health navigator strives to empower residents to handle issues for themselves. For example, she coaches residents on the types of questions they should ask and information they should share at a doctor's appointment. The health navigator is seeing some success with residents on this front. One resident recently thanked the navigator, expressing

pride at being able to ask a doctor questions, suggested by the health navigator, which yielded information the resident wanted to know about their health.

## Building Community

IEHP also hopes to build community and connections among residents. In a recent diabetes education class hosted by the health plan, a resident with diabetes sat next to another resident who had been recently diagnosed with diabetes. The first resident, a long-term diabetic, gave the other resident their phone number and told the resident to call them so they could answer questions and help the new diabetic learn how to manage the disease. This is the kind of support IEHP hopes to facilitate among residents.

## Next Steps

---

The Health Navigator Program at Mount Rubidoux Manor is in an initial stage, and the partners are continuing to discover ways to improve their coordination with each other and identify elements they can add to the program.

### Working with Case Managers

IEHP may explore opportunities to make better connections between health plan case managers and their clients living at Mount Rubidoux Manor. Plan members are often confused about who their case manager is or what the case manager does. As a result, these members may not be responsive when case managers reach out to them. Case managers have begun to ask the health navigator to help them get in touch with their clients at the housing community. IEHP may also explore the possibility of consolidating the number of case managers who are connected to residents in the building.



### Behavioral Health Support

To help address behavioral health needs in the housing community, IEHP is exploring the possibility of bringing a behavioral health specialist on site to provide one-on-one support to residents with the help of the health navigator.

### Sharing Information

IEHP and Mount Rubidoux Manor will also continue examining how they share information while respecting residents' privacy. Currently, all information sharing is verbal, and no electronic data is exchanged. The partners would like to see if they can reach a point where assessment information that the resident service gathers about new residents can be passed to the health navigator so the navigator is not asking residents duplicate questions.

### Working with Care Partners

IEHP and Mount Rubidoux Manor also plan to explore ways in which they may be able to work more successfully with aides from the In-Home Supportive Services (IHSS) program. IHSS is a Medi-Cal program that provides individuals who would otherwise need a nursing home level of care with in-home care services to help them remain safely in their home. IHSS care providers help eligible participants meet their needs for meal preparation, shopping, laundry, and personal care, including bathing and dressing.

Residents hire their IHSS care providers directly. They can hire someone they know, such as a family member or friend, or someone from a registry of care providers maintained by a county entity. The care providers are not connected to IEHP or the housing community. About 50 Mount Rubidoux Manor residents, including several who are members of IEHP, have IHSS care providers. Because the care providers spend a great amount of time with, and provide important care to, their plan members, IEHP would like to see if it could develop better connections and communication with the care providers as a way to better support their mutual clients.

In an effort to provide resources and tools for the IHSS care providers assisting IEHP members, IEHP conducted a training session highlighting health plan benefits and local resources. Eight IHSS care providers, some of whom work with several Mount Rubidoux Manor residents, attended the education session. IEHP hopes to provide additional training to IHSS care providers and help create a network among the IHSS aides who work in the housing community. Many of the care providers are independent contractors and do not work for an agency that could provide them with these types of support.

### Tailoring Programming

IEHP stratifies plan members by clinical risk scores to help guide their engagement with plan members. Risk scores predict a person’s probability of using health care services, particularly hospital and emergency department services. Individuals with higher risk scores are more likely to use these types of services.

Adjusted Clinical Group (ACG) Risk Category	# of IEHP Members
High Risk	20
Rising risk	37
Low risk	39
Incomplete data	5

IEHP examined the risks scores for the 101 IEHP members living in Mount Rubidoux Manor in June 2020. Approximately one-fifth of these members were considered high risk and about one-third were categorized as rising risk. Going forward, IEHP will consider how the services and programming offered at Mount Rubidoux Manor can help stabilize or decrease risk scores for plan members in the housing community.



*Research bridging policy and practice*

**WASHINGTON, DC OFFICE**

2519 Connecticut Avenue NW  
Washington, DC 20008  
202-508-1208  
LTSScenter@leadingage.org

**BOSTON OFFICE**

Wheatley Hall, 3rd Floor, Room 124A  
University of Massachusetts Boston  
100 Morrissey Blvd.  
Boston, MA 02125  
617-287-7324  
LTSScenter@umb.edu

Visit [www.LTSSCenter.org](http://www.LTSSCenter.org) to learn more.