Housing for New Hope's Assertive Engagement Team

Overview

Housing For New Hope's Assertive Engagement Intensive Case Management Team (AE) meets people where they are at, literally (e.g., street, shelter, woods, crisis facility, etc.) and figuratively to address various life domain issues and behavioral health needs for the uninsured homeless. Through assertive engagement, motivational interviewing, and other recognized evidenced-based and best practices, AE works to get individuals connected and/or reconnected to needed healthcare providers, housing resources, and a sense of hope and possibility.

AE was made possible through start-up funding by the Kate B. Reynolds Foundation (a three-year grant of $180,000, beginning in 2008) and the GlaxoSmithKline Foundation. Based on the success of the program, the Durham Center began funding AE in 2009, and has increased funding to expand the team from three to four staff and the caseload to fifty.

Outcomes

- Nearly 100 percent (95.3 percent) of individuals are met in person by AE staff on the day of the referral. Oftentimes, after the individual is assessed at Durham Center Access by the Assessment Team and is referred to AE, staff will meet the individual within an hour or two at DCA to discuss treatment goals, begin the intake, and begin getting the individual connected to behavioral health and primary care.
- Nearly 90 percent of individuals not already connected to a primary care provider are connected and have an appointment with a primary care giver within 60 days of service—oftentimes through Lincoln Homeless Health Clinic. Nearly 100 percent are connected within 90 days of service.
- AE allows for the level of care that is needed, and enables staff to ensure individuals make their needed appointments through community outreach, transportation, and follow-up services. For many individuals, AE is the greatest form of aftercare that can be afforded, as traditional community-based services and funding structures make it difficult to engage with a population that tends to be very transient, oftentimes not having regular access to a phone or a regular address.
- AE follows-up with 100 percent of individuals they serve that are hospitalized/institutionalized and is a part of discharged planning whenever asked to ensure community-based resources are in place wherever possible.