

H² FINAL REPORT



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Planning Sessions Materials Development, and HMIS Data Collection Tools & Materials, with a performance period of October 2014 – March 2017. Cooperative Agreement # V-11-TA-MA-3003 consists of one work plan - Housing-Healthcare Systems Integration TA Products and Tools, with a performance period of October 2014 – March 2017.

Three technical assistance firms, which comprise HUD's Affordable Care Act (ACA) TA Work Group, were selected to carry out the tasks contained within these four work plans: American Institutes for Research (AIR) Collaborative Partnership / Sub-Contractor HomeBase as the Lead Agency, along with Technical Assistance Collaborative, Inc. (TAC) and Training & Development Associates (TDA) / Collaborative Solutions, Inc. (CSI).

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EXECUTIVE SUMMARY

HUD's Office of Special Needs Assistance Programs (SNAPS) and Office of HIV/AIDS Housing (OHH)¹ coordinated with the U.S. Interagency Council on Homelessness (USICH) and Federal Partners at the U.S. Department of Health and Human Services (HHS) whose grant and policy priorities align with those of SNAPS and HOPWA to sponsor the Housing and Healthcare (H²) Systems Integration Initiative, a comprehensive technical assistance (TA) effort to support states and communities in undertaking the systems changes needed to enhance integration and collaboration between the housing and healthcare systems. The goal was to maximize care coverage for people who are homeless and/or low income and living with HIV/AIDS and to increase the coordination of comprehensive healthcare and supportive services with housing. This TA was made available to all recipients, sub-recipients and project sponsors of the following HUD programs: Continuum of Care (CoC), Emergency Solutions Grants (ESG), and Housing Opportunities for Persons with AIDS (HOPWA).

The Housing and Healthcare (H²) Systems Integration Initiative encompassed three complementary components that worked together to support communities and states in taking systems-level action to improve the effective utilization of mainstream healthcare services and coordination of care for program participants needing both housing and healthcare services.

1. **Action Planning Sessions:** These 1.5-day sessions were the core of the H² Initiative, and were held in 20 communities and states nationwide. These sessions convened representatives from Continuums of Care and ESG programs, HIV/AIDS provider networks (including HOPWA-funded programs), local/state healthcare agencies, HUD and HHS regional and field offices, and other interested parties to develop action plans to guide system-level integration efforts to improve access to and effective utilization of healthcare services for SNAPS- and OHH-supported program participants.
2. **Communication, Knowledge Dissemination and Coordination:** Information was developed to support state and local action to integrate efforts to address housing and health needs, including a series of webinars, ongoing listserv messages from HUD on key topics, and a HUD ACA webpage providing access to helpful resources and tools.
3. **Data Collection and Quality Improvement:** Recommendations were developed for adjusting the CoC program Annual Performance Report (APR) template and HMIS data collection requirements in order to better capture health insurance status. A tool was developed to assist CoC frontline workers in more easily collecting health insurance status information from program participants.

Overview of Key Accomplishments²

Initiative level Accomplishments

- 20 action planning sessions were carried out, reaching 102 Continuums of Care and involving 1,249 stakeholders representing federal, state and local homeless, housing, and healthcare systems.
- A H² Learning Community was launched, with a total of 3 gatherings taking place.
- Performance measures and benchmarks were developed that can be used to monitor and document progress toward housing/healthcare integration (see below).

¹ OHH administers the Housing Opportunities for Persons with AIDS (HOPWA) program.

² More detail on the accomplishments can be found in the body of the report.

- Based on the Action Planning Sessions, a suite of tools to support CoCs in working toward housing and healthcare integration have been developed (See Appendices).

State and Community Level Accomplishments

The H² Action Planning state and community level accomplishments have been documented in terms of progress toward the H Initiative objectives of integrating homeless assistance and healthcare systems and services. Progress towards these objectives can be measured in each of six performance categories laid out in the table below. More detailed listings of the accomplishments in each performance category, organized by target outputs and outcomes, can be found in the body of the report; along with emerging best practices and community success highlights.

H Initiative Objective: Integrated and coordinated housing and healthcare that fosters: <ul style="list-style-type: none"> • Housing stability, health and wellness for people who are homeless or at risk • Efficient, effective use of healthcare and housing resources. 	
Performance Category ³	Key Community Accomplishments
1. Systems Change Planning and Leadership	<ul style="list-style-type: none"> • Leadership Teams and Action Plans are being incorporated into existing state level structures, such as interagency councils or state plans. • Medicaid Directors and other high level staff are participating in Action Plan implementation.
2. Enrollment	<ul style="list-style-type: none"> • Federal resources, including Cooperative Agreements to Benefit Homeless Individuals (CABHI), Health Care for the Homeless, and others, are being used to support and expand Medicaid enrollment efforts. • Communities are exploring how to streamline the Medicaid application process, including by linking eligibility to SSI eligibility and through use of a single application for Medicaid and SSI.
3. Engagement	<ul style="list-style-type: none"> • Healthcare staff are being out-stationed at shelters and homeless programs. • Clinics are being co-located at permanent supportive housing and other affordable housing sites.
4. Integration	<ul style="list-style-type: none"> • Discharge planning programs are being developed, involving cross-system coordination. • Establishment of recuperative care programs are being explored, including securing funding from hospitals and MCOs. • Common or shared assessment processes are being developed, including participation of health providers in the coordinated entry system. • Cross- trainings are being conducted between the homeless assistance/housing and healthcare systems.

³ Note: Though the categories are derived from the action planning *Model Strategies Framework* the numbering is not the same as the Systems Change Planning and Leadership category has been added in at the top of the list.

5. Data-Driven Interventions	<ul style="list-style-type: none"> • Data matches are being conducted across systems to both demonstrate the need for collaboration and identify members of target populations, including: <ul style="list-style-type: none"> ◦ Frequent user data matches across systems (e.g. homeless assistance, criminal justice, healthcare) to identify most vulnerable. ◦ Comparison of existing State Medicaid plan covered services with those most needed by people experiencing homelessness in order to target Medicaid enrollment to people who need/use those services.
6. Resource Maximization	<ul style="list-style-type: none"> • Communities are leveraging support of Federal Partners: <ul style="list-style-type: none"> ◦ HRSA: Building or improving relationships with Federally Qualified Health Centers, including encouraging Health Centers to apply to open new sites in strategic locations and/or for funding to serve people experiencing homelessness. ◦ SAMHSA: Applying for and utilizing CABHI grants to facilitate H² Action Plan implementation. ◦ CMS: Applying for and participating in CMS Innovation Accelerator Program Technical Assistance efforts. • States are seeking to maximize use of Medicaid to support housing stability through submittal of waivers and state plan amendments⁴. • Communities are working with Public Housing Authorities to create set-asides or preferences for people experiencing homelessness and/or people who are ready to transition out of PSH but still need affordable housing.

Communication, Knowledge Dissemination and Coordination Accomplishments

- Built relationships and interaction among Federal Partners through monthly phone conferences, participation in action planning sessions, and other engagement.
- Facilitated alignment with other TA initiatives, including connecting H² communities/Leadership Teams to ongoing or future programs (e.g. CMS' Medicaid Innovation Accelerator Program; NHCHC's assistance with creating/funding recuperative care programs to assist with H² Action Plan implementation).
- Created the HUD Exchange ACA website, including an H² "mini-site," which provides information on each of the H² Action Planning session sites.
- Completed series of six webinars and sent several listserv messages.

⁴ HomeBase was able to leverage lessons learned from the H² Initiative to advance complementary efforts in Washington and California (under Chronic Homeless Policy Academy technical assistance). In Washington, HomeBase assisted the state in preparing and submitting an 1115 waiver application that includes a supportive housing benefit, and continues to help the state build capacity to implement the benefit. In California, three H²-like planning sessions were held (in Northern, Central, and Southern California) to assist counties throughout the state in maximizing the use of the state's Medicaid program (including through a recently approved 1115 waiver and Health Homes amendment) to fund services that support housing stability and to increase coordination across housing and healthcare systems.

Data Collection and Quality Improvement Accomplishments

- Recommended changes to APR questions, leveraging data already collected in the HMIS (See Appendix P).
- Recommended additions and improvements to HMIS data standards (See Appendix Q).
- Developed a sample benefits decoder tool to assist front line workers in gathering information on health insurance status (See Appendix R).

Recommended Next Steps (2017-2019)

- Provide additional support to H² communities, including holding a H² Leadership Academy; convening a Learning Community Series; continuing Federal Partner support and involvement in Action Plan implementation efforts; maintaining an up-to-date website; conducting quarterly webinars; continuation of the Listserv; and development of implementation tools to help communities track progress.
- Develop a Data Enhancements Mini-Team to further explore the role of HMIS in empowering CoCs to effectively advocate for their clients, including incorporating changes to HMIS Data Element 4.4 (Health Insurance); developing additional HMIS Data Elements to improve healthcare management functionality; and exploring the HIPAA/privacy implications of these proposals.
- Re-open the H² Action Planning opportunity to 20 additional states and communities.
- Develop performance measures on healthcare delivery and housing, based on the performance categories and target outputs and outcomes developed for the H² Initiative.
- Develop web-based H² action planning session training modules and other tools.

Three technical assistance firms, which comprise HUD's ACA TA Work Group, carried out the H² Initiative, including: American Institutes for Research (AIR) Collaborative Partnership / Sub-Contractor HomeBase as the Lead Agency along with Technical Assistance Collaborative, Inc. (TAC) and Training & Development Associates (TDA) / Collaborative Solutions, Inc. (CSI).

I. HOUSING AND HEALTHCARE (H²) SYSTEMS INTEGRATION INITIATIVE OVERVIEW⁵

BACKGROUND/CONTEXT

The U.S. Department of Housing and Urban Development (HUD)'s Office of Special Needs Assistance Programs (SNAPS) and Office of HIV/AIDS Housing (OHH) serve the nation's most vulnerable people experiencing or at-risk of homelessness. This population faces disproportionately high rates of chronic and co-occurring health and behavioral health conditions, which when untreated, undermine their ability to access and maintain stable housing. As such, addressing their health-related needs is recognized as a key component of efforts to prevent and end homelessness.

It has also become increasingly clear that addressing the need for stable housing is essential to helping people maintain health and wellness, as well as to controlling costs that stem from unnecessary emergency room utilization and hospital admissions. This intersection between the housing and healthcare systems offers potential to better serve vulnerable individuals who are experiencing or at-risk of homelessness and to reduce costly duplicative and inefficient service provision. This is important to HUD's mission to prevent and end homelessness and also to the mission of its Federal Partners at the U.S. Department of Health and Human Services (HHS) whose programs target these same populations.

The passage of the Patient Protection and Affordable Care Act (ACA)⁶ – with its option to expand eligibility to include most people who are homeless and its emphasis on integrated, whole-person care – significantly expanded

the possibilities for improving and creating linkages between the housing and healthcare systems, and therefore to achieve better outcomes for the people served. At the same time, proven examples of how to accomplish such linkages are emerging from around the country, including health homes, permanent supportive housing, healthcare and housing navigators, and case management/care coordination strategies, to name just a few. Unfortunately, in a response to a HUD survey by 410 homeless Continuums of Care (CoCs)⁷ in the country, most indicated that they were unprepared to take advantage of ACA opportunities and did not have significant relationships with healthcare entities in their communities. This lack of connection with mainstream systems and services is also evidenced by data from the 2014 CoC awards showing that a full 25% of awards nationally are for supportive services (see chart below).

HUD Encourages CoCs to Maximize Use of Mainstream Services

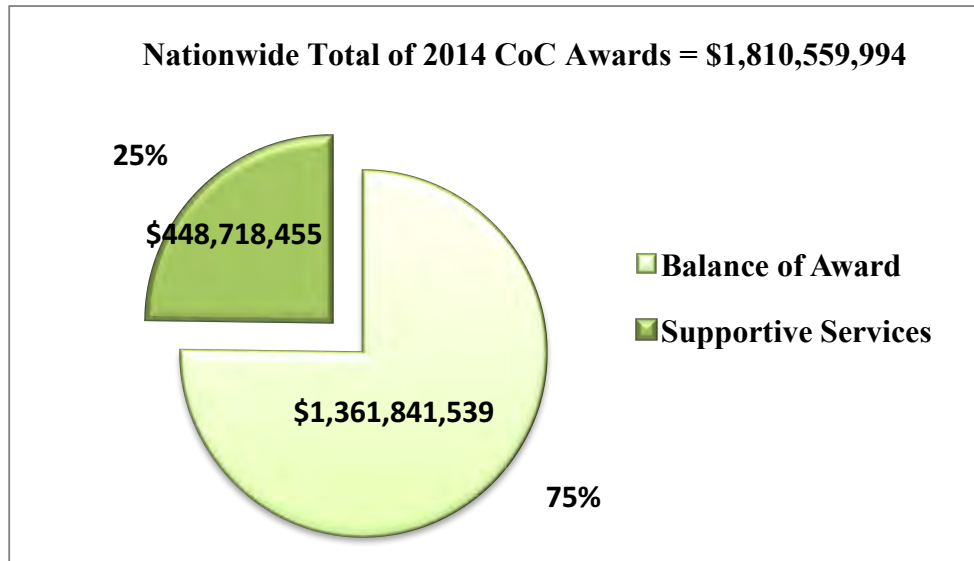
"... it is more efficient for CoCs to use mainstream resources, where possible, and use HUD funds for housing-related costs. CoCs should proactively seek and provide information to recipients within the geographic area about mainstream resources and funding opportunities."

Source: 2013-2014 CoC Program NOFA

⁵ More information on the H² Initiative is available at: <https://www.hudexchange.info/programs/aca/h2/>.

⁶ Beginning in 2014, the ACA provided for a Medicaid expansion to nearly all individuals with incomes up to 138% of the federal poverty level (FPL) (\$15,415 for an individual or \$26,344 for a family of three in 2012). The ACA also included new requirements for states to significantly streamline Medicaid enrollment processes.

⁷ Refers to a mandatory question by HUD in the 2013-14 CoC Competition. Outcomes cited in: Community Planning and Development Powerpoint, "HUD's Technical Assistance (TA) to Improve Integration between Housing and Healthcare Systems", presented by Roula K. Sweis, SNAPS Senior Program Advisor, Office of Special Needs Assistance Programs (SNAPS).



While the CoC Program Interim Rule allows for the payment of certain supportive service costs and Supportive Services Only projects, HUD strongly encourages CoCs and project applicants to maximize the use of all available mainstream services, thereby allowing more HUD funds to be used for housing-related costs. For example, mental health services, outpatient health services, and substance abuse treatment services are all services permitted to be funded by CoC grant funds, but which could be funded by other federal mainstream resources. In 2012, spending on those three types of healthcare services by CoC grantees accounted for 11.3% of the total CoC award budget.

Against this backdrop of grantee need and HUD priorities, HUD's Office of Special Needs Assistance Programs (SNAPS) and Office of HIV/AIDS Housing (OHH)⁸ coordinated with the U.S. Interagency Council on Homelessness (USICH) and Federal Partners at the U.S. Department of Health and Human Services (HHS) whose grant and policy priorities align with those of SNAPS and HOPWA to sponsor the Housing and Healthcare (H²) Systems Integration Initiative, a comprehensive technical assistance (TA) effort to support states and communities in undertaking the systems changes needed to enhance integration and collaboration between the housing and healthcare systems. The goal was to maximize care coverage for people who are homeless and/or low income and living with HIV/AIDS and to increase the coordination of comprehensive healthcare and supportive services with housing. This TA was made available to all recipients, sub-recipients and project sponsors of the following HUD programs: Continuum of Care (CoC), Emergency Solutions Grants (ESG), and Housing Opportunities for Persons with AIDS (HOPWA).

Three technical assistance firms, which comprise HUD's ACA TA Work Group, were selected to carry out the H² Initiative, including: American Institutes for Research (AIR) Collaborative Partnership / Sub-Contractor **HomeBase** as the Lead Agency along with Technical Assistance Collaborative, Inc. (**TAC**) and Training & Development Associates (**TDA**) / Collaborative Solutions, Inc. (**CSI**).

H² Goal: to maximize care coverage for people who are homeless and/or low income and living with HIV/AIDS and to increase the coordination of comprehensive healthcare and supportive services with housing.

⁸ OHH administers the Housing Opportunities for Persons with AIDS (HOPWA) program.

H² INITIATIVE COMPONENTS

The Housing and Healthcare (H²) Systems Integration Initiative encompassed three complementary components that worked together to support communities and states in taking systems-level action to improve the effective utilization of mainstream healthcare services and coordination of care for program participants needing both housing and healthcare services. The core of this TA initiative was the Housing and Healthcare Systems Integration Action Planning Sessions that were provided to 20 selected communities and states nationwide.

4. Action Planning Sessions: These 1.5-day sessions convened representatives from Continuums of Care and ESG programs, HIV/AIDS provider networks (including HOPWA-funded programs), local/state healthcare agencies, HUD and HHS regional and field offices, and other interested parties to develop action plans to guide system-level integration efforts to improve access to and effective utilization of healthcare services for SNAPs- and OHH-supported program participants.
5. Communication, Knowledge Dissemination and Coordination: A series of webinars was developed and presented to support state and local action to integrate efforts to address housing and health needs. In addition, HUD sends ongoing listserv messages on key topics that support state and local efforts to improve HUD program participants' access to, and effective utilization of, healthcare services in the context of ACA. HUD launched, and then improved, its ACA webpage in order to facilitate easy access to helpful resources and tools focused on bridging housing and healthcare services, including guidance through the "Ask A Question" (AAQ) portal and the development of a special H² mini-site to profile the work accomplished through the Action Planning Sessions. Regular phone conferences among the Federal Partners took place to coordinate and advance the H² initiative. Newsletter articles for internal HUD communication were developed and published.
6. Data Collection and Quality Improvement: HUD is working to adjust the CoC program Annual Performance Report (APR) template and HMIS data collection requirements in order to better capture health insurance status, thus facilitating tracking of this critical measure. HUD is also developing tools to assist CoC frontline workers in more easily collecting health insurance status information from program participants, to facilitate both insurance enrollment and connection to services. Recommendations have been submitted from the TA team on these two tasks, with additional materials forthcoming. Additionally, information was being collected on all housing/healthcare integration efforts underway across the nation, and data was collected and analyzed on the H² Action Planning Sessions to guide evaluation and development of best practices.

ALIGNMENTS WITH FEDERAL GOALS AND PRIORITIES

The H²TA Initiative aligns with numerous federal goals and priorities.

- ➔ HUD Strategic Goal:
 - ✓ Utilize Housing as a Platform for Improving Quality of Life
- ➔ Federal Strategic Plan to Prevent and End Homelessness Goals:
 - ✓ Promote Collaborative Leadership
 - ✓ Strengthen Capacity and Knowledge
 - ✓ Integrate Healthcare with Housing
 - ✓ Advance Health and Housing Stability for Youth
 - ✓ Advance Health and Housing Stability for Adults
- ➔ SNAPS Priorities:
 - ✓ Maximize Use of Mainstream Resources
 - ✓ Build/Sustain Innovative Collaborations that promote the goals of the HEARTH Act
 - ✓ Data Reporting, Analysis and Management
- ➔ HOPWA Priorities:
 - ✓ Increase Housing Stability
 - ✓ Improve Access to Services
 - ✓ Prevent Homelessness
- ➔ HUD's 2015 and 2016 CoC Program NOFA Policy Priority:
 - ✓ Strategic Resource Allocation, including maximizing the use of mainstream resources and leveraging resources through partnerships

II. H² ACTION PLANNING SESSIONS

UNDERLYING RESEARCH AND ASSUMPTIONS

The H²Action Planning Sessions and related Tools and Products were designed to help communities bring together the disparate stakeholders and systems of care that serve people who are homeless and/or low income and living with HIV/AIDS in order to evaluate current service provision, success and gaps, and then jointly plan how to coordinate and integrate housing and healthcare systems and services. The focus is to better meet the needs of the target population and reduce redundancies and inefficiencies in care provision. This is important because:

- Access to preventive, acute, and chronic healthcare, as well as mental health and substance abuse services, will allow more members of the target population to achieve housing stability and ongoing wellness.
- With more HUD-assisted tenants becoming covered by Medicaid or other healthcare insurance, permanent supportive housing and other homeless programs will be able to claim reimbursements for supportive services they provide, thus offering access to a new source of badly needed housing funding.
- Greater integration between the homeless, housing and healthcare systems offers potential opportunities for data sharing to enhance understanding of clients' needs and improved targeting of resources and outcomes.

The impetus behind these sessions was based on growing evidence and experience demonstrating that housing is a key social determinant of health and that lack of action to address the combined housing and healthcare needs of the target populations is prohibitively expensive.

- **Housing Is a Key Determinant of Health.** Poor living conditions, caused by poverty and homelessness, affect people's vulnerability to illness and disease and their ability to benefit from treatment and manage their health conditions. People who are homeless have to contend with increased contact with communicable diseases and infections, exposure to extreme weather, malnutrition, stress, lack of running water to maintain cleanliness, and lack of refrigeration for medications.⁹
- **People Who Are Homeless Are at Greater Risk for Poor Health.** They have high rates of infectious and acute illnesses (skin diseases, TB, pneumonia, asthma); chronic diseases (diabetes, hypertension, HIV/AIDS, cardiovascular disease); poor mental health and/or substance abuse; and being victims of violence. In addition, their mortality rate is 3-4 times higher than for the general population.¹⁰
- **Health Issues Are Likely to Increase as the Homeless Population Ages.** The number of homeless people in the U.S. between the ages of 51-61 increased 32% from 2007 to 2013.¹¹ Rates of chronic health conditions and potential for extended stays in nursing homes increase with age.

⁹ *Social Determinants of Health*, Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services, retrieved March 30, 2015, <http://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health>.

¹⁰ <http://www.cdc.gov/features/homelessness/> and Kaiser Commission on Medicaid and the Uninsured, "Medicaid Coverage and Care for the Homeless Population: Key Lessons to Consider for the 201 Medicaid Expansion", September 2012, available at: <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8355.pdf>

¹¹ End Chronic Homelessness Policy Academy Team presentation delivered at Washington Legislature Adult Behavioral Health System Task Force Meeting on September 19, 2014. For more information, please contact actionplanning@homebaseccc.org.

- **HIV/AIDS Is Correlated with Homelessness.** Many domiciled individuals face the threat of homelessness once they or someone in their family becomes infected with HIV. Additionally, people experiencing homelessness are at risk of contracting HIV due to the prevalence of high-risk behaviors, such as injection drug use, unsafe sex, and “survival sex” (i.e. the exchange of sex for food, shelter, or money).¹² The likelihood of being HIV positive is three times higher among people who are homeless as compared to the general population.¹³ Studies indicate that the prevalence of HIV among homeless people can be as high as 20%.^{14, 15} In addition, lack of housing has been identified as one of the top five barriers for HIV+ persons accessing medical care, and it is linked with poorer health. In 2014, HIV+ persons with stable housing had a viral suppression rate of 84.4%; only 45% of those with unstable housing achieved viral suppression.
- **Homelessness Is Correlated with High Healthcare Costs.** The high proportion of complex health needs and co-occurring health and behavioral health disorders increases the number, intensity, and scope of services needed. Homelessness inhibits the long-term, consistent care needed for many of these conditions, with the result that problems are aggravated, making them more dangerous and more expensive. Homelessness also increases the likelihood of excessive use of the emergency room (ER), inpatient treatment, and crisis services.
- **Permanent Supportive Housing (PSH) Improves Health Outcomes and Reduces Healthcare Costs.** PSH, affordable housing linked with comprehensive health and support services, serves people with severe and complex needs, including those who have been chronically homeless. Research and experience repeatedly demonstrate that PSH results in reductions in costs for hospitalization, ER visits, crisis services, shelter, jail, and detox; high rates of housing stability and retention; and improved health and recovery. Changes under the ACA expand opportunities to use Medicaid to fund PSH services.¹⁶

¹² St. Lawrence, J., Brasfield, T.L. (1995). HIV risk behavior among homeless adults. *AIDS Education and Prevention*, V. 7, 22-31. Guilford Press: New York.

¹³ National Alliance to End Homelessness (2006). “Fact Sheet: Homelessness and HIV/AIDS.” Available at: <http://www.endhomelessness.org/library/entry/fact-sheet-homelessness-and-hiv-aids>.

¹⁴ National Coalition for the Homeless, (2007). HIV/AIDS and homelessness [Online], www.nationalhomeless.org/publications/facts/HIV.pdf

¹⁵ Rickles, M. 2015. Ryan White Part A Nashville Transitional Grant Area 2015 Needs Assessment. Retrieved from: nashrpc.com/data. Nashville Regional HIV Planning Council.

¹⁶ ASPE, Medicaid and Permanent Supportive Housing for Chronically Homeless Individuals: Emerging Practices from the Field, available at: <http://aspe.hhs.gov/daltcp/reports/2014/EmergPrac.pdf>

Abundant Data Documents the High Costs of Homelessness^o

- A Clarke County, GA study released in February 2007 found that Athens hospitals spent at least **\$12.4 million** in 2005 caring for the homeless, an average of almost **\$20,000 per homeless patient**.ⁱ
- A 2009 study in Chicago found that without healthcare or housing interventions, 204 homeless adults with chronic medical illnesses experienced **743 hospitalizations** and **3.77 emergency room visits per person per year** over an 18-month period.ⁱⁱ
- In California, the Frequent Users of Health Services Initiative found that approximately **45% of individuals** who were high utilizers of emergency departments were homeless.ⁱⁱⁱ
- A report in the New England Journal of Medicine documents that homeless people spent an average of four days longer per hospital visit than comparable non-homeless people at an **extra cost of approximately \$2,414 per hospitalization**.^{iv}
- A two-year study in Boise, ID estimates that public services for one person experiencing chronic homelessness in Boise for one year ranges **from \$40,000-\$85,000**, including case management, police, incarceration, paramedics, fire department, emergency room, hospital care, and shelter services.^v
- According to a University of Texas two-year survey of homeless individuals, each person costs the taxpayers **\$14,480 per year** across public systems, primarily for overnight jail.^{vi}

Housing is a Cost Effective Solution

- A 2014 New Mexico study found a **13% decrease in emergency room costs** and **83.8% decrease in hospital inpatient costs** after study group members were housed for a year, compared to the prior year.^{vii}
- A 2012 study by the City of Knoxville found that the cost of community services (case management, emergency shelter, supportive services, jail stays, and emergency medical services) for 41 chronically homeless individuals **decreased by \$76,721 after one year in PSH**.^{viii}
- The Chicago Housing for Health Partnership provides PSH to chronically ill homeless individuals. Those served in the program experience **1/3 fewer inpatient hospital days and ¼ fewer emergency room visits** as compared to their peers relying on the usual care system. Evidence indicates that every **100 chronic homeless individuals housed will save \$1 million** in public funds/year and every **100 short-term homeless individuals housed will save \$630,000/year**.^{ix}
- 1811 Eastlake in Seattle, WA provides PSH to chronically homeless people with severe alcoholism and high use of crisis services. Outcomes include significant cost reduction in service usage (health, behavioral health, criminal justice and shelter) after one year of enrollment with median monthly costs dropping from **\$4,066/person to \$958/person** and alcohol use dropping by about a third. The savings far exceed the cost of the housing.^x
- The Housing Crisis Center in Dallas, TX houses 105 chronically homeless disabled adults, primarily veterans. Costs for housing each individual is **approximately \$10,000/year as compared to an average cost of \$60,000-\$100,000/year** to care for someone who is chronically homeless on the streets of Dallas. In 2013, residents demonstrated a 96% increase in housing stability, 59% increase in income, and 100% increase in sense of self-determination.^{xi}
- Moore Place, a Housing Works Program of the Urban Ministry Center in Charlotte, NC provides PSH to adults with extensive histories of homelessness and a disabling condition (mental health and substance abuse disorders, chronic health disorders, physical disabilities, developmental disabilities). A 2014 study on the program documented that **hospital bills, emergency room visits, and lengths of hospitalizations significantly decreased** during tenants' first year of housing.^{xii}

° Table Endnotes

ⁱ "Cost Analysis of Medical Services to Homeless Persons" (2007) Athens-Clarke County Dept. of Human and Economic Development, as cited in "Addressing Homelessness through Collaboration," State Housing Trust Fund Annual Report, January 1, 2008, <http://www.dca.state.ga.us/housing/specialneeds/publications/2008HTFAnnualReport.pdf>.

ⁱⁱ http://www.aidschicago.org/resources/legacy/pdf/2012/chhp_data_sheet_2012.pdf and http://usich.gov/usich_resources/solutions/explore/chicago_housing_for_health_partnership.

ⁱⁱⁱ Linkins, Brya, & Chandler, 2008, available at: <http://www.aidschicago.org/pdf/2009/hhrpn/FUHCS/1-FrequentUsersofHealthServicesInitiative-FinalEvaluation.pdf>

^{iv} Salit S.A., Kuhn E.M., Hartz A.J., Vu J.M., Mosso A.L. Hospitalization costs associated with homelessness in New York City. New England Journal of Medicine 1998; 338: 1734-1740.

^v Boise's 10 Year Plan to Reduce and Prevent Chronic Homelessness, November 2007., available at: https://www.cdavid.org/files/municipal_services/Boise10YrPlan.pdf

^{vi} National Alliance to End Homelessness, "Cost of Homelessness," http://www.endhomelessness.org/pages/cost_of_homelessness.

^{vii} Study by Institute for Social Research, June 2014. From: <http://news.unm.edu/news/unm-study-reveals-cost-benefits-in-housing-the-homeless>

^{viii} Study by the City of Knoxville, "Comparative Costs and Benefits of Permanent Supportive Housing in Knoxville, Tennessee," 2012, available at: <http://shnny.org/uploads/Knoxville-study.pdf>.

^{ix} AIDS Chicago, "Studies on Supportive Housing Yield Results for Health of Homeless and Cost Savings," Data Sheet, 2012, http://www.aidschicago.org/pdf/2012/chhp_data_sheet_2012.pdf

^x Downtown Emergency Service Center, "JAMA Research Shows Housing for Homeless Saves Taxpayers Millions," April 2009, http://www.desc.org/documents/DESC_1811_JAMA_info.pdf and Mary E. Larimer, et al, "Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems," JAMA, 2009, http://shnny.org/uploads/Health_Care_and_Public_Service_Use.pdf.

^{xi} Housing Crisis Center, "2013 Annual Report," http://www.hccdallas.org/wp-content/uploads/2014/04/HCC_2013_AnnualReport.pdf

^{xii} Urban Ministry Center, "Permanent Supportive Housing," 2015, <http://www.urbanministrycenter.org/helping-the-homeless/housing-for-homeless/>.

COMMUNITY SELECTION PROCESS

Twenty states and communities were selected across the nation to participate in the H² action planning sessions. Site selection occurred through a three-step process, as follows.

1. SITES REQUEST ASSISTANCE

Information about the H² initiative was disseminated, including posting on HUD Exchange website, sending a listserv message, briefing the SNAPS Homeless Assistance Response TA Team (HARTT) Work Group and Regional Teams along with an invitation to request Action Planning assistance. The Supervisory Program Advisor to the Office of the Assistant Secretary for Community Planning and Development (CPD), also conducted outreach to CPD Field Office Directors. Interested communities were instructed to submit a TA request to HomeBase with the following information:

- Name and contact information for the point of contact on the TA request
- Affirmation of support from the CoC Coordinator for this TA, and the role in the CoC of the person requesting TA
- Key concern to be resolved by the TA
- Brief description of who should be at the planning session, and aim of the outcomes.

2. REQUESTS EVALUATED

The H² TA Team evaluated all requests, gathering additional information through direct contact with the individual requesting the TA and other research. Requests were divided into four geographic categories: Statewide, Large Urban, Medium Urban/Suburban and Small Suburban/Rural. Recommendations were made to HUD within each category, based on the following criteria:

Criteria	How Criteria are Quantified
1. Need	
<ul style="list-style-type: none">• No. of Homeless	Total Homeless from 2014 Point-in-Time Count <ul style="list-style-type: none">• <u>High</u>: Over 2,000• <u>Medium</u>: Between 1,000 – 2,000• <u>Low</u>: Under 1,000
<ul style="list-style-type: none">• No. of Uninsured	Uninsured Rate in 2013 (Compared to Nat'l Avg. of 13%) <ul style="list-style-type: none">• <u>High</u>: Uninsured Rate at or above 15%• <u>Medium</u>: Uninsured Rate between 11-15%• <u>Low</u>: Uninsured Rate at or below 11%
<ul style="list-style-type: none">• HIV/AIDS Incidence	Rate/100,000 adults and adolescents living with an HIV diagnosis in 2013 (Compared to Nat'l Rate of 353.2)) <ul style="list-style-type: none">• <u>High</u>: Rate at or above 360• <u>Medium</u>: Rate between 200-359• <u>Low</u>: Below 200

2. Readiness <ul style="list-style-type: none"> TA Request Content 	Level of Preparation/Thought in TA Request <ul style="list-style-type: none"> <u>High</u>: Request is responsive to TA announcement, reflects a deep understanding of the issues, and will result in Action Planning that may be replicable in other communities <u>Medium</u>: Request is clear and reflects an understanding of the main issues and barriers <u>Low</u>: Request is unclear and/or non-responsive to TA announcement (e.g., request calls for a training/webinar)
3. Geographic Diversity <ul style="list-style-type: none"> HUD Regions 	Level (high, medium, low) based on number of TA requests received/approved from the same HUD Region

3. INFORMATION SOLICITED FROM FEDERAL PARTNERS

HUD Field Office Directors and the Federal Partners were asked for responses to the following questions:

- Are you aware of any initiative or endeavor (TA or otherwise) underway in any of the states or communities listed that is duplicative of, or conflicts with, the H² action planning session TA?
- Are you aware of any ongoing investigations or audits in any of the states or communities listed that would preclude us from providing H² action planning session TA?
- Are you aware of any other information (including particular strengths, accomplishments, or need) about any of the states or communities listed that should be considered in responding to their H² Action Planning session TA request?

Based on the TA Team's evaluation and incorporating information from HUD and the Federal Partners, the following twenty communities were selected.¹⁷

Site	HUD Region	Medicaid Expansion?	Homeless Count ¹⁸	State Uninsured Rate ¹⁹	HIV/AIDS Incidence ²⁰
Connecticut (Fairfield County)	1	Yes	1,083	7%	335.5
Florida (Jacksonville)	4	No	2,049	15%	606.1
Georgia (Athens)	4	No	247	16%	512.7

¹⁷ roster of additional sites that have requested or expressed interest in receiving an on-site Action Planning Session has been maintained throughout the initiative.

¹⁸ Based on 2014 Point-in-Time data.

¹⁹ 2011 data from <http://kff.org/state-category/health-coverage-uninsured/>.

²⁰ Estimated Rates (per 100,000) of adults and adolescents living with an HIV diagnosis. 2013 data from Kaiser Family Foundation (<http://kff.org/hivaids/state-indicator/estimated-rates-per-100000-of-adults-and-adolescents-living-with-an-hiv-diagnosis/>) All data in this column is state-wide.

Hawaii	9	Yes	6,918	5%	205.6
Idaho	10	No	2,104	11%	65.7
Illinois (Chicago)	5	Yes	6,287	9%	322.9
Michigan	5	Yes	12,227	7%	185.4
Montana	8	No	1,745	13%	46.4
Nevada	9	Yes	10,556	13%	331.8
New Mexico	6	No	2,746	16%	155.7
New York (Upstate)	2	Yes	12,780	8%	784.1
North Carolina	4	No	11,491	16%	326.3
North Dakota	8	Yes	1,258	9%	36.2
Pennsylvania (Pittsburgh)	3	Yes	1,573	8%	299.6
Tennessee (Nashville)	4	No	2,234	10%	297.2
Texas	6	No	28,495	17%	345.8
Utah	8	No	3,081	12%	114.6
Virginia	3	Yes	7,020	10%	314.5
West Virginia	3	Yes	2,013	6%	105.3
Wisconsin	5	No	6,055	7%	115.0



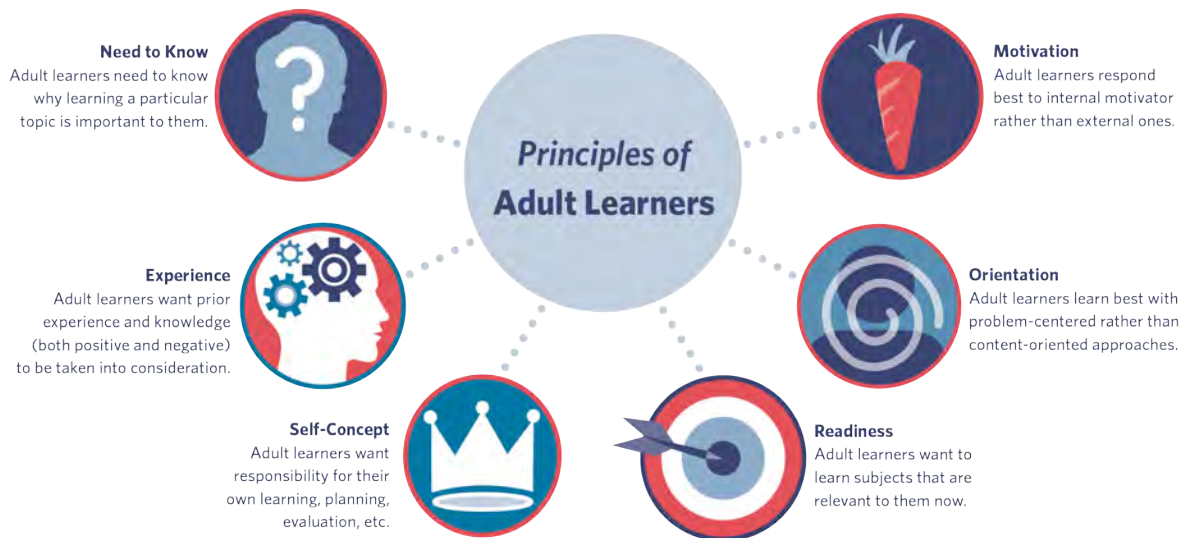
THE H² ACTION PLANNING SESSION MODEL OF PRACTICE

The H² Action Planning Sessions Model of Practice was developed based on the following theory of change, in which the specific inputs or TA provided were selected to achieve outputs that lay an essential base for action to realize the projected H² outcomes. This base includes the structures, leadership, relationships and consensus needed for cross-sector coordinated action and integration of care.

H² Action Planning Session Theory of Change		
H² Goals: <ul style="list-style-type: none"> ✓ Maximize care coverage for people who are homeless and/or low income and living with HIV/AIDS ✓ Increase the coordination of comprehensive healthcare and supportive services with housing 		
TA Provided / Inputs	Outputs	Objectives
<ul style="list-style-type: none"> Assistance to help states and communities integrate subsidized housing and healthcare services on a systems level for persons experiencing homelessness and those who are low-income and living with HIV/AIDS. ✓ Direct TA, including live, on-site event facilitation and Action Planning TA, along with subject matter expertise knowledge dissemination. This is supported by pre- and post-session remote TA, including logistics support, Leadership Team development and facilitation, and implementation coaching. ✓ Tools and Products TA, including development of session informational materials and Action Planning tools.²¹ 	<p><u>Initiative Level</u></p> <ul style="list-style-type: none"> Development and refinement of the Action Planning session design and stakeholder participation process. Development and refinement of planning session tools and materials. <p><u>State/Community Level</u></p> <ul style="list-style-type: none"> Knowledge exchange across systems. Establishment of connections between people and providers serving the same population. Development of Action Plans to close the gap between needs and services and provide a cross-system blueprint to guide integration efforts. Establishment of a Leadership Team structure to oversee Action Plan implementation. 	<ul style="list-style-type: none"> Integrated and coordinated housing and healthcare that fosters: <ul style="list-style-type: none"> ✓ Housing stability and health and wellness for people who are homeless or at-risk ✓ Efficient, effective use of healthcare and housing resources. Integration and coordination taking place at federal, state and local levels, in a way that is simultaneous and mutually reinforcing.

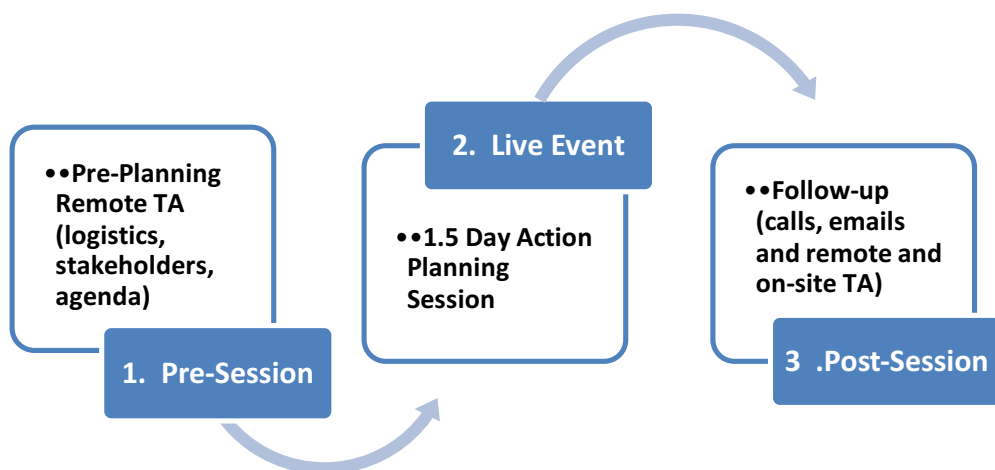
²¹ Additionally, the other two components of the H² TA Initiative also include Tool and Product TA – See Section IV for more information on mid-term outcomes.

The H² Action Planning Session Model of Practice also incorporates characteristics of adult learning into its action planning session design based on the principles in the graphic below. This enables the H² Action Planning Model to be responsive to participant learning needs and thus more effective in disseminating knowledge and in assisting participants to synthesize and apply that knowledge, based on their own knowledge and experiences. The result is the development of Action Plans that are more thoughtful as well as realistic, and an experience that is more satisfying for participants.



Knowles, M. et al. (2015). The Adult Learner: 8th ed., Routledge.

In addition, the H² Action Planning Session Model of Practice was piloted in two states and then further refined based on experiences and feedback from those sessions. It encompasses three sequential steps as diagramed below. The chart which follows provides details on the elements and tasks within each step as well as the specific tools and products developed for each step. The model functioned as a work in progress, characterized by continuing evaluation and refinement of design and materials, based on each Action Planning session.



H² Action Planning Session Model of Practice: Key Elements / Tasks²²

STEP 1. PRE-SESSION

Pre-Planning Remote TA (logistics, stakeholders, agenda development)

- Initial Outreach to TA Requestor/Recipient
- Leadership Team Development
- Stakeholder List Preparation and Outreach/Communication, to achieve participation by essential housing and healthcare stakeholders at all levels
- Planning Calls
- Customization of Session Design and Agenda
- Site-Specific Research and Data Gathering
- Materials Development, incorporating site-specific research

Tools and Products

- Stakeholder List –stakeholder categories to facilitate creation of invitation lists
- Agenda Topics List – baseline list of topics that can potentially be included in an Action Planning session from which the TA team, working with the local planning group members, builds a community-focused session agenda
- Communication Tools (e.g. email templates, call agendas, talking points) – to facilitate consistent and productive communications with planning group members and outreach to stakeholders

STEP 2. LIVE EVENT

1.5-Day Action Planning Session

Designed to maximize value from the mingling of diverse stakeholders at a live event

- Provide opportunities for peer learning, discussion and relationship building
- Promote cross-fertilization of ideas and innovation
- Develop basic understanding of various disciplines' technical terms and language
- Facilitate development of a joint vision, goals and actions to be taken to increase collaboration and integration of housing and healthcare systems and to close the gap between target populations' needs and the scope of services available and accessible

Venue Set-Up

- Inviting Space, allowing plenary and break-out sessions
- Accessible to participants
- Mixed Sector Seating to facilitate cross-sector interaction

Technology Set Up to Allow

- PowerPoint overview of H² session, customized with local data
- Model framework cycling PowerPoint throughout Day 1
- Laptops used to capture session discussion at each facilitated breakout group table
- Day 2 plan draft segments projected in real time to whole group
- PowerPoint presentations by local presenters to share resources and current initiatives and programs

²² Federal Partner support was involved in each of the steps.

Process

- Agenda, designed to facilitate both knowledge dissemination, stakeholder participation and strategy discussions
- Subject Matter Knowledge Dissemination through presentations covering national best practice integration strategies
- Local Knowledge Application through presentations/discussions about local profiles of the population at the intersection of HUD-assisted housing and healthcare assistance, including their housing and health needs, services currently being provided, and current payment sources for those services
- Facilitated breakout discussions, mixing people across sectors to foster collaboration and innovation
- Ballots to Engage with Model Strategies and build consensus
- Action Plan Templates and Planning Support
- Expert large and small group facilitation combined with note-taking support

Tools and Products

- Session Agenda
- Handouts and Worksheets – customized for each session; updated with latest resources and research on innovative practice models; adapted from venue to venue to incorporate feedback
- Model Strategies Ballots – developed from the Model Framework process tool. Each ballot contains a subset of the strategies and action steps set forth in the Model Framework and provides a means by which participants can engage the Model Framework, “voting” on whether specific model strategies and action steps should be included in their community’s H² Action Plan.
- “Script” Agendas - to assist the facilitators with keeping the sessions consistent and on schedule, while leaving room for flexibility
- Note-Taking Template - to assist with capturing the content of the breakout group discussion
- Draft Action Plan Template - to assist with creation of the initial draft plan using ideas emerging from the breakout group discussions (includes instructions for reviewing, revising, and supplementing the draft to facilitate the second day’s planning and implementation discussions)

STEP 3. POST-SESSION

Follow-Up Calls, Emails, and Remote TA to ensure lasting results from the event

- Assistance with:
 - ✓ Strengthening and Strategic Positioning of Leadership Team
 - ✓ Action Plan Implementation Support, including prioritization, resource identification, and addressing barriers
 - ✓ Alignment with and Connection to Other Existing Initiatives and Programs – including through NHCHC, CSH, Priority Community TA – to support implementation
 - ✓ Post-Session Research and Analysis
- Establishment of Peer Learning Communities
- Development of Content for H² Site Web Profiles on HUD’s ACA Website
- Action Planning TA Assessment
- Coaching, guidance, SME assistance, and limited on-site TA to support implementation on key areas
- TA Alignment with Other Federally-funded TA on ACA implementation

Tools and Products

- Action Plans – community-centered action plans, with goals and objectives, strategies, action steps, and implementation details.
- Web Profiles – an overview of each action planning session, including a description of participants, topics covered, strategies emerging, and the following resources: Leadership Team Contact Information, Community-Specific Housing Assistance Resources, Medicaid Coverage Overview and Community-Specific Healthcare Resources, and Data Snapshots
- Email Templates for follow-up communications with Leadership Teams and session participants
- Online feedback form for participants to supplement direct feedback solicited at Action Planning sessions.

KEY BARRIERS FACED BY COMMUNITIES

Over the course of organizing and facilitating the H² Action Planning Sessions, communities identified the barriers they faced in better integrating their housing and healthcare systems and in better serving the target population.

Key barriers identified across communities, include the following:

- Lack of coordination, communication and relationships, among HUD-funded programs, and with other systems of care (health, behavioral health, HIV/AIDS, criminal justice)
- Lack of understanding of opportunities under Medicaid, including opportunities stemming from ACA, for the target population
- Lack of connection to decision-makers regarding the State's Medicaid Plan, including maximizing Plan options to cover housing support services
- Lack of infrastructure (internal agency billing systems and/or partnerships with healthcare providers) to allow billing for case management and housing support services provided by CoC agencies
- Lack of coordination and integration between health and behavioral health systems, and lack of behavioral health system capacity
- Resistance by clients to accessing care, particularly mainstream health services, and the need for sensitivity training and more outreach
- Lack of transportation to services
- Difficulties in collecting, sharing and analyzing data across systems, and lack of HMIS capacity to act as a central platform
- Lack of knowledge about best practices and innovations in integrating housing and healthcare supports, including strategies to cover services in supportive housing
- Lack of coordinated cross-system prevention homeless strategies, including diversion programs.

H² ACTION PLANNING SESSIONS ASSESSMENT AND EVALUATION

Ongoing assessment and evaluation were key elements of the H² Action Planning Sessions. There has been constant learning and improvements in how best to engage and support TA recipients through the solicitation of feedback at each event and its use to inform subsequent session structure and materials.

First, direct verbal feedback was sought on site from participants during the final wrap-up session at each event. This participant input helped improve subsequent sessions. For example:

- Early session participants asked for a Glossary of Terms which then became part of the packet of handouts.

- Local Leadership Team members asked for a quick guide at the top of each worksheet, for ease of use in subsequent H² implementation activity.
- Consumer participants asked for a slower pace, and more explanation, which led to a redesign of the agenda and materials.

Feedback on the action planning sessions was also gathered from participants as part of the post-session process. Post-event thank-you notes were sent out, referring participants to a link to an online feedback instrument. This particular process did not generate useful information. Most participants did not respond, and some that did were confused about which TA initiative they were being asked to provide input for. The Local Leadership Team members said they felt no need to respond to the online feedback form, as the work was ongoing and they had already provided input on site.

Post-session feedback was also gathered through a Federal Partners call. Local Leadership Team members and Federal Partners attending sessions, including HUD Field Office representatives, were invited to report on their experience. Feedback from these calls has also been the source of many improvements.

The most common positive feedback received via the various avenues for providing input were as follows:

- The materials were very well done and contained a large amount of helpful information about local programs and resources and examples from around the country. The information was helpful for the sessions and also as reference materials going forward.
- Knowledge about the “other” system of care (i.e., the healthcare system for people that work in housing and vice versa) was helpful for the session discussions as well as moving forward. It gave participants a new perspective about their work and how they can better help their clients.
- Having subject matter experts as facilitators was a great aspect of the sessions, and the facilitation was extremely well done.
- Dividing people into smaller discussion groups was very helpful, as was mixing up stakeholders to ensure diversity of experience in each group.
- Being able to review a draft plan on the second day made the event feel worth-while and allowed participants to review the ideas of those that were not in their groups on the first day.
- The process was very well organized²³ and the planning sessions were very productive.

The most common types of constructive feedback received were as follows:

- The amount of information presented was a lot to digest in the time allotted, without having seen the information ahead of time.
- Ensuring additional specific stakeholders (specifically, more healthcare or state-level stakeholders) would have been helpful.

In addition, recent information posted by host CoCs²⁴ show that:

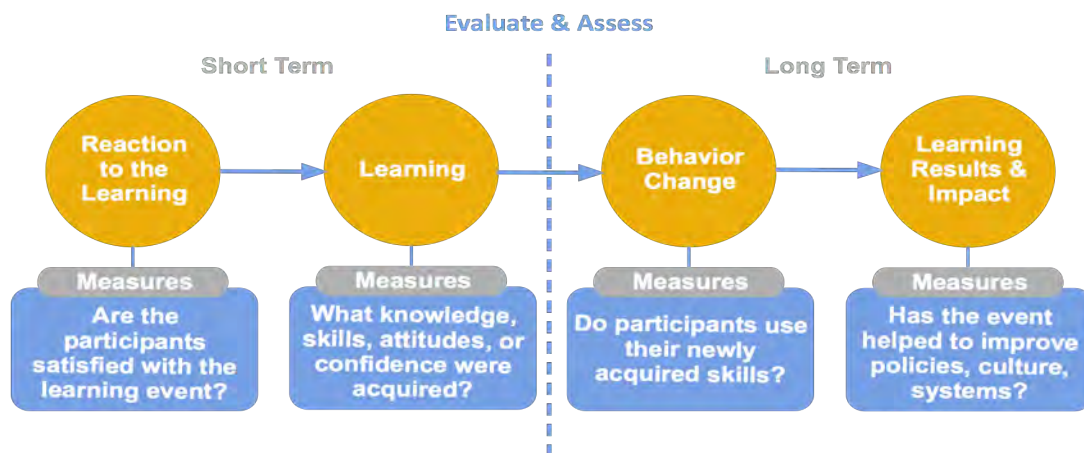
- 9 CoCs representing 7 H² sites found the TA provided greatly valuable.
- 8 CoCs representing 8 H² sites found the TA to be beneficial for increasing cross systems collaboration and facilitating healthcare enrollment.

²³ This particular comment became common as the process was adapted to incorporate feedback from previous sessions.

²⁴ The information was posted locally in connection with the CoCs’ applications in response to HUD’S FY 2015 CoC Program Competition.

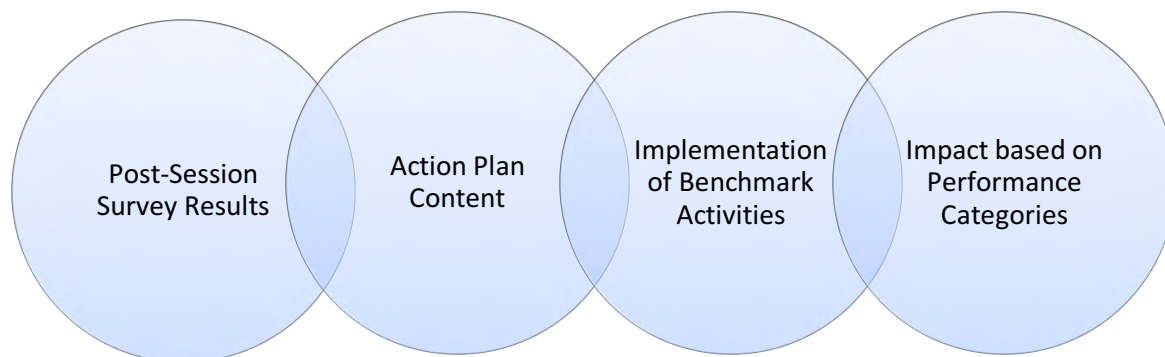
- 4 CoCs representing 4 H² sites expressed great satisfaction with their H² Action Plans and their implementation progress.
- Additionally, CoCs expressed that the H² TA helped them increase coordination and collaboration with healthcare organizations; better address first time homelessness and chronic homelessness; maximize their current resources; and strengthen Housing First and PSH strategies in their communities.

Longer term impacts of the H² Action Planning Sessions are being evaluated based on 6 Performance Categories along with related outputs and outcomes. These were developed based on the model strategies framework used in all the Action Planning Sessions. Accomplishments in each of the 6 Performance Categories are outlined in Section III of this report.



Kirkpatrick, D. L. (1975). "Techniques for Evaluating Training Programs". Evaluating training programs in D. L. Kirkpatrick (ed.) Alexandria, VA: ASTD.

Sources of Data for Evaluation Efforts



III. H² ACTION PLANNING SESSIONS: ACCOMPLISHMENTS

OVERVIEW OF ACCOMPLISHMENTS

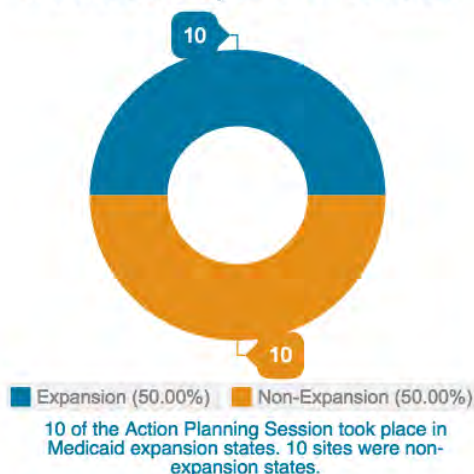
This overview of the accomplishments of the H² Action Planning Sessions includes both initiative-level accomplishments and state/community-level accomplishments.

INITIATIVE-LEVEL ACCOMPLISHMENTS

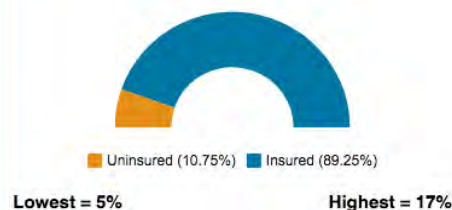
Action Planning Sessions: By The Numbers

102 CoCs covered by the Sessions

Medicaid Expansion States

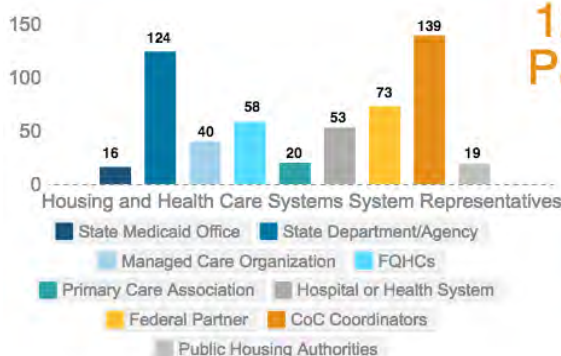


Average Uninsured Rate Across 20 Sites



121,962

Total Number of People Experiencing Homelessness in the geographic area covered by the 20 sessions



1249 Stakeholders Participated Across 20 Sites

The Action Planning Sessions brought together stakeholders from across the housing and health care systems to partake in cross-system knowledge exchange and collaboration. This chart highlights the representation of diverse stakeholders across the 20 Action Planning sites and across the housing and healthcare systems.

Graphic Citations:

Average Uninsured Rate – The Henry J. Kaiser Foundation, “State Health Facts – Health Insurance Coverage of the Total Population,” 2015, <http://kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

Number of People Experiencing Homelessness – HUD Exchange, “PIT and HIC Data since 2007,” November 2015, <https://www.hudexchange.info/resource/3031/pit-and-hic-data-since-2007/>

- Developed, piloted and refined Action Planning sessions design and supporting tools and materials
- Engaged Federal Partners in Action Planning efforts, including monthly Federal Partner phone conference, selection of planning sites, participation by representatives in the events and ensuing implementation efforts, and circulation of internal HUD newsletter updates of completed Action Planning sessions.
 - Action Planning session attendees have included representatives from HRSA, HUD, SAMHSA, and USICH.

Action Planning session participants have stressed the importance of H² being a federal initiative in order to catalyze needed system change. With federal support, it is easier to engage local cross-system leadership and representatives and to find the necessary champions who can serve as the face and voice of the initiative.

- Developed content for an H² “mini-site,” hosted on the HUD Exchange ACA website. The H² mini-site contains a profile of each H² Action Planning session, including participating stakeholders, the venue’s Action Plan, Leadership Team contact information, and details regarding community-specific resources. As of July 10, 2016, the H² mini-site had been viewed 4,376 times.
- Launched an H² Learning Community at the NAEH July 2015 Conference on Ending Homelessness; two other sessions were held at the February 2016 NAEH Conference on Ending Youth and Family Homelessness and the July 2016 NAEH Conference on Ending Homelessness.
- Data analysis from Action Planning sites to identify best practices and track other key information is underway.
- Developed performance measures and benchmarks that can be used to monitor and document progress toward housing/healthcare integration
- Promoted Health/Housing integration in a number of forums, including presentations by The Supervisory Program Advisor to the Office of the Assistant Secretary for Community Planning and Development (CPD) at NAEH, NSCC, and COSCDA conferences, and participation in the National Academy of Sciences-HCH-NAEH November 2014 convening on homelessness and implications of changes to the US health system; 4 presentations including the HUD TA Institute, Fall 2015; and presentations by HomeBase staff at the National Health Care for the Homeless Council Conference in June 2016, and multiple HRSA- and SAMHSA-sponsored webinars.

STATE/COMMUNITY-LEVEL ACCOMPLISHMENTS

The H² Action Planning state and community level accomplishments have been documented in terms of progress toward the H² Initiative objectives. Progress towards these objectives can be measured in each of six performance categories²⁵ laid out in the table below.

²⁵ The performance categories and target outputs and outcomes were developed as an outgrowth of the TA work. HomeBase developed a “*Taxonomy of Healthcare-Related Strategies that Should Be Part of Every CoC’s Efforts to End Homelessness*” that informed the initial Action Planning Session materials used in the H² pilots, ultimately becoming the *Model Strategies Framework* used in the opening section of the Action Planning Sessions. Ballots were developed, based on the *Framework* to facilitate Action Planning Session participants’ prioritizing strategies and actions for their state/community’s Action Plans. The

H² Initiative Objective: Integrated and coordinated housing and healthcare that fosters:

- Housing stability, health and wellness for people who are homeless or at risk
- Efficient, effective use of healthcare and housing resources.

Performance Category ²⁶	Key Community Accomplishments
1. Systems Change Planning and Leadership	<ul style="list-style-type: none"> • Leadership Teams and Action Plans are being incorporated into existing state level structures, such as interagency councils or state plans. • Medicaid Directors and other high level staff are participating in Action Plan implementation.
2. Enrollment	<ul style="list-style-type: none"> • Federal resources, including Cooperative Agreements to Benefit Homeless Individuals (CABHI), Health Care for the Homeless, and others, are being used to support and expand Medicaid enrollment efforts. • Communities are exploring how to streamline the Medicaid application process, including by linking eligibility to SSI eligibility and through use of a single application for Medicaid and SSI.
3. Engagement	<ul style="list-style-type: none"> • Healthcare staff are being out-stationed at shelters and homeless programs. • Clinics are being co-located at permanent supportive housing and other affordable housing sites.
4. Integration	<ul style="list-style-type: none"> • Discharge planning programs are being developed, involving cross-system coordination. • Establishment of recuperative care programs are being explored, including securing funding from hospitals and MCOs. • Common or shared assessment processes are being developed, including participation of health providers in the coordinated entry system. • Cross- trainings are being conducted between the homeless assistance/housing and healthcare systems.
5. Data-Driven Interventions	<ul style="list-style-type: none"> • Data matches are being conducted across systems to both demonstrate the need for collaboration and identify members of target populations, including: <ul style="list-style-type: none"> ○ Frequent user data matches across systems (e.g. homeless assistance, criminal justice, healthcare) to identify most vulnerable. ○ Comparison of existing State Medicaid plan covered services with those most needed by people experiencing homelessness in order to target Medicaid enrollment to people who need/use those services.

performance categories and target outputs and outcomes are derived from both the *Model Strategies Framework* as well as the actual Action Plans developed in the twenty participating sites. The performance categories and target outputs and outcomes are thus grounded in the work of participating states and communities, in what they have judged as possible and as important.

²⁶ Note: Though the categories are derived from the action planning *Model Strategies Framework*, the numbering is not the same as the Systems Change Planning and Leadership category has been added in at the top of the list.

6. Resource Maximization

- Communities are leveraging support of Federal Partners:
 - HRSA: Building or improving relationships with Federally Qualified Health Centers, including encouraging Health Centers to apply to open new sites in strategic locations and/or for funding to serve people experiencing homelessness.
 - SAMHSA: Applying for and utilizing CABHI grants to facilitate H² Action Plan implementation.
 - CMS: Applying for and participating in CMS Innovation Accelerator Program Technical Assistance efforts.
- States are seeking to maximize use of Medicaid to support housing stability through submittal of waivers and state plan amendments²⁷.
- Communities are working with Public Housing Authorities to create set-asides or preferences for people experiencing homelessness and/or people who are ready to transition out of PSH but still need affordable housing.

In the following sections, target outputs and outcomes are listed for each category as a means to clearly measure community and state progress in integrating their homeless assistance and healthcare systems and services. In addition, emerging best practices and community success highlights are provided.

The following sections provide an overview of what has been accomplished as of September 30, 2016 in each of the six categories.

1. SYSTEMS CHANGE PLANNING AND LEADERSHIP

Activity in this category demonstrates that system-level cross-agency planning and implementation is taking place with the involvement of high-level leaders/champions from multiple systems.

H Activities Completed

Action Planning sessions have taken place in 20 states/communities to produce Action Plans that identify consensus strategies to foster integration of housing and healthcare, and address barriers. Thirteen action plans have statewide scope and seven have a regional or CoC-level scope.

Each state/community has a Leadership Team in place, composed of representatives from medical and behavioral health, housing and other sectors. Each has developed an implementation plan or guidelines and identified priority strategies for short-term implementation or is in the process of doing so. Additionally, some communities have embedded their Leadership Team and/or Action Plan in other plans, systems and structures.

²⁷ HomeBase was able to leverage lessons learned from the H² Initiative to advance complementary efforts in Washington and California (under Chronic Homeless Policy Academy technical assistance). In Washington, HomeBase assisted the state in preparing and submitting an 1115 waiver application that includes a supportive housing benefit, and continues to help the state build capacity to implement the benefit. In California, three H2-like planning sessions were held (in Northern, Central, and Southern California) to assist counties throughout the state in maximizing the use of the state's Medicaid program (including through a recently approved 1115 waiver and Health Homes amendment) to fund services that support housing stability and to increase coordination across housing and healthcare systems.

Performance Category: Systems Change, Planning and Leadership

Target Outputs/Outcomes	N/A	Not Yet Started	Increased Understanding or Skills	Applied Knowledge/ Concrete Progress	Accomplished
Action Planning session completed			20	20	20
Action Plan (including implementation guidelines) finalized			20	20	14
Ongoing and regular Leadership/Implementation Team meetings, with active participation by representatives from housing, healthcare, and other mainstream systems			20	20	16
H ² Plan components embedded in other system plans, structures	10		10	8	5

Emerging Best Practices

- Incorporate Leadership Team and/or Action Plan into existing state level structures, such as interagency councils or state plans.
- Establish a multi-county/multi-CoC Leadership Structure to oversee implementation and facilitate working together on common challenges and successes.
- Create a two-tier oversight structure, with a policy level Leadership Group and that is informed by Regional Housing-Healthcare Advisory Councils.
- Create work groups to focus on discrete plan sections or strategies.
- Link Action Plan strategies to large on-going efforts, such as emerging coordinated entry systems, as a means to leverage implementation momentum from these complementary efforts.

Community Success Highlight(s)

<p style="text-align: center;">Virginia</p> <p>The H² Leadership Team and Action Plan are formally incorporated into the Governor’s Coordinating Council on Homelessness. The State Medicaid Director is involved in Action Plan implementation work.</p>
<p style="text-align: center;">West Virginia</p> <p>The West Virginia H² Leadership Team reports to the West Virginia Interagency Council on Homelessness.</p>
<p style="text-align: center;">Chicago</p> <p>Chicago expanded and strengthened its Leadership Team, turning it into a 33-member Leadership Council that includes key leaders in the community, including those who participated in the action planning session as well as those who did not. The Leadership Council meets twice per year, providing structure and oversight to ensure forward movement in implementing their Action Plan. Participation by Federal Partners in these biannual meetings has helped to keep interest and participation by Leadership Council members high. The Leadership Council has established workgroups for each of the Action Plan’s three priorities; these workgroups meet monthly.</p>

2. ENROLLMENT

Activity in this category demonstrates that states/communities are working to achieve the goal of 100% enrollment in Medicaid or other health insurance by people experiencing homelessness and/or low income and living with HIV/AIDS.

H² Activities Underway

All states/communities included action steps in their Plans aimed at improving enrollment levels, including educational efforts to build client and front-line staff awareness about Medicaid eligibility requirements and enrollment resources; identification of individuals who are eligible for Medicaid through coordinated entry processes or other comprehensive screening tools; provision of enrollment assistance through the SOAR Program²⁸ or similar efforts, health navigators and/or community health workers working in partnership with community-based organizations; and establishment of policies allowing presumptive eligibility or other expedited enrollment procedures.

Performance Category: Enrollment					
Target Outputs/Outcomes	N/A	Not Yet Started	Increased Understanding or Skills	Applied Knowledge/Concrete Progress	Accomplished
Expertise regarding Medicaid eligibility requirements and enrollment resources in homeless assistance agencies			20	15	12
Identification of homeless/housing system clients in need of Medicaid and benefit program enrollment or renewal assistance			20	10	2
Medicaid and other benefit program enrollment assistance available and offered to all eligible uninsured homeless/housing system clients			20	10	
100% enrollment in Medicaid and SSI/SSDI of eligible members of the H- Target Populations: (1) people experiencing homelessness and (2) low-income people living with HIV/AIDS			20	5	

²⁸ SAMHSA's SSI/SSDI Outreach, Access, and Recovery Program. The program seeks to end homelessness through increased access to SSI/SSDI income supports, and is designed to increase access to the disability income benefit programs administered by the Social Security Administration for eligible adults who are experiencing or at risk of homelessness and have a mental illness, medical impairment, and/or a co-occurring substance use disorder.

Emerging Best Practices

- Conduct a CoC-wide survey of people experiencing homelessness or in permanent housing programs (PSH, Rapid Re-Housing (RRH)) to determine who is eligible and not yet enrolled in Medicaid or other health insurance.
- Create “one-page” reference guides for case workers and frontline staff regarding eligibility and enrollment in Medicaid and other mainstream benefits (e.g. SSI/SSDI, TANF).
- Increase use of SOAR programs, including having SOAR workers train staff at housing agencies on benefits eligibility and enrollment. Approach hospitals about partnerships to help pay the cost of SOAR staff.
- Explore creation of presumptive eligibility for people meeting HUD’s definition of chronically homeless.
- Outstation Medicaid enrollment staff and/or Medicaid presumptive eligibility “determiners” at shelters, soup kitchens, permanent supportive housing sites, and other places people experiencing homelessness.
- Align efforts supported by different federal, state, local and private funding sources to achieve common client enrollment goals.
- Train charting staff at hospitals and other healthcare providers to properly “document disabilities” to improve success rates of SSDI applications.

Community Success Highlight(s)

<p style="text-align: center;">Virginia</p> <p>Virginia is exploring using resources from their CABHI grant to expand capacity in the SOAR program. They are also exploring how to streamline application and enrollment into Medicaid for those eligible for SSI, including through automatic enrollment or a single application.</p>
<p style="text-align: center;">West Virginia</p> <p>West Virginia is leveraging flexible Health Care for the Homeless money to hire staff to do coordinated outreach to homeless individuals.</p>
<p style="text-align: center;">Idaho</p> <p>Idaho is identifying points in their coordinated entry system where eligibility assessment and enrollment assistance should happen, aiming to provide SOAR training to key staff at each such point.</p>

3. ENGAGEMENT

Activity in this category demonstrates that states/communities are working to ensure that people experiencing homelessness and/or with low incomes and living with HIV/AIDS have access to appropriate care, including that they are linked with a primary care provider; those with chronic conditions are receiving appropriate care; and emergency services are not used for routine healthcare management or to address untreated chronic conditions.

H Activities Underway

All states/communities included action steps in their Plans aimed at improving engagement of the target populations. These include efforts to facilitate access to services both by increasing availability of key services, as well as through use of peer navigators; addressing transportation needs; use of mobile healthcare teams and out-

stationing arrangements; and educating clients on how to navigate the system. Action steps also focused on reducing inappropriate use of emergency room and inpatient services through emergency room diversion strategies, peer specialists and client education.

Performance Category: Engagement					
Target Outputs/Outcomes	N/A	Not Yet Started	Increased Understanding or Skills	Applied Knowledge/ Concrete Progress	Accomplished
Connection to ongoing primary care for all homeless/housing system clients			20	5	
Increased rates of medication and health appointment adherence among homeless/housing system clients	10		10		
Improved measurable health outcomes for homeless/housing system clients with one or more chronic conditions			20		
Reduction of avoidable use of emergency and inpatient hospital services			20	8	
Reduction in costs incurred and/or number of visits to emergency rooms for non-emergencies			20	5	

Emerging Best Practices

- Facilitate coordination and partnerships between CoCs and healthcare providers to engage the target population, including:
 - Locating FQHC clinics at shelters and/or permanent housing buildings, or having mobile vans visit shelters and conduct outreach to unsheltered people.
 - Identification of health plan members through MCO/HMIS data matches and assistance by CoC agencies to locate, engage and connect members to health services. MCOs can pay “finders fees” to CoC agencies for this assistance.
 - Install housing navigators in healthcare provider settings, and healthcare navigators in homeless assistance/coordinated entry systems.
- Address transportation barriers by incorporating tele-health/tele-medicine technologies, including for behavioral health.

Community Success Highlight(s)

Connecticut

A health bus goes to the shelter, facilitating engagement with health services. In addition, plans are under way to locate a medical center on the first level of a new housing project under development.

A hospital funds a navigator position which is split between working with people who frequently use emergency services and people experiencing homelessness.

North Carolina

In one county, managed care organizations (MCOs) have agreed to make weekly on-site visits to shelters.

4. INTEGRATION

Activity in this category demonstrates that states/communities are working to integrate housing, healthcare and other services through partnerships and other forms of collaboration that reduce fragmentation and unnecessary duplication, and which collectively support housing retention and ongoing wellness, especially for people with multiple needs.

H Activities Underway

All states/communities included action steps in their Plans aimed at improving integration of care provided. These include cross-training of staff on available resources; case conferencing; use of housing stability measures in managed care organization contracts; and use of Home Health and Accountable Care Organization partnership models. Actions also focused on linking medical and behavioral healthcare providers with the homeless coordinated entry system and expanding coordinated discharge planning efforts, including recuperative care facilities.

Performance Category: Integration

Target Outputs/Outcomes	N/A	Not Yet Started	Increased Understanding or Skills	Applied Knowledge/ Concrete Progress	Accomplished
Written policies or agreements that require housing system-healthcare system connection (e.g. Memoranda of Understanding between housing agency and Federally Qualified Health Center; hospital policies that require participation in CoC)			10	5	
Direct links from healthcare providers to CoC Coordinated Entry System(s)			20	8	3
Awareness and understanding of CoC Coordinated Entry System(s) by healthcare providers			20	5	

Regular participation by healthcare providers in CoC Coordinated Entry System(s)			20	7	5
Discharge planning processes (in hospitals, jails, alcohol and drug treatment programs) that include consideration of housing needs and, if necessary, link to housing assistance system			20	8	
Integration of primary care and other health services into CoC and/or Coordinated Entry System(s)			20	3	
Integration Models (e.g., FQHC that has agreed to healthcare to each member of Target Populations that seeks housing assistance) operating in each CoC/county/community			20	5	

Emerging Best Practices

- Create structures and practices that facilitate cross-system information-sharing, planning, and discussion, including how Medicaid can fund supportive services in housing, how to involve CoC agencies in providing these services, and other topics.
 - Establish cross-system coalitions consisting of representatives from CoC agencies, hospitals, MCOs, FQHCs, State Medicaid, etc. to meet regularly regarding housing and healthcare integration and coordination.
 - Regularly set aside time at existing forums or coalition meetings for cross-system education and discussion on key topics (e.g. Coordinated Entry; obligations of Managed Care organizations to serve members).
- Incorporate care coordination/case conferencing models that cross systems for highly vulnerable or high-cost clients that have housing, health and other needs. Start with pilot programs for priority subpopulations.
- Improve discharge planning protocols at hospitals, jails/prisons, psychiatric institutions so that the discharge planning process begins at point of admission and includes housing element/connection to CoC.
- Engage MCOs and hospitals in funding recuperative care beds – saves costs of patients staying in hospital longer than medically necessary due to not having a place to live while finishing a course of treatment.
- Create cross-system accountability for housing outcomes. For example, insert housing/housing stability outcomes into managed care contracts.
- Connect healthcare (FQHCs, HCH, emergency rooms) and supportive service providers that are not part of the HUD-funded CoC system to the Coordinated Entry System (CES). This can range from formal agreements with non-CoC providers entering data into the HMIS or CoC agency staff outstationed at hospital emergency rooms or informal strategies such as education of non-CoC providers on the “entry points” into the CES for patients that need housing assistance.
- Re-cast homelessness as a public health issue and get public health departments engaged to create a patient management network model where care includes medical, dental, substance abuse, mental health, emergency financial assistance, health insurance premiums, and medicines.

Community Success Highlight(s)

North Carolina

Housing outcomes have been incorporated into behavioral health managed care contracts. In addition, in one CoC, emergency rooms and other health-related providers are making use of the coordinated entry system.

New Mexico

The homeless assistance/housing system is coordinating with MCOs to link needs assessments conducted by each system. The goals of this effort include:

- Each needs assessment incorporates basic elements of other system's (e.g. MCO identifies potential housing issues in addition to conducting its comprehensive health needs assessment).
- Each system facilitates a warm handoff to the other following a needs assessment.
- CoC clients that score highly on the VI-SPDAT are referred to the MCO to complete a comprehensive health needs assessment to identify those who are eligible for additional Medicaid services and assist with needed documentation.

They are also exploring how to create incentives FQHC and other health provider staff to use ICD-10 codes related to homelessness and housing instability.

Connecticut

Community Care Teams (CCTs) are working on integrating primary care, including making sure that primary care and hospital care is coordinated. The Partnership for Strong Communities (PSC) has recently secured foundation funding to expand the Opening Doors-CT Hospital Initiative, coordinating a network of Community Care Teams (CCTs) in five additional Connecticut hospitals by the end of 2017.

Pittsburg

UPMC Mercy Hospital is working on a hospital discharge planning pilot program to prevent discharge of patients to the street. Discharge planning will begin at the point of admissions and will seek to expedite referrals into shelters for vulnerable patients, starting with those who have a chronic illness and/or mental health issues. The program also aims to streamline people into primary care. Additional hospitals are beginning to express interest in the program. UPMC Mercy is also exploring the development of a medical recuperative care program as part of the discharge planning pilot.

UPMC Mercy is also working with Operation Safety Net to create a clinical team for people on the street. As part of that, if a patient presents multiple times within a certain amount of time, the hospital will agree to keep them as patients for an extra 2-3 days to allow time for effective interventions to be lined up.

A medical insurance company is teaming up with the CoC to identify members of the street homeless population who are in the hospital. The insurance company works with them while they are in-patients, and coordinates with the CoC to provide housing, services, and identify needed recuperative care options. The insurance company is now considering contributing money.

The CoC is also working with street outreach teams and local hospitals to develop protocols for getting outreach teams to engage homeless people while they are still in the hospital.

Virginia

Through a CABHI grant, Virginia is piloting 2 multidisciplinary teams linked with dedicated supportive housing resources.

<p style="text-align: center;">Chicago</p> <p>The CoC has a contract with a hospital, which provides \$250,000 per year to house their frequent utilizers. The CoC is pairing that money with HUD-funded units.</p> <p>With the goal of improving health outcomes and coordination between homeless services and Medicaid managed care, they have also engaged in extensive cross-training between care coordinators from MCOs and case managers from CoC agencies. They have also carried out education sessions about PSH.</p>
<p style="text-align: center;">Utah</p> <p>The H² team is exploring building medical care into permanent supportive housing (PSH). They are considering a nurse care management model, where the nurse is part of an interdisciplinary team linked to a health clinic and mobile health team. Currently, there are 6 ACT teams serving people who are chronically homeless and helping them get into PSH, enrolled in Medicaid, and find employment. The teams are currently funded through CABHI. Medicaid funding to make them sustainable is being explored.</p>
<p style="text-align: center;">West Virginia</p> <p>West Virginia has been awarded a CABHI grant, which will benefit all of the State's CoCs, including through funding additional housing case managers, aligned with clinic support from West Virginia University. The State is also applying HRSA funds to fund a health navigation position that also helps locate housing.</p>

5. DATA-DRIVEN INTERVENTIONS

Activity in this category demonstrates that states/communities are working to use cross-system data to target interventions to priority sub-populations.

H Activities Underway

All states/communities included action steps in their Plans aimed at enhancing data collection, analysis and utilization. These include development of cross-system data collection and data sharing standards and protocols; facilitating health provider participation in HMIS; and development of targeted interventions based on data studies.

Performance Category: Data-Driven Interventions					
Target Outputs/Outcomes	N/A	Not Yet Started	Increased Understanding or Skills	Applied Knowledge/ Concrete Progress	Accomplished
Healthcare data systems that collect housing-related information (e.g., consistent use of ICD10 codes relating to homelessness by all hospitals)			20	5	
Sharing of data between homeless/housing assistance providers and healthcare providers			20	5	3
Integration of data across homeless/housing assistance and			20	1	1

healthcare system					
Identification of shared priority sub-populations and development of targeted interventions			20	5	1

Emerging Best Practices

- Compare cross-system data (including emergency medical support, jails, Medicaid, housing system) to identify individuals who frequently come into contact with two or more systems and/or frequently receive high-cost services. Create pilot programs to focus assistance from all systems on identified clients to get them connected to permanent housing and needed health and social services.
- Ensure hospitals and other healthcare providers are accurately and consistently using the ICD-10 codes that relate to homelessness and housing instability.
- Explore creation of a data warehouse to allow for aggregate data analysis across systems.
- Encourage data collection/sharing across not just housing and healthcare systems but also Education, Criminal Justice, Public Libraries, and any other system likely to serve the same population to create a more comprehensive picture of homelessness.

Community Success Highlight(s)

Utah

The Utah Department of Workforce Services (DWS) conducted a match of the data available in the Homeless Management Information System (HMIS) and eREP (Medicaid eligibility system) for the state. Utah DWS is using this data match to create aggregate data to evaluate current performance, historical trends, and performance expectations at the time of contract renewals. It is also using it to identify CoC clients not enrolled in Medicaid and target enrollment assistance, and to provide estimates on additional people to be covered by a Medicaid waiver being evaluated in the legislature.

Utah also conducted a data match between the County jail and HMIS and between County Behavioral Health providers and HMIS. With County Behavioral Health, they have identified a significant need for PSH linked to substance abuse services and they are working to put together an application for tax credits. Another outcome of this is that the County is working on a Pay for Success model with Goldman Sachs, County Behavioral Health and Corrections which will look at high shelter users and potentially coordinate funding and ability to rapidly rehouse and track housing stability.

This increase in Utah's cross-system integrated data capacity helps the state facilitate better understanding of system-level operations, effectiveness, and efficiency, and supports their goal to engage in data-driven decision-making around homeless health and housing service provision.

Nevada

In Clark County, Nevada, the University Medical Center and Dignity Health Pilot are participating in the HMIS and participation by Las Vegas Fire Rescue, Las Vegas Metro Police Department and MCOs is in process. Private hospitals, family services, and the state Health Information Exchange have also expressed interest in joining the effort. This expanded participation in HMIS by mainstream agencies allows the HMIS to function as a cross-system central data repository/warehouse.

They are also working to assist agencies in integrating HMIS data into their day-to-day business practices in order to both improve individual client care as well as the efficiency and coordination of the system as a whole.

West Virginia

A draft report has been developed for a long-term data study based on 3 years of HMIS and Medicaid data (from hospitals and MCOs) to understand healthcare costs connected to homelessness. Preliminary data shows an average of \$224 million in Medicaid spending per year for individuals in the HMIS.

Virginia

A data match is planned between City of Richmond HMIS and Department of Mental Health and Addiction Services Medicaid data to identify population overlap and costs, and evaluate if the spending is optimal in terms of cost/client. Additionally, they are hoping to use the data to build a case for PSH for this population, and to determine how they can best influence the current changes underway with the State's Medicaid program.

Chicago

Chicago (including Cook County) is working with managed care to enable data sharing between HMIS, Medicaid, and Aetna databases. They are re-working consent forms to enable data systems to communicate with identified data.

6. RESOURCE MAXIMIZATION

Activity in this category demonstrates that states/communities are working to maximize the use of Medicaid and other sources of funding to finance services that support housing access and stability and improved health. This also includes use of policy levers to facilitate prioritized access to housing and services by the target population.

H Activities Underway

All states/communities included action steps in their Plans aimed at expanding resources for housing and services for the target populations and/or expanding efficient utilization of existing resources. These include consideration of use of waivers and state plan options to fund services that support stable housing, expanded use of risk-based systems of care (e.g. accountable care organizations/ACOs), and fostering partnerships between health providers and CoC agencies to facilitate Medicaid billing for case management and housing support services. Actions also focused on expanding available resources such as by identifying new sources of funding for housing and services and by using preferences and set-asides to target Public Housing Authority (PHA) units to the target population.

Performance Category: Resource Maximization

Target Outputs/Outcomes	N/A	Not Yet Started	Increased Understanding or Skills	Applied Knowledge/ Concrete Progress	Accomplished
Expansion, waivers, state plan options, demonstration programs and other action to maximize use of Medicaid to support housing stability			20	5	
Medicaid billing for services provided by homeless housing and services providers (through direct			20	3	

billing by providers or partnerships with managed care organizations or other health providers)					
Maximization of health and human services funding (i.e., increased successful applications for relevant funding opportunities)			20	8	4
Increased percentage of CoC funds going toward direct housing costs / Decreased percentage of CoC funds going toward services/treatment			20	5	

Emerging Best Practices

- Review State Medicaid Plans to determine what services that support housing stability are currently covered, identify those that are needed, and determine how best to cover tenancy and housing stabilization services (which waiver or state plan amendment would work best).
- Work with Public Housing Authorities to create preferences or set-asides for people experiencing/exiting chronic homelessness. Consider a “move-up” strategy: preference or set-aside for formerly homeless people who have been living in PSH and no longer need the full range of support services but still need affordable housing.

Community Success Highlight(s)

<p style="text-align: center;">Chicago</p> <p>Thresholds is certified to bill Medicaid for services in housing. It has 1,200 units of PSH and is one of the largest Medicaid billers in the city.</p> <p>Secured agreement from County Health Department to commit \$1,000,000 dollars of matching funds for every \$3,000,000 in HUD funding that is secured for permanent supportive housing.</p>
<p style="text-align: center;">New Mexico</p> <p>New Mexico received a CABHI grant that will cover many of the actions in their H² Action Plan. In addition, the H² Leadership Team has been working with Public Housing Authorities to create set-asides or preferences for people experiencing homelessness and/or people who are ready to transition out of PSH but still need affordable housing.</p>
<p style="text-align: center;">Nevada</p> <p>Based on CMS’ June 2015 Informational Bulletin on Medicaid coverable tenancy and housing support services, a group working on a new proposed Medicaid waiver for the State has designed a supportive housing benefit to be included in the application.</p>
<p style="text-align: center;">Virginia</p> <p>The H² Leadership Team, which is part of the Governor’s Coordinating Council on Homelessness, is advocating to include some housing support pieces in their upcoming Medicaid waiver submittal for people with substance abuse disorders. Virginia is also exploring using resources from their CABHI grant to expand capacity in the SOAR program. They are also exploring how to streamline application and enrollment into</p>

Medicaid for those eligible for SSI, including through automatic enrollment or a single application.
<p style="text-align: center;">West Virginia</p> <p>The H² Leadership Team is investigating how to credential people to provide in-home services once people are housed so that Medicaid can be billed for this care.</p>
<p style="text-align: center;">Idaho</p> <p>The Idaho Housing Finance Agency announced additional tax credit points to developers willing to include permanent supportive housing units in their developments. Multiple developers applied and one was granted the additional points. The H² group is now helping to facilitate partnering the developer with an appropriate service team to ensure fidelity of the permanent supportive housing model.</p> <p>They are also working to increase the involvement of private landlords in subsidy programs, which make housing affordable for those who are homeless or at-risk.</p>

Tool Created

To support H² Action Plan implementation planning, HomeBase created a tool to assist communities in the development of a Medicaid benefit to pay for services in supportive housing. Specifically, the tool outlines three preliminary determinations, and describes components of the decision-making progress that should be given consideration at each of those three determination points. The Decision Aid Tool is included as Appendix P.

IV. OTHER H² INITIATIVE COMPONENTS: ACCOMPLISHMENTS

COMMUNICATIONS, KNOWLEDGE DISSEMINATION AND COORDINATION

Other H² accomplishments include:

- Monthly Federal Partners phone conferences initiated and continuing
- Alignment with other TA initiatives, including connecting H² communities/Leadership Teams to ongoing or future programs (e.g. CMS' Medicaid Innovation Accelerator Program; NHCHC's assistance with creating/funding recuperative care programs to assist with H² Action Plan implementation).
- Launched, then revamped, the HUD Exchange ACA website, including ongoing efforts to refresh the HUD Exchange ACA and H² pages with up-to-date information, resources, and H² site progress reports.

Materials and Tools Available for Public Use on the H² Website: www.hudexchange.info/programs/aca/h2

	Number of Action Planning Sites
Action Plan Overview	20
Action Plan	5
Leadership Team Contact Information	20
Community-Specific Housing Assistance Resources	20

Medicaid Coverage Overview and Community-Specific Healthcare Resources	20
Data Snapshot	20

- Completed series of six webinars:
 - A Hear from Your Peers' Webinar – Successful Housing and Healthcare Integration Strategies
 - Strategies to Support Homeless or at-Risk Clients with Effectively Utilizing the Healthcare System
 - Strategies to Increase Health Insurance Enrollment for People Who Are Homeless
 - HUD, USICH and HHS on Housing and Healthcare: Opportunities to Partner
 - Spotlighting Communities that are Successfully Coordinating Healthcare & Housing Resources to End Veteran Homelessness
 - A Hear from Your Peers' Webinar – Effective Coordination between Hospitals and CoC Homeless Assistance Providers Results in Improved Residential Stability and Reduced Costs
- Listserve messages
 - Encouraged H² participants to subscribe
 - Advertised webinars and H² Action Planning Session availability
 - Provides information about new material, studies, and opportunities relevant to the housing and community development audience

Message Subject	Send Date	# Successful Deliveries ²⁹	# Unique Opens ³⁰	Open Rate ³¹	Unique Clicks ³²	Click Rate ³³
Resources of Interest for Housing & Healthcare (H ²) Communities	Mar. 18, 2016	19,791	3,223	16.29%	432	2.18%
Resources of Interest for Housing & Healthcare (H ²) Communities: Overview of the Resources Featured on the ACA Landing Page	Jan. 25, 2016	19,345	3,114	16.10%	189	0.98%
Upcoming: Accountable Health Communities (AHC) Model Webinar - Overview & Application Requirements	Jan. 14, 2016	17,250	2,647	15.34%	241	1.4%
Centers for Medicare & Medicaid Services Currently Accepting Applications for the Accountable Health Communities Model	Jan. 13, 2016	17,094	3,006	17.59%	300	1.76
State Approaches for Integrating Behavioral Health into Medicaid Accountable Care Organizations	Nov. 16, 2015	18,735	3,054	16.30%	230	1.23
Federal Partners Announce Availability of Program Support for State Medicaid-Housing Agency Partnerships	Nov. 10, 2015	17,862	3,369	18.86%	366	2.05

²⁹ The number of recipients that didn't hard or soft bounce on this campaign.

³⁰ This number counts each subscriber that opens a campaign. This count does not include multiple opens from individual recipients.

³¹ Percentage of successfully delivered campaigns that registered as an open.

³² This number counts each subscriber that clicks a link in a campaign. This count does not include multiple clicks from individual recipients.

³³ Percentage of successfully delivered campaigns that registered a click.

Save the Date: Coordination between Hospitals and CoC Homeless Assistance Providers Results in Improved Residential Stability	Oct. 30, 2015	18,574	2,790	15.02%	272	1.46
View Housing and Healthcare (H ²) Initiative Action Plans by State	Aug. 21, 2015	17,785	3,111	17.49%	347	1.95
Resources of Interest for Housing & Healthcare (H ²) Communities	Aug. 3, 2015	17,685	3,123	17.66%	259	1.46
CMS Releases New Informational Bulletin on Coverage of Housing-Related Activities and Services for Individuals with Disabilities	June 26, 2015	17,183	3012	17.53%	577	3.36
Maximizing Medicaid Options and Promoting Practices in the Field Webinar - April 29, 2015 - 2 PM EDT	April 21, 2015	16,596	3017	18.18%	520	3.13
Healthcare and Housing (H ²) Initiative: First Round of Sites Selected for Homeless and Healthcare Systems Integration; HUD Still Accepting New Requests	Feb. 2, 2015	16,189	2853	17.62%	555	3.43
New Video: HUD Secretary Castro's Message on Affordable Care Act Open Enrollment	Jan. 15, 2015	16,087	2332	14.50%	126	0.78
Reminder—HUD, USICH and HHS on Housing and Healthcare: Opportunities to Partner—January 6, 2015 at 2:00 PM EST	Jan. 5, 2015	16,164	2609	16.14%	446	2.76
Register Today: Kaiser Family Foundation's Web Briefing to Examine Early Impacts of the Medicaid Expansion on the Homeless Population	Dec. 12, 2014	3,807	775	20.36%	152	3.99%
SNAPS and HOPWA Technical Assistance Announcement	Oct. 17, 2014	15,612	2,768	17.73%	16	0.10%

DATA COLLECTION AND QUALITY IMPROVEMENT

The goal of HUD's Data Enhancement Initiative is to analyze the information already collected (or that could be collected) to improve linkages between the housing/homeless and healthcare systems, including by:

- Supporting front-line staff in ensuring eligible clients are enrolled and remain enrolled in appropriate insurance programs, including Medicaid
- Measuring and incentivizing increased rates of enrollment at program and CoC system levels
- Facilitating more efficient connections with healthcare providers by tracking referrals and treatment, supporting a culture of crossover
- Enhancing understanding of barriers to accessing insurance and healthcare

The analysis performed by the H² TA Team tasked with this work resulted in recommended changes to APR questions, which would leverage data already collected in HMIS, and recommended changes to HMIS Data standards. The former category of recommended changes would require revisions to the CoC APR Guidebook, Programming Specifications, and related materials; The latter would require revisions to the HMIS Data Standards and related materials.

APR RECOMMENDATIONS: USING EXISTING HMIS STANDARDS

Four recommendations to create APR questions utilizing existing HMIS Data Standards were proposed:

1. Question(s) that track program performance in enrolling clients in health insurance
2. Question that lists the reason for a client's lack of insurance coverage
3. Question(s) that compares the number of people with documented health conditions vs. the number of people who have received treatment
4. Question that counts the number of times clients were provided services

Additional details regarding these recommendations, including the proposed information to utilize, the rationale for the recommendation, potential barriers, and potential utilizers are presented in Appendix P.

ADDITIONS AND IMPROVEMENTS TO HMIS STANDARDS

Throughout the H² planning process, participating communities identified significant existing barriers within HMIS and other data systems that currently present challenges to fully leveraging Affordable Care Act and Medicaid Expansion to better serve their clients. Adjusting and better targeting data collection, management, and analysis can further synergy between the housing and healthcare systems, and improve client access to whole-person care. HMIS is a critical component in these planning efforts, particularly its evolution into a multi-system client data management platform in many communities. As communities work to improve coordination of efforts and resources across multiple systems of care, targeted improvements to HUD annual reporting requirements along with supporting changes in the HMIS data standards can build HMIS capacity and empower CoCs to better leverage HMIS data to effectively advocate for clients and better meet their healthcare needs.

The H² TA Team proposed modifications to data element 4.4 (Health Insurance) to leverage HMIS to better meet the management needs of CoCs and the healthcare needs of clients. This is primarily accomplished by including additional detail regarding health insurance applications and enrollment information within the framework of the existing data element to enable providers to better track clients' health insurance enrollment status. A series of additional data elements and modifications to HMIS programming/functionality were also proposed, which would enable HMIS to better support basic healthcare case management and ultimately better client outcomes. These proposed data elements would include information regarding healthcare providers, recent medical emergencies, ongoing health conditions, and active prescriptions.

The proposed changes are all designed to maximize HMIS capacity to empower CoCs to effectively advocate for their clients and meet their healthcare needs. Homeless and healthcare providers need the ability to ensure full and complete benefit enrollment, facilitate access to care, and aid clients in navigating services and treatment. To this end, the proposed changes are oriented around five concepts voiced through the H² process:

1. **Increase homeless service provider capacity to serve as points of contact to facilitate enrollment.** Many eligible individuals remain uninformed of their appropriate healthcare coverage options, and thus remain uninsured. HMIS adjustments can allow communities to monitor and incentivize the enrollment of eligible homeless program participants. This supports homeless providers in increasing awareness and developing capacity to maximize healthcare coverage and harness critical mainstream resources.
2. **Create the data structure required to support HMIS functionality and workflows that promote frequent, easy updates of client records.** Currently, outside of program entry and exit, most CoC programs are only

required to update client information once a year, and the workflow of most HMIS systems is built around these minimum requirements. This timeline provides limited opportunity to use HMIS data elements to meaningfully track the enrollment process and healthcare service(s) utilization.

3. **Incorporate renewal reminders into HMIS to improve coverage maintenance.** Insured homeless clients have difficulty sustaining coverage and complying with renewal requirements. Many are missing renewal windows due to issues related to clients' residential instability (e.g., misdirected correspondence). HMIS modifications can increase provider capacity to support enrolled clients by making it easy to build in healthcare maintenance checks (e.g., renewal deadline reminders) into regular client interactions.
4. **Support efforts to use HMIS to identify coverage breakdowns, propose solutions, and increase accountability for cross-enrollment.** Homeless housing and healthcare providers need to be better informed to support clients' connections to care and housing. Expanding HMIS functionalities around enrollment and renewal tracking can help support deeper performance analysis and provider accountability. Consider creating an ROI standard form with each managed care entity in the state that enables the MCO to report health insurance status changes directly to the HMIS administrator for the purpose of updating client records in HMIS. Strengthen ties with criminal justice system to report on coverage impacts of incarceration.
5. **Provide clear guidance, training, and technical assistance on privacy law and regulations as they apply to HMIS, including ensuring compliance with HIPAA and other major federal and state laws.** Integration of healthcare data into HMIS requires the ability to ensure confidence in the system's ability to protect the privacy and security of that personal information. Tasks like navigating HIPAA privacy rules and drafting business associate agreements, however, are beyond the comfort level of many HMIS administrators. Overcoming these obstacles is crucial to the integration of client-level healthcare data into HMIS.

The specific proposed HMIS Data Element changes that were submitted to HUD are included as Appendix Q.

BENEFITS DECODER

In response to challenges and needs expressed during H2 planning sessions, a reference guide was created to both improve data quality relating to health insurance coverage and improve service delivery. The Benefits Decoder works by assisting line workers to quickly and accurately:

- Evaluate the scope of a client's current health care coverage
- Determine which health care plans a client is eligible for
- Recommend health insurance plans that meet a client's financial and medical needs; and
- Enter data about a client's health insurance into an HMIS database.

A sample Benefits Decoder (created for San Francisco) and a manual to assist communities in creating their own Benefits Decoder are included as Appendix R.

V. RECOMMENDED NEXT STEPS FOR THE H² TA INITIATIVE

A. ADDITIONAL SUPPORT FOR H² COMMUNITIES

Since the H² TA did not come with housing vouchers, money to fund coordination activities, or other resources, feedback from participants and leadership team members made clear that, although the planning sessions were a great starting point, additional assistance (if not funding) is crucial to meaningful, impactful implementation. In the majority of H² communities, support to enhance local capacity is needed to enable action on the ideas that emerged from the action planning sessions, including but not limited to: creation of a coordinator or oversight position, additional staff capacity, and support for communication and idea dissemination.

Every site that has been offered additional implementation and planning support has eagerly accepted, and expressed a desire for as much follow-up support as possible. There is a strong sense in each H² community that the amount of work contemplated by the H² action plans is very exciting and necessary, but also overwhelming, particularly in light of the lack of knowledge, capacity, and oversight structure (at both the state and local level) to ensure that the H² strategies are implemented. Even when action plans are significantly streamlined following the planning sessions, Leadership Teams have expressed concern at the lack of staff, resources, and expertise needed to implement the remaining strategies in a meaningful way. H² planning sessions were a very valuable starting point for each community, but there is a risk that the excitement and momentum created by the sessions will be lost without continued and additional support.

To maximize the impact of the H² Initiative in the twenty H² communities, as well as throughout the country, the following next steps are recommended over the next three years to build upon the work that has been completed or is currently underway.

H² LEADERSHIP ACADEMY

- 1.5-day group institute to be held in DC
- More intensive engagement with key leaders from H² sites that have completed Action Planning Sessions
- Focus on key new areas of work or practice models and how to approach them, building on H² successes currently underway
- Cultivate local capacity to carry out additional work
- Develop in first half of 2017
- Deliver beginning mid-2017 through 2019

LEARNING COMMUNITY SERIES

- Opportunities for information sharing and peer learning, including both successful strategies generated and obstacles to implementation encountered
- Quarterly Events (in-person and remote) for Action Planning Session participants
- Attendees/sessions may be divided by geography, implementation issues, or other relevant factors

WEB-BASED ACTION PLANNING 2.0

- Web-based and IT disseminated modular training for remote TA delivery of H² Planning Sessions
- Cover steps of H² planning in “how to” modules, with examples from work to date, including recordings by peer presenters from H² communities
- Develop content knowledge into easily absorbed “10 things that should be underway everywhere” series, building on Model Framework of Strategies evolving from on-site H² Action Planning Sessions
- Develop in 2017
- Deliver beginning 2018 into 2019

WEBSITE

- Continue to refresh HUD Exchange ACA and H² pages with up-to-date information, resources, and H² site progress reports
- Maintain an H² Community Forum for information and idea sharing among peers

ADDITIONAL WEBINARS

- Quarterly webinars at least through 2019 on distinct, key topics vital to Action Plan implementation

LISTSERV

- Continuation of existing outreach and communication, including awareness of new materials, studies, and opportunities relevant to the housing and community development audience

COORDINATION

- Continue Federal Partner calls (Quarterly)
- Continued and increased participation by Federal Partner representatives in H² communities’ implementation planning
- Involve on-site Federal Partner representatives in post-Action Planning Session plan drafting and implementation process
- Provide an H² TA Initiative status report at the annual HUD-DHHS Housing/Healthcare convening
- TA Firm coordination – monthly meeting of TA Task Leads to solve problems, check progress, assure accountability, and coordinate similar or overlapping TA initiatives

ANNUAL PROGRESS REPORT RECOMMENDATIONS

- Develop implementation tools to assist localities with tracking progress, including data collection linked to benchmarks

ADDITIONS/IMPROVEMENTS TO HMIS STANDARDS

- Development of a Data Enhancements Mini-Team to further explore the role of HMIS in empowering CoCs to effectively advocate for their clients;
- Convening a working group to discuss implementation of the proposed alterations to the HMIS programming specifications;
- Incorporating changes to HMIS Data Element 4.4 (Health Insurance) to improve the utility of HMIS in facilitating access to and maintenance of healthcare;
- Development of additional HMIS Data Elements to improve healthcare management functionality; and,
- Exploring HIPAA/privacy implications of these proposals, as well as developing additional trainings and additional modifications to HMIS programming specifications and/or Privacy and Security rules to support these changes

B. EXPANSION OF H² ACTION PLANNING OPPORTUNITIES TO ADDITIONAL COMMUNITIES

The feedback received from H² session participants was overwhelmingly positive. Setting aside venue-specific limitations such as difficulty hearing one's table mates due to room size or challenging acoustics, the only non-positive feedback that was expressed by more than one person was that the materials presented in the participant packet contained a tremendous amount of information, which was difficult to digest in the time allotted. However, participants at almost every session expressed gratitude for the information assembled in the packet, and noted that it would be an excellent resource going forward.

Other feedback received consistently included:

- Having subject matter experts as facilitators was very helpful.
- The site-specific research done by the TA Team was appreciated and helpful.
- The packet of materials contained a tremendous amount of useful information, in the context of the session itself as well as for the future.
- Meeting and having face-to-face time to discuss issues with others that work with the same populations was extremely valuable, both in terms of learning about other resources and programs and beginning to build necessary relationships.
- Having a document (i.e. the draft action plan) in hand by the end of the convening is a valuable output.

Many participants at multiple sessions stated that the H² action planning session was among, if not the, best TA they had ever received or participated in.

Given the overwhelmingly positive feedback about the value of the action planning sessions and materials, the opportunity should be re-opened to allow additional communities and states to benefit.

- Re-open the H² Action Planning opportunity to 20 additional states and communities. (Approximately 15 currently outstanding requests from 10 different states, without advertising or announcing availability of additional sessions).
- Incorporate additional stakeholders, integrate new research and practice examples into materials, and improve process based on feedback.
- Build a HUD Exchange mini-site for pre-education, marketing, registration, etc.

- Align with other TA initiatives.
 - HIV Housing Care Continuum Regional Meetings and Implementation Efforts.
 - CMS Innovation Accelerator Program (IAP) Medicaid-Housing Partnership TA.
 - CSH and HCH work in H² states.

Although other current TA initiatives are complementary, none provides the same breadth and type of assistance as H² Action Planning Sessions. The CMS Medicaid-Housing Partnership TA, for example, relates only to Medicaid, which is only one of a number of topics addressed by H². H² involves discussions about Federally Qualified Health Centers, coordination, coordinated entry, and maximizing resources (including but not limited to Medicaid). Additionally, H² work starts at the CoC/Community-level, emphasizing coordination at the agency and system levels. Successful coordination and work of that kind is only possible when work begins directly with local communities. Just as resources flow differently in the housing and healthcare worlds, the way relationships form and work is completed works differently, too. Medicaid expansion and maximization is vital, but is not sufficient on its own. Coordination and partnerships from the community level and up are crucial. Progress in those areas begins with work like H².

C. HEALTHCARE AND HOUSING PERFORMANCE MEASURES/OUTCOMES

The performance categories and target outputs and outcomes laid out in Section III, can serve as the basis for the development of performance measures on healthcare delivery and housing that can be used to measure community-level outcomes resulting from health/housing integration efforts. This could be carried out as part of a future phase of work within or following the H² Initiative.

APPENDICES SUITE OF TOOLS TO SUPPORT COCS IN WORKING TOWARD HOUSING AND HEALTHCARE INTEGRATION

Appendix A. *Connection Between Housing and Healthcare Needs: Growing Evidence Base for Housing as a Social Determinant of Health*

An overview of research and successful permanent supportive housing experience supporting the importance of addressing housing and health needs in an integrated manner.

Appendix B. *Stakeholder Checklist*

A list of potential stakeholders to consider engaging to accomplish systems coordination and integration.

Appendix C. *Glossary of Housing and Healthcare Terms*

A glossary of frequently used terms and acronyms to assist stakeholders working in the health system to understand unfamiliar housing language and vice versa.

Appendix D. *Housing-Healthcare Partnership Profile*

A list of potential homeless assistance, housing, and healthcare partners each CoC should consider engaging and partnering with when working toward system integration.

Appendix E. *Process Presentation*

A slideshow presentation used to open each H² Action Planning Session, which contains a helpful overview and process map for systems integration.

Appendix F. *Housing Resources*

Descriptions of homeless assistance and affordable housing programs and resources. Includes resources and programs funded by the U.S. Department of Housing and Urban Development, as well as other federal resources.

Appendix G. *Healthcare Resources + Healthcare Changes Underway*

Descriptions of healthcare resources for people with low incomes and people experiencing homelessness – including Medicaid, Veteran health resources, HIV/AIDS health resources, and behavioral health resources – and information about health system changes underway that may benefit people with low incomes and people experiencing homelessness.

Appendix H. *Data Snapshots*

Descriptions of and links to publicly available data relating to homelessness, poverty, and certain types of health resources accessed by people with low incomes and people experiencing homelessness.

Appendix I. *Model Strategies and Framework*

An overview of five key health-care related model strategies to consider in developing an Action Plan to improve health outcomes and housing stability for people experiencing homelessness.

Appendix J. *Data-Driven Strategies*

Overview of data-driven strategies (including case studies) for identifying homeless individuals across multiple service systems and effectively linking them to the range of housing, health, and supportive services they need.

Appendix K. *Innovative Partnership Strategies*

Descriptions of innovative, cross-system partnership and coordination strategies, including case studies and examples from communities around the country.

Appendix L. Innovative Funding Strategies

Descriptions of innovative funding mechanisms and potential funding streams for creating and expanding housing and supportive service programs. Examples and case studies from communities around the country are also presented.

Appendix M. Progress Tracking Tool

A tool for communities to identify and track their progress in integrating their homeless assistance and healthcare systems and services.

Appendix N. Lessons Learned from H² Action Planning

A selection of lessons learned regarding implementation planning and structure and facilitating coordination between housing and healthcare providers, as well as an Emerging Framework for Systems-Level Alignment to End Homelessness.

Appendix O. Developing a Medicaid Supportive Housing Services Benefit – Considerations and Decision Points

A tool designed to assist States in the development of a Medicaid benefit to pay for services in supportive housing.

Appendix P. Recommended Additional Questions to HUD's Annual Performance Report

A summary of recommended health coverage and treatment-related questions to add to HUD's CoC Annual Performance Report (APR), utilizing existing HMIS Data Standards.

Appendix Q. Proposed changes to HMIS Data Standards

Recommendations for changes to HMIS Data Element 4.4 (Health Insurance), as well as additional optional changes, intended to build HMIS capacity and empower CoCs to better leverage HMIS data to effectively advocate for clients and better meet their healthcare needs.

Appendix R. Benefits Decoder

A reference guide to help line workers assist clients in identifying their health coverage and benefits and ensuring accurate corresponding data entry into HMIS: contains both a sample decoder and a manual to assist communities to create their own Benefits Decoder tool

The resources included in these appendices are also available to view and download at:

<http://homebaseccc.org/hb/index.php/blog/H2-Systems-Integration>

APPENDIX A: CONNECTION BETWEEN HOUSING AND HEALTHCARE NEEDS – GROWING EVIDENCE BASE FOR HOUSING AS A SOCIAL DETERMINANT OF HEALTH

The following is an overview of the growing evidence base for housing as a social determinant of health. It includes information about research and successful permanent supportive housing programs supporting the importance of addressing housing and health needs in an integrated manner.

The Connection Between Housing and Healthcare Needs: Growing Evidence Base for Housing as a Social Determinant of Health

- **Housing Is A Key Determinant Of Health.** Poor living conditions, caused by poverty and homelessness, affect people's vulnerability to illness and disease and their ability to benefit from treatment and manage their conditions. People who are homeless have to contend with contact with communicable diseases and infections, exposure to extreme weather, malnutrition, stress, lack of running water to maintain cleanliness, and lack of refrigeration for medication.¹
- **People Who Are Homeless Are At Greater Risk For Poor Health.** They have high rates of infectious and acute illnesses (skin diseases, TB, pneumonia, asthma); chronic diseases (diabetes, hypertension, HIV/AIDS, cardiovascular disease); poor mental health and/or substance abuse; and being victims of violence. In addition, their mortality rate is 3-4 times higher than for the general population.²
- **Health Issues Are Likely To Increase As The Homeless Population Ages.** The number of homeless people in the U.S. between the ages of 51-61 increased 32% from 2007 to 2013.³ Rates of chronic health conditions and potential for extended stays in nursing homes increase with age.
- **HIV/AIDS is Correlated with Homelessness.** Many domiciled individuals face the threat of homelessness once they or someone in their family becomes infected with HIV/AIDS. Additionally, people experiencing homelessness are at risk of contracting HIV due to the prevalence of high risk behaviors such as injection drug use, unsafe sex, and "survival sex" (i.e. the exchange of sex for food, shelter, or money).⁴ Studies indicate the prevalence of HIV among homeless people can be as high as 20%.⁵
 - Lack of housing has been identified as one of the top 5 barriers for HIV+ persons accessing medical care.⁶
 - In 2014, HIV+ persons with stable housing had a viral suppression rate of 84.4%; only 45% of those with unstable housing achieved viral suppression.⁷
 - 21.7% of HIV+ respondents to a services needs survey indicated that they were homeless at some point in the last year.⁸
 - Of the estimated 3.5 million people who are homeless every year in the U.S. as many as 3.4% are HIV positive, a rate 3 times higher than that of the general population.⁹
 - In Houston, approximately 1 out of every 12 homeless persons was diagnosed with HIV in 2013, and 1.6% of homeless persons report that they were triggered into homelessness by an HIV diagnosis.¹⁰
 - In Northeast Georgia, 82% of the clients served by AIDS Athens live below the poverty line.¹¹
- **Homelessness Is Correlated With High Health Care Costs.** The high proportion of complex health needs and co-occurring health and behavioral health disorders increases the number, intensity, and scope of the services needed. Homelessness inhibits the long-term, consistent care needed for many of these conditions, with the result that problems are aggravated, making them more dangerous and more costly. Homelessness also increases the likelihood of excessive use of the ER, inpatient treatment, and crisis services.
 - A report in the New England Journal of Medicine documents that homeless people spent an average of four days longer per hospital visit than comparable non-homeless people at an **extra cost of approximately \$2,414 per hospitalization.**¹²

¹ *Social Determinants of Health*, Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services, retrieved March 30, 2015, <http://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health>.

² <http://www.cdc.gov/features/homelessness/> and Kaiser Commission on Medicaid and the Uninsured, "Medicaid Coverage and Care for the Homeless Population: Key Lessons to Consider for the 2014 Medicaid Expansion", September 2012, available at: <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8355.pdf>

³ End Chronic Homelessness Policy Academy Team presentation delivered at Washington Legislature Adult Behavioral Health System Task Force Meeting on September 19, 2014. For more information, please contact Gillian Morshedi (gillian@homebasecc.org) at HomeBase.

⁴ St. Lawrence, J., Brasfield, T.L. (1995). HIV risk behavior among homeless adults. *AIDS Education and Prevention*, V. 7, 22-31. Guildford Press: New York.

⁵ National Coalition for the Homeless, (2007). HIV/AIDS and homelessness [Online], www.nationalhomeless.org/publications/facts/HIV.pdf

⁶ Jennifer A. Pellowski, "Barriers to care for rural people living with HIV: A Review of domestic research and health care models," *J Assoc Nurses AIDS Care*. 2013 Sep-Oct; 24(5): 422-437.

⁷ Thakrar K et al, "Homelessness, HIV, and Incomplete Viral Suppression," *Journal of Health Care for the Poor and Underserved*, February 27, 2016 (1): 145-156.

⁸ Rickles, M. 2015. Ryan White Part A Nashville Transitional Grant Area 2015 Needs Assessment. Retrieved from: nashrpc.com/data. Nashville Regional HIV Planning Council.

⁹ National Alliance to End Homelessness (2006). "Fact Sheet: Homelessness and HIV/AIDS." Available at: <http://www.endhomelessness.org/library/entry/fact-sheet-homelessness-and-hiv-aids>

¹⁰ The 2013 Houston Area Integrated Epidemiologic Profile for HIV/AIDS Prevention and Care Services Planning. Reporting period: January 1 to December 31, 2011. Available at: <http://www.rwpchouston.org/Publications/2013%20Epi%20Profile%20--%20APPROVED%20--%2005-09-13.pdf>

¹¹ AIDS Athens, "HIV/AIDS Statistics," 2015, <http://aidsathens.org/get-support/hiv-aids-statistics/>.

¹² Salit S.A., Kuhn E.M., Hartz A.J., Vu J.M., Mosso A.L. Hospitalization costs associated with homelessness in New York City. *New England Journal of Medicine* 1998; 338: 1734-1740.

- In California, the Frequent Users of Health Services Initiative found that approximately **45 percent of individuals who were high utilizers of emergency departments were homeless**.¹³
- 37 homeless men and women in Asheville, North Carolina, over a three-year period, cost the City and County **over \$800,000 each year**. The total costs included \$120,000 for 280 episodes of EMS services, and \$425,000 in hospitalization costs.¹⁴
- A 2014 New Mexico study found **13% decrease** in emergency room costs and **83.8% decrease in hospital inpatient costs** after study group members were housed for a year, compared to the prior year.¹⁵
- A two-year study in Boise, Idaho led to an estimate that **homeless services for one person experiencing chronic homelessness in Boise for one year ranges from \$40,000-\$85,000**, including case management, police, incarceration, paramedics, fire department, emergency room, hospital care, and shelter services.¹⁶
- A 2012 study by the City of Knoxville found that the cost of community services (case management, emergency shelter, supportive services, jail stays, and emergency medical services) for 41 chronically homeless individuals **decreased by \$76,721 after one year in permanent supportive housing**.¹⁷
- A 2009 study in Chicago found that without healthcare or housing interventions, 204 homeless adults with chronic medical illnesses experienced **743 hospitalizations** and **3.77 emergency room visits per person per year** over an 18-month period.¹⁸
- A study conducted by West Virginia University (WVU) and the West Virginia Coalition to End Homelessness found that 267 persons experiencing homelessness who received care at WVU Ruby Memorial Hospital over a one-year period incurred **\$5,979,463 in service costs**, including **785 emergency department visits totaling \$1,128,036 in care costs** and **257 inpatient stays totaling \$3,743,699 in care costs**.¹⁹
- According to a University of Texas two-year survey of homeless individuals, each person costs the taxpayers **\$14,480 per year** across public systems, primarily for overnight jail.²⁰
- A Clarke county study released in February 2007 found that Athens hospitals spent at least **\$12.4 million** in 2005 caring for the homeless, an average of almost **\$20,000 per homeless patient**.²¹
- A Philadelphia homelessness cost study found that the top 20% of individuals experiencing chronic homelessness plus substance abuse cost the City approximately **\$22,000 per person per year in behavioral health services, homeless services, prison, and jail**.²²
- A study of hospital admissions of homeless people in Hawaii revealed that **1,751 adults were responsible for 564 hospitalizations and \$4 million in admission costs**. Their rate of psychiatric hospitalization was over 100 times higher than their non-homeless cohort.²³
- A 2004 analysis of Duval County conservatively estimated taxpayers pay **\$35,000,000 a year** providing services for the homeless, including healthcare system costs such as emergency rooms, untreated illnesses, unreimbursed expenses, ambulance service, and crisis stabilization units.²⁴
- A 2014 report found that the average annual cost for **incarceration, emergency rooms and inpatient hospitalizations** for a cohort of 107 chronically homeless individuals in Florida's Orange, Seminole and Osceola counties is **\$3,323,955**.²⁵

¹³ Linkins, Brya, & Chandler, 2008, available at: <http://www.aidschicago.org/pdf/2009/hhrpn/FUHCS/1-FrequentUsersofHealthServicesInitiative-FinalEvaluation.pdf>

¹⁴ From National Academy for State Health Policy, "Chronic Homeless and High Users of Health Services" available at

http://nashp.org/sites/default/files/chronic_homelessness.pdf?q=Files/chronic_homelessness.pdf

Charlotte Chaplan, Staff Report: 10-Year Plan to End Homelessness, (Asheville, NC and Buncombe County, NC January 11, 2005); retrieved 16 November 2007; <http://www.ich.gov/slocal/plans/asheville.pdf>.

¹⁵ Study by Institute for Social Research, June 2014. From: <http://news.unm.edu/news/unm-study-reveals-cost-benefits-in-housing-the-homeless>

¹⁶ Boise's 10 Year Plan to Reduce and Prevent Chronic Homelessness, November 2007., available at: https://www.cdavid.org/files/municipal_services/Boise10YrPlan.pdf

¹⁷ Study by the City of Knoxville, "Comparative Costs and Benefits of Permanent Supportive Housing in Knoxville, Tennessee," 2012, available at:

<http://shnny.org/uploads/Knoxville-study.pdf>.

¹⁸ http://www.aidschicago.org/resources/legacy/pdf/2012/chhp_data_sheet_2012.pdf and

http://usich.gov/usich_resources/solutions/explore/chicago_housing_for_health_partnership.

¹⁹ R, David Parker, "An inexpensive, interdisciplinary, methodology to conduct an impact study of homeless persons on hospital based services," as cited in the West Virginia Interagency Council on Homelessness 2014 Report, available at:

http://www.wvcommerce.org/App_Media/assets/download/ndrc/WVICH_Progress_Report_2014.pdf.

²⁰ National Alliance to End Homelessness, "Cost of Homelessness," http://www.endhomelessness.org/pages/cost_of_homelessness.

²¹ "Cost Analysis of Medical Services to Homeless Persons" (2007) Athens-Clarke County Dept. of Human and Economic Development, as cited in "Addressing Homelessness through Collaboration," State Housing Trust Fund Annual Report, January 1, 2008,

<http://www.dca.state.ga.us/housing/specialneeds/publications/2008HTFAAnnualReport.pdf>.

²² Stephen R. Poulin, Marcella Maguire, Stephen Metraux, and Dennis P. Culhane. "Service Use and Costs for Persons Experiencing Chronic Homelessness in Philadelphia: A Population-Based Study" *Psychiatric Services* 61.11 (2010): 1093-1098.

²³ Martell J.V., Seitz R.S., Harada J.K., Kobayashi J., Sasaki V.K., Wong C. Hospitalization in an urban homeless population: the Honolulu Urban Homeless Project. *Annals of Internal Medicine* 1992; 116:299-303.

²⁴ Ability Housing, "Home is Where Our Heart Is," 2007 Annual Report, http://abilityhousing.org/docs/AH_07AnnualReport.pdf.

- A 2010 study by the U.S. Department of Housing and Urban Development (HUD) found that in Kalamazoo **Medicaid costs for children in a cohort of homeless families were 26% higher than the statewide average** Medicaid cost for children; Medicaid costs for adults were **78% higher than the statewide average.**²⁶
- In New York, over **89% of people predicted to be at high risk for hospital readmissions** were homeless.²⁷
- In 2009, the emergency department of St. Patrick Hospital in Missoula, MT was visited by 514 people identified as homeless. These individuals accounted for **1,219 separate visits to the ER** and were provided with **\$3,028,359 in charity care**. Three years later in 2012, the cost was closer to **\$4,000,000.**²⁸
- As of 2009, Billings estimated each homeless person cost the city over **\$15,000 per year in public services**, with an estimated cost of **\$115,000 to serve each chronically homeless individual** per year. With nearly 2,400 people experiencing homelessness in Billings each year, **costs exceed \$54 million annually.**²⁹
- A rough estimate for the total annual cost of homelessness in Flathead County, Montana in 2013 was in the **multi-million dollar range.**³⁰
- **Permanent Supportive Housing (PSH) Improves Health Outcomes And Reduces Health Care Costs.** PSH, affordable housing linked with comprehensive health and support services, serves people with severe and complex needs, including those who have been chronically homeless. Research and experience repeatedly document that PSH results in reductions in costs for hospitalization, emergency room visits, crisis services, shelter, jail, and detox; high rates of housing stability and retention; and improved health and recovery. Changes under the ACA **expand opportunities to use Medicaid to fund PSH services.**³¹

SUCCESSFUL PERMANENT SUPPORTIVE HOUSING PROGRAMS

1811 Eastlake in Seattle, WA³²

- **Serves:** Chronically homeless people with severe alcoholism & high use of crisis services
- **Outcomes:** Significant cost reduction in service usage (health, behavioral health, criminal justice and shelter) after one year of enrollment with median monthly costs dropping from \$4,066/person to \$958/person and alcohol use dropping by about a third. The savings far exceed the cost of the housing.

Denver Housing First Collaborative³³

- **Serves:** 100 chronically homeless individuals with disabilities
- **Outcomes:** Comparing 2 years pre-housing with 2 years post-housing, residents had 34% fewer ER visits, 40% fewer inpatient visits, 82% fewer detox visits, and 76% fewer incarceration days.

San Francisco Direct Access to Housing³⁴

- Plaza Apartments serves high cost system users.
- **Outcomes:** Approximately \$2,226,568 million in healthcare reductions in first year.
- Mission Creek serves 51 homeless seniors.
- **Outcomes:** 82% reduction in total cost of health care utilization, including emergency department, hospital

²⁵ Central Florida Commission on Homelessness, "The Cost of Long-Term Homelessness in Central Florida," 2014, http://abilityhousing.org/docs/AH_07AnnualReport.pdf.

²⁶ U.S. Department of Housing and Urban Development, "Costs Associated with First-Time Homelessness for Families and Individuals," March 2010, https://www.huduser.gov/publications/pdf/Costs_Homeless.pdf.

²⁷ California Department of Health Care Services Webinar, "Medi-Cal Managed Care Plans and Homeless Members," October 1, 2014. Available at: https://www.youtube.com/watch?v=32xyeUzTqys&feature=player_embedded

²⁸ Missoula Reaching Home Workgroup, "Reaching Home: Missoula's 10-Year Plan to End Homelessness 2012-2022," October 2012: 11, <http://www.ci.missoula.mt.us/DocumentCenter/View/21013>

²⁹ City of Billings Mayor's Committee on Homelessness Community Development Division, "Welcome Home Billings," October 2009: 5, <http://www.ci.billings.mt.us/DocumentCenter/Home/View/4985>

³⁰ Flathead Homelessness Interagency Resource and Education, "Finding the Way Home: Five-Year Plan to Address Homelessness (2014-2019)," 2014: 13, <http://flatheadhealth.org/wp-content/uploads/2015/01/5-Year-Plan-to-Address-Homelessness.pdf>

³¹ ASPE, Medicaid and Permanent Supportive Housing for Chronically Homeless Individuals: Emerging Practices from the Field, available at: <http://aspe.hhs.gov/daltcp/reports/2014/EmergPrac.pdf>

³² Downtown Emergency Service Center, "JAMA Research Shows Housing for Homeless Saves Taxpayers Millions," April 2009, http://www.desc.org/documents/DESC_1811_JAMA_info.pdf and Mary E. Larimer, et al, "Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems," JAMA, 2009, http://shnny.org/uploads/Health_Care_and_Public_Service_Use.pdf.

³³ Jennifer Perlman and John Parvensky, "Denver Housing First Collaborative: Cost Benefit Analysis and Program Outcomes Report," Colorado Coalition for the Homeless, December 11, 2006, http://www.denversroadhome.org/files/FinalDHFCCostStudy_1.pdf.

³⁴ San Francisco Department of Public Health, Cost-Effective Strategies for Housing Homeless Clients presentation.

inpatient, psych inpatient and skilled nursing facilities.

Moore Place, a Housing Works Program of the Urban Ministry Center in Charlotte, NC³⁵

- **Serves:** adults with extensive histories of homelessness and a disabling condition (mental health and substance abuse disorders, chronic health disorders, physical disabilities, developmental disabilities).
- **Outcomes:** 2014 study reported area hospital bills, emergency room visits, and lengths of hospitalizations significantly decreased during tenants' first year of housing.

Healthy Home Peer Experts Supportive Housing Program, Santa Fe County, NM³⁶

- **Serves:** adults with severe mental illness & co-occurring disorders experiencing or at risk of homelessness
- **Outcomes:** As of April, provided housing supports to 282 individuals. Comprehensive Community Support Services by Certified Peer Support Specialists. Created Peer Evaluator position and accompanying manual.

The Next Door Freedom Recovery Community in Nashville, TN³⁷

- **Serves:** Homeless single women and mothers diagnosed with a substance abuse addiction and/or a mental illness, many of whom have been incarcerated
- **Outcomes:** The recidivism rate for formerly incarcerated women who stay at least 90 days is only 20%, compared to a statewide average of over 60%. 72% of residents find employment within 25 business days of admission, with an average of 17 days from admission to employment.

Chicago Housing for Health Partnership³⁸

- **Serves:** Chronically ill homeless individuals
- **Outcomes:** 1/3 fewer inpatient hospital days and 1/4 fewer emergency room visits for program participants as compared to their peers relying on the usual care system. Evidence indicates that every 100 chronic homeless individuals housed will save \$1 million in public funds/year and every 100 short term homeless individuals housed will save \$630,000/year.

Housing Crisis Center in Dallas, TX³⁹

- **Serves:** 105 chronically homeless disabled adults, primarily veterans.
- **Outcomes:** The Housing Crisis Center houses each chronically homeless individuals for approximately \$10,000 annually, compared to an average cost of \$60,000-\$100,000 to care for someone who is chronically homeless on the streets of Dallas. In 2013, residents demonstrated a 96% increase in housing stability, 59% increase in income, and 100% increase in sense of self-determination.

AIDS Athens in Athens, GA⁴⁰

- **Serves:** Homeless persons living with HIV/AIDS

Outcomes: Those AIDS Athens' housed in 2013/14 experienced a 69% reduction in incarceration rates, 93% compliance with medical care, and a 17% increase in earned income due to improved health.

Housing Initiatives, Inc. in Madison, WI⁴¹

- **Serves:** Homeless persons living with severe mental illness

Outcomes: Housing Initiatives provides PSH to clients for \$10,000/year (compared to the estimated \$40,000/year spent by tax-payers on mentally ill persons who are homeless), with 95% of clients never returning to homelessness.

Pathways to Housing PA in Philadelphia, PA⁴²

- **Serves:** Chronically ill, seriously mental ill homeless individuals
- **Outcomes:** Comparing one year pre-housing to one-year post housing, Community Behavioral Health hospitalization episodes decreased by 70 and mental health hospitalizations decreased by 54%. The program saves the public a total of \$421,893 per year, or \$4,219 for each client served.

Ability Housing in Jacksonville, FL⁴³

³⁵ Urban Ministry Center, "Permanent Supportive Housing," 2015, <http://www.urbanministrycenter.org/helping-the-homeless/housing-for-homeless/>.

³⁶ From New Mexico's Application for FY 2015 Cooperative Agreements to Benefit Homeless Individuals for States (CABHI-States) grants.

³⁷ GuideStar, "The Next Door," 2015, <https://www.guidestar.org/organizations/43-2001774/next-door.aspx>.

³⁸ AIDS Chicago, "Studies on Supportive Housing Yield Results for Health of Homeless and Cost Savings," Data Sheet, 2012,

http://www.aidschicago.org/pdf/2012/chhp_data_sheet_2012.pdf

³⁹ Housing Crisis Center, "2013 Annual Report," http://www.hccdallas.org/wp-content/uploads/2014/04/HCC_2013_AnnualReport.pdf

⁴⁰ AIDS Athens, "Annual Report 2013/14," <http://aidsathens.org/wp-content/uploads/2015/06/2013-2014-Annual-Report.pdf>.

⁴¹ Housing Initiatives, Inc., "2014 Annual Report," <http://housinginit.org/wp-content/uploads/2015/08/Final-HII-2014-Report.pdf>.

⁴² Center City District, "Evaluation of Pathways to Housing PA," January 2011:

https://cymcdn.com/sites/www.philanthropynetwork.org/resource/resmgr/research_reports/pathways_to_housing_report.pdf

⁴³ Ability Housing, "2013 Annual Report to the Community," http://abilityhousing.org/wp-content/uploads/2014/08/2013_AnnualReport_AbilityHousing.pdf.

- **Serves:** Persons experiencing homelessness, at-risk of homelessness, and adults with disabilities.
- **Outcomes:** In 2013, Ability Housing housed 204 formerly homeless persons with a 91% housing stability rate. Provided 720 hours of case management services and saw decreased community crime, police and jail expenses, community medical expenses, and use of emergency services.

Cooper House in Fargo, ND⁴⁴

- **Serves:** Homeless individuals, with preference given to those experiencing chronic or long-term homelessness, veterans, and people with disabilities.
- **Outcomes:** After one year of housing, there was a total cost savings for all residents of \$204,140, including a decrease in healthcare and medical costs of \$15,130 (10%) and a drop in detox costs of \$53,520 (71%).

Neighborhood Service Organization (NSO) Bell Building in Detroit, MI⁴⁵

- **Serves:** 155 one-bedroom apartments serving homeless and formerly homeless adults
- **Outcomes:** The NSO Bell Building is expected to save taxpayers more than \$5 million annually, as some estimates show that a single person experiencing chronic homelessness can cost taxpayers \$50,000 or more a year in police calls, ambulance calls, emergency room visits, and time spent in the hospital.

Lansing Inn & Hill Street Inn, Joseph's House and Shelter in Troy, NY⁴⁶

- **Serves:** 55 single homeless adults, most chronically homeless with severe and persistent mental illness
- **Outcomes:** Lansing Inn & Hill Street Inn have an 85% retention rate, with five residents newly enrolling in SSI/SSDI benefits and an average tenant income increase by \$206 once housed.

FOCUS ON “MAINSTREAMING”

HUD strongly encourages and incentivizes communities to apply the resources of a broad spectrum of health, education, human, and social services programs to the response to homelessness. This “mainstreaming” approach is also found in the Homeless Emergency and Rapid Transition to Housing (HEARTH) Act of 2009.

HUD’s study, “Strategies for Improving Homeless People’s Access to Mainstream Benefits and Services,” found that communities intent on improving access to mainstream services had success reducing structural barriers.⁴⁷

The U.S. Interagency Council on Homelessness (USICH)’s “Opening Doors: Federal Strategic Plan to Prevent and End Homelessness,” as amended in 2015, outlines an interagency collaboration that aligns mainstream housing, health, education, and human services to prevent Americans from experiencing homelessness.⁴⁸ The Plan emphasizes the full integration of targeted programs with mainstream programs, and calls on all relevant mainstream programs to prioritize housing stability for people experiencing or at risk of homelessness.

⁴⁴ Dan Madler (Beyond Shelter, Inc.), “Providing More Than A Roof: Supportive Housing Collaboration,” NDHFA 2014 Statewide Housing Conference, <https://www.ndhfa.org/About%20Us/HousingConference/2014/Madler-ProvidingMorethanRoof.pdf>.

⁴⁵ Neighborhood Service Organization, “NSO Bell Building,” <http://www.nso-mi.org/bell-building.php>.

⁴⁶ Joseph’s House and Shelter, “Joseph’s House Statistics,” Joseph’s House & Shelter, Inc. 2015 Annual Report, http://www.josephshousetroy.org/?page_id=99

⁴⁷ Martha Burt, et al, “Strategies for Improving Homeless People’s Access to Mainstream Benefits and Services,” March 2010, http://www.huduser.org/portal/publications/povsoc/homeless_access.html

⁴⁸ U.S. Interagency Council on Homelessness, “Opening Doors: Federal Strategic Plan to End Homelessness,” Amended 2015: 29,42. http://usich.gov/resources/uploads/asset_library/USICH_OpeningDoors_Amendment2015_FINAL.pdf.

APPENDIX B: STAKEHOLDER CHECKLIST

The following is a list of potential stakeholders to consider engaging to accomplish systems coordination and integration.

Housing-Healthcare Systems Integration: Stakeholder Checklist

The following is a list of potential stakeholders to consider engaging to support efforts to coordinate and integrate across service and treatment systems.

Housing
Continuum of Care (CoC) Coordinators
Permanent Supportive Housing Providers
Other Housing Providers (e.g., Rapid Rehousing Providers, Emergency Shelters)
Supportive Service Providers
HOPWA Providers
Public Housing Authorities
HMIS administrators
Healthcare
FQHCs (Federally Qualified Health Centers) / Community Health Centers
Healthcare for the Homeless Programs
Hospital and medical facilities (including VA medical centers)
Mental Health/Behavioral Health agencies
Managed Care Organizations & Behavioral Health Organizations
Ryan White Providers
Primary Care Association
Hospital Association(s)
Free clinics and Indigent Care Clinics
SAMHSA Grantees
Center for Substance Abuse Treatment (CSAT) Grantees
Center for Mental Health Services (CMHS) Grantees
Rural Health Clinics/Rural Health Centers
Accountable Care Organizations
Health and Human Services
Department of Health
Indian Health Services/Indian Health Care Providers (including tribal clinics)
Federal Agencies
HUD Field Office and CPD Directors
HRSA Regional Administrators
SAMHSA Regional Administrators
Dept. of Justice
Dept. of Labor
USDA (Office of Rural Development)
Centers for Medicare and Medicaid Services (CMS)
Dept. of Veterans Affairs
Dept. of Education
USICH Regional Coordinators
Insurance
State Medicaid Program
County/Local Health Plans (if applicable)
Centers for Consumer Information and Insurance Oversight (CCIO) Grantees
Criminal Justice
Funding Programs

APPENDIX C: GLOSSARY OF HOUSING AND HEALTHCARE TERMS

The following is a glossary of frequently used terms and acronyms to assist stakeholders working in the health system to understand unfamiliar housing language and vice versa.

GLOSSARY OF HOUSING AND HEALTH CARE TERMS

ACRONYM / TERM	DEFINITION / DESCRIPTION
ACA	Affordable Care Act
ACO	Accountable Care Organization
ACT	Assertive Community Treatment. A team-based treatment model that provides multidisciplinary, flexible treatment and support to people with mental illness 24/7.
ASPE	Assistant Secretary for Planning and Evaluation. The principle advisor to the Secretary of the U.S. Department of Health and Human Services on policy development. Responsible for major activities of policy coordination, legislation development, strategic planning, policy research, evaluation, and economic analysis.
Behavioral health	An umbrella term that includes mental health and substance abuse.
CABHI	Cooperative Agreement to Benefit Homeless Individuals. Program funded by SAMHSA, Center for Substance Abuse Treatment and Center for Mental Health Services to help states increase capacity to provide services, permanent housing, and supports for veterans experiencing homelessness and other individuals experiencing chronic homelessness.
Capitation	A method of payment for health services in which an individual or institutional provider is paid a fixed amount for each person served, without regard to the actual number or nature of services provided to each person in a set period of time.
CHIP	Children's Health Insurance Program. Offers free or low-cost health coverage for eligible children and other family members.
Chronically Homeless	HUD defines this population as an unaccompanied homeless individual with a disabling condition or a family with at least one adult member who has a disabling condition who has either been continuously homeless for a year or more OR has had at least four (4) episodes of homelessness in the past three (3) years.
CMS	Centers for Medicare & Medicaid Services. The government agency within the Department of Health and Human Services that directs the Medicare and Medicaid programs. Formerly Health Care Financing Administration.
CMMI	The Center for Medicare & Medicaid Innovation (The Innovation Center)
CoC or Continuum of Care (Housing)	A Continuum of Care is a local or regional system for helping people who are homeless or at imminent risk of homelessness in the community, from homeless prevention to permanent housing.
Continuum of care (Health Care)	Clinical services provided during a single inpatient hospitalization or for multiple conditions over a lifetime. Provides a basis for evaluating quality, cost, and utilization over the long term.
CoC Homeless Providers	Non-profit agencies or State and Local Governments that provide housing and services for homeless persons.

ACRONYM / TERM	DEFINITION / DESCRIPTION
Coordinated Entry	A coordinated system across a CoC and its programs to initially assess the eligibility and needs of each individual or family who seeks homeless assistance, and to coordinate the entry and provision of referrals to programs. Through the coordinated entry process, people seeking assistance receive prevention, housing, and/or other related services.
Disability	Per the ADA: With respect to an individual, disability means: (1) a physical or mental impairment that substantially limits one or more majority life activities of such individual; (2) a record of such an impairment; or (3) being regarded as having such an impairment.
Disabling Condition	Per HUD: (1) a disability as defined in Section 223 of the Social Security Act; (2) a physical, mental, or emotional impairment which is expected to be of long-continued and indefinite duration, substantially impedes an individual's ability to live independently, and of such a nature that the disability could be improved by more suitable conditions; (3) a developmental disability as defined in Section 102 of the Developmental Disabilities Assistance and Bill of Rights Act; (4) the disease of acquired immune deficiency syndrome or any condition arising from the etiological agent for acquired immune deficiency syndrome; or (5) a diagnosable substance abuse disorder.
DSRIP Program	Delivery System Reform Incentive Payment Program. Program that provides states with funding that can be used to support hospitals and other providers in changing how they provide care to Medicaid beneficiaries.
Dual eligible	A person who is eligible for two health insurance plans, often referring to a Medicare beneficiary who also qualifies for Medicaid benefits.
DV	Domestic Violence
Emergency Shelter (ES)	Any facility that the primary purpose of which is to provide temporary or transitional shelter for the homeless in general or for specific subpopulations of the homeless, while they prepare to move into more stable housing. The housing and services are typically provided for up to 90 days or until specific goals are accomplished by the client.
EMS	Emergency medical services. Services utilized in responding to the perceived individual need for immediate treatment for medical or psychological illness or injury.
ER/ED	Emergency Room/Emergency Department
FMR	Fair Market Rent. The amount of money a property would rent or lease for if it was on the market at a given time.
FMS	Financial Management Services.
Federal Poverty Level (FPL)	Measure of income level issued annually by the Department of Health and Human Services, used to determine eligibility for certain programs and benefits. For 2015, the FPL is \$11,770 for individuals; \$15,930 for a family of two; \$20,090 for a family of 3; \$24,250 for a family of four.
Fee for Service	Method of billing for health care services under which a provider charges separately for each patient encounter or service rendered.

ACRONYM / TERM	DEFINITION / DESCRIPTION
FQHC	Federally Qualified Health Center. Federally funded nonprofit health centers or clinics that service medically underserved areas and populations and are eligible to receive cost-based Medicare and Medicaid reimbursement. FQHCs provide primary care services regardless of ability to pay.
HCH	Health Care for the Homeless.
HMIS	Homeless Management Information System. A computerized data collection system that tracks services received by homeless people, helps identify gaps in services within the CoC, and allows for greater collaboration among service providers by providing a "history" of a homeless person's involvement in the system of care.
Home- and Community-Based Services (HCBS)	Any care or services provided in a patient's place of residence or in a non-institutional setting located in the immediate community.
HOPWA	Housing Opportunities for Persons with AIDS. Federal program dedicated to the housing needs of people living with HIV/AIDS. Under the program HUD makes grants to local communities, State, and nonprofit organizations for projects that benefit low-income persons living with HIV/AIDS and their families.
Housing First	An approach to ending homelessness that centers on providing people experiencing homelessness with housing as quickly as possible, and then providing services as needed. Key elements are a low threshold for entry and no clinical prerequisites such as completion of a course of treatment or evidence of sobriety.
HRSA	Health Resources and Services Administration. The primary federal agency for improving access to health care services for people who are uninsured, isolated, or medically vulnerable. Part of the U.S. Department of Health and Human Services.
HUD	U.S. Department of Housing and Urban Development
Mainstream Programs	Programs that are not specifically targeted to homeless people, including Medicaid, food stamps (SNAP), Social Security Insurance, Social Security Disability Insurance, Workforce programs, Temporary Aid for Needy Families (TANF), etc.
Managed Care Organization (MCO)	A health care delivery system consisting of affiliated and/or owned hospitals, physicians, and others that provide a wide range of coordinated health services; an umbrella term for health plans that provide health care in return for a predetermined monthly fee and coordinate care through a defined network of physicians and hospitals.
Medicaid	A Federally aided, State-operated and administered program that provides medical benefits for certain indigent or low-income persons in need of health care. Subject to broad Federal guidelines, States determine benefits covered, program eligibility, rates of payment for providers, and methods of administering the program.

ACRONYM / TERM	DEFINITION / DESCRIPTION
ONDCP	Office of National Drug Control Policy. Component of the Executive Office of the President of the United States. Its goal is to establish policies, priorities, and objectives to eradicate illicit drug use, manufacturing, and trafficking; drug-related crime and violence; and drug-related health consequences in the U.S.
Outreach	The initial and most critical step in connecting or reconnecting a homeless person to needed health, mental health, recovery, social welfare, and housing services. Outreach is viewed as a process rather than an outcome, with a focus on establishing rapport and a goal of engaging homeless persons into accepting services and housing.
PATH	Projects for Assistance in Transition from Homelessness. Administered by SAMHSA's Center for Mental Health Services. Provides services to people with serious mental illness, including those with co-occurring substance use disorders, who are experiencing homelessness or at imminent risk of becoming homeless.
Permanent Supportive Housing (PSH)	Provides long-term (not time-limited), safe, and decent housing for homeless persons with disabilities, enabling independent living. May be provided in a single structure or at scattered sites.
PHA	Public Housing Authority
PLWHA	Persons living with HIV/AIDS
Point-in-Time (PIT) Count	A one-day statistically reliable unduplicated count of sheltered and unsheltered homeless individuals and families in a specific area. CoCs are only required to conduct a one-day point-in-time count every two years (biennially) however, HUD strongly encourages CoCs to conduct an annual point-in-time count, if resources allow.
Presumptive Eligibility	Gives an uninsured individual access to immediate, temporary Medicaid if they appear to be eligible, allowing the person to access health care services without having to wait for their application to be fully processed. If someone is deemed "presumptively eligible," the full eligibility process is performed.
Primary Care Association (PCA)	A group of clinics in a defined geographic location that offers care for people who are uninsured or who lack means to pay for care. A state's PCA is the umbrella organization for FQHCs in that state.
Rapid Re-Housing (RRH)	Places a priority on moving a family or individual experiencing homelessness into permanent housing as quickly as possible, ideally within 30 days of the client becoming homeless or entering a program. Duration of financial assistance may vary.
Respite care (health care system)	Care given to a hospice patient by another caregiver so that the usual caregiver can get rest.
Respite/Recuperative care (housing assistance system)	Program that provides short-term medical care and case management to homeless persons recovering from acute illness or injury whose condition would be exacerbated by being discharged to the street or a shelter.

ACRONYM / TERM	DEFINITION / DESCRIPTION
Ryan White HIV/AIDS Program	Works with cities, states, and local community-based organizations to provide services to people living with HIV/AIDS who do not have sufficient health care coverage or financial resources. The program is administered by HRSA's HIV/AIDS Bureau (HAB).
Safe Haven	Program that serves hard-to-reach homeless persons who have severe mental illness, are on the streets, and have been unable or unwilling to participate in supportive services. Safe Havens do not require participation in services and referrals as a condition of occupancy.
SAMHSA	Substance Abuse and Mental Health Services Administration. Agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. Its mission is to reduce the impact of substance use and mental illness on America's communities.
SSDI	Social Security Disability Insurance. Pays monthly benefits to workers who are no longer able to work due to significant illness or impairment expected to last at least a year or to result in death within a year. Benefits are based on past earnings.
SSI	Supplemental Security Income. A Federal cash assistance program for low-income aged, blind, and disabled individuals.
SOAR Program	SAMHSA's SSI/SSDI Outreach, Access, and Recovery Program. The program seeks to end homelessness through increased access to SSI/SSDI income supports, and is designed to increase access to the disability income benefit programs administered by the Social Security Administration for eligible adults who are experiencing or at risk of homelessness and have a mental illness, medical impairment, and/or a co-occurring substance use disorder.
Supportive Services Only (SSO)	Projects that address the service needs of homeless persons. Projects are classified as this component only if the project sponsor is not also providing housing to the same persons receiving the services. SSO projects may be in a structure(s) at a central location.
Tenant-Based Rental Assistance (TBRA)	Provides homeless families and individuals with very low and extremely low incomes with housing assistance. TBRA programs allow participants to choose their own housing and retain the rental assistance if they move.
TBI	Traumatic Brain Injury. TBI is an insult to the brain caused by an external physical force, for example; fall, motor vehicle accident, assault, sports related, IED explosion.
Transitional Housing (TH)	Type of supportive housing used to facilitate the movement of homeless individuals and families to permanent housing. It is housing in which homeless persons may live up to 24 months and receive supportive services that enable them to live more independently. The supportive services may be provided by the organization managing the housing or provided by other public or private agencies.
Unsheltered Homeless	Someone who is living on the streets or in a vehicle, encampment, abandoned building, garage, or any other place not normally used or meant for human habitation.
USICH	United States Interagency Council on Homelessness

ACRONYM / TERM	DEFINITION / DESCRIPTION
VI-SPDAT	Vulnerability Index-Service Prioritization and Decision Assistance Tool. An evidence-based, street-use-informed assessment tool that is designed to help providers determine the most appropriate housing intervention for a particular individual or family.

Build Your Own Glossary

ACRONYM / TERM	DEFINITION / DESCRIPTION

Note: This document was generated by TA providers to support direct TA for H² Initiative communities, and incorporates information from multiple sources without attribution to the original source material. The information was collected from publicly available online sources, and therefore not every piece of information may be completely accurate or up to date. Participants that notice incorrect or outdated information are encouraged to speak up so that everyone at the Planning Session receives the most complete and current information available.

This is not a HUD-endorsed document and is not intended for distribution outside the Action Planning Session.

APPENDIX D: HOUSING-HEALTHCARE PARTNERSHIP PROFILE

The following is a list of potential homeless assistance, housing, and healthcare partners each CoC should consider engaging and partnering with when working toward system integration.

Housing-Healthcare Partnership Profile

PATH Program Grantees

- State/local information available at <http://www.samhsa.gov/homelessness-programs-resources/grants-programs-services/path-program/state-provider-contacts>

Ryan White HIV/AIDS Program Grantees

- State/local information available at <https://careacttarget.org/grants-map/1437>

VA Veterans Medical Centers

- State/local information available at <http://www.va.gov/directory/guide/allstate.asp>

Healthcare for the Homeless Programs

- State/local information available at <https://www.nhchc.org/resources/grantees/national-hch-grantee-directory/>

Permanent Supportive Housing Providers

- State/Local Information available at <https://www.hudexchange.info/programs/coc/coc-housing-inventory-count-reports/>

Public and Indian Housing Authorities

- State/Local Information available at http://portal.hud.gov/hudportal/HUD?src=/program_offices/public_indian_housing/pha/contacts

Federally Qualified Health Centers (FQHCs)

- State/Local Information available at <http://bphc.hrsa.gov/uds/datacenter.aspx?q=d&year=2014&state=HI#glist>

Rural Health Clinics (RHCs)

- State/local information available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/rhclistbyprovidername.pdf>

Critical Access Hospitals (CAHs)

- State/local information available at <http://www.flexmonitoring.org/data/critical-access-hospital-locations/>

IHS- and Tribally Operated Indian Health Service Units and Facilities

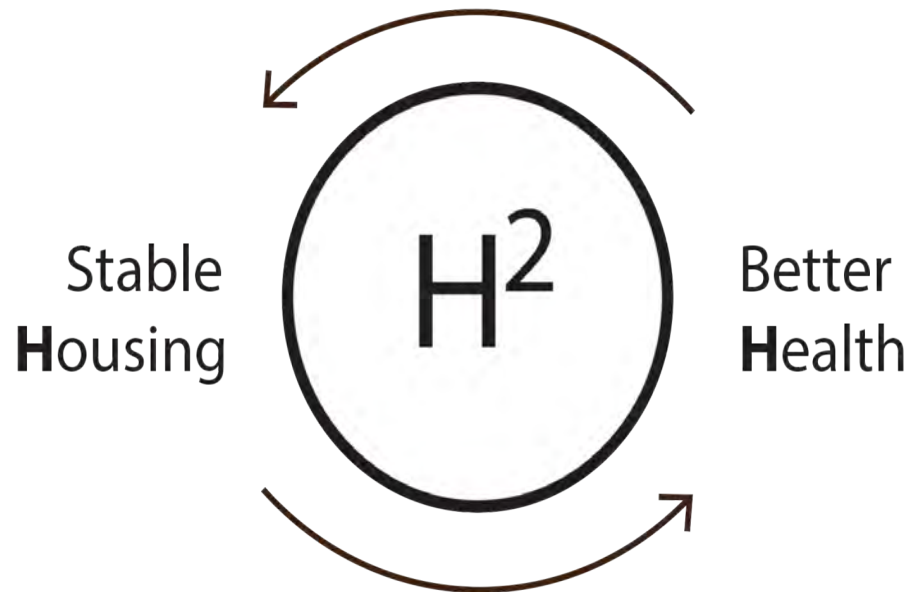
- State/local information available at <https://www.ihs.gov/findhealthcare/?CFID=29155634&CFTOKEN=11717221>

APPENDIX E: HOUSING-HEALTHCARE SYSTEMS INTEGRATION PROCESS PRESENTATION

The following is a slideshow presentation used to open each H² Action Planning Session, which contains a helpful overview and process map for systems integration.

Housing – Healthcare (H²) Integration Initiative

Action Planning Sessions



Montana State
May 12-13, 2016

H² Coalition of Federal Partners



HUD Policy Priorities

From 2014-2015 CoC Program NOFA:

“HUD strongly encourages CoCs and project applicants to ensure that they are maximizing the use of all mainstream services available. While [the CoC Program Interim Rule] allows for the payment of certain supportive service costs, it is more efficient for CoCs to use mainstream resources where possible. CoCs should proactively seek and provide information to all stakeholders within the geographic area about mainstream resources and funding opportunities, particularly new opportunities made available under the Affordable Care Act and related technical assistance initiatives.”

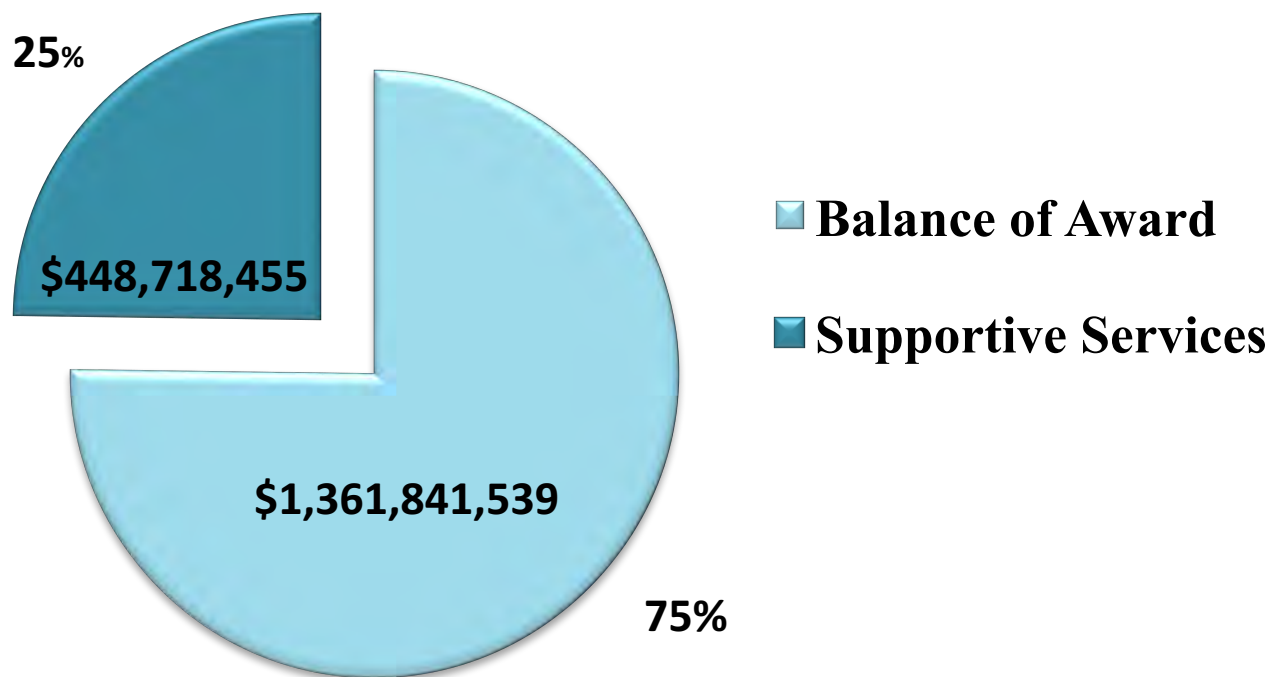
Eligible Costs – Supportive Services

In general, grant funds may be used on those services listed in the CoC Program interim rule *only*:

- **Assessing service needs**
- **Moving costs**
- **Case management**
- Child care
- **Education services**
- **Employment assistance & job training**
- **Food**
- Housing search & counseling services (**Case management**)
- Legal services
- **Life skills training**
- **Mental health services**
- **Outpatient health services**
- Outreach services
- **Substance abuse treatment services**
- **Transportation**
- Utility Deposits (**Moving Costs**)

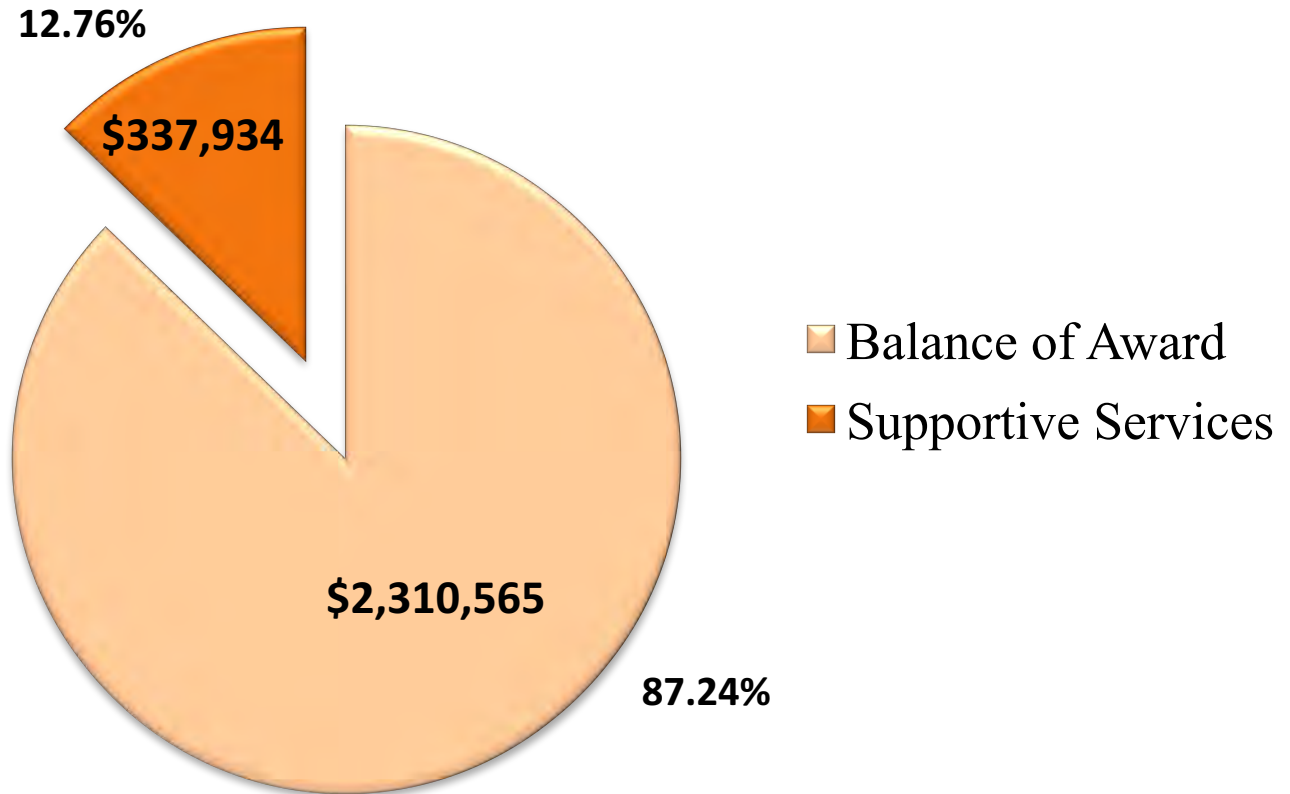
Fiscal Year 2014 CoC Awards

Nationwide Total = \$1,810,559,994



Fiscal Year 2014 CoC Award

State of Montana = \$2,648,499



What are we doing today?

- ✓ Convening representatives from the housing and healthcare service systems
- ✓ To complete an action plan to improve access to and effective utilization of healthcare services for homeless and at-risk program participants
- ✓ Goal: ensure effective coordination linkages between housing and healthcare services to maximize care coverage and increase access to comprehensive health care and supportive services that can be coordinated with housing

Objective for this Convening

- ❑ Create a draft plan for you to carry forward.
- ❑ The Plan will envision a permanent new way of doing business in each system, with routine cooperation, and interdependent outcomes.

How will we proceed?

- Series of planning discussion sessions
- Looking at the system components of the housing and the healthcare worlds
 - Determining eligibility
 - Access/entry
 - Services/housing available for those found eligible
 - Services/housing provided, when/where/and by whom
 - Funding and sources of support
 - Data collected, analyzed, and used to improve the system



HOUSING

TWO SYSTEMS

HEALTH CARE



Common Process
Components

Determine Eligibility

Session 2

Service Delivery

Session 3

Funding & Financing

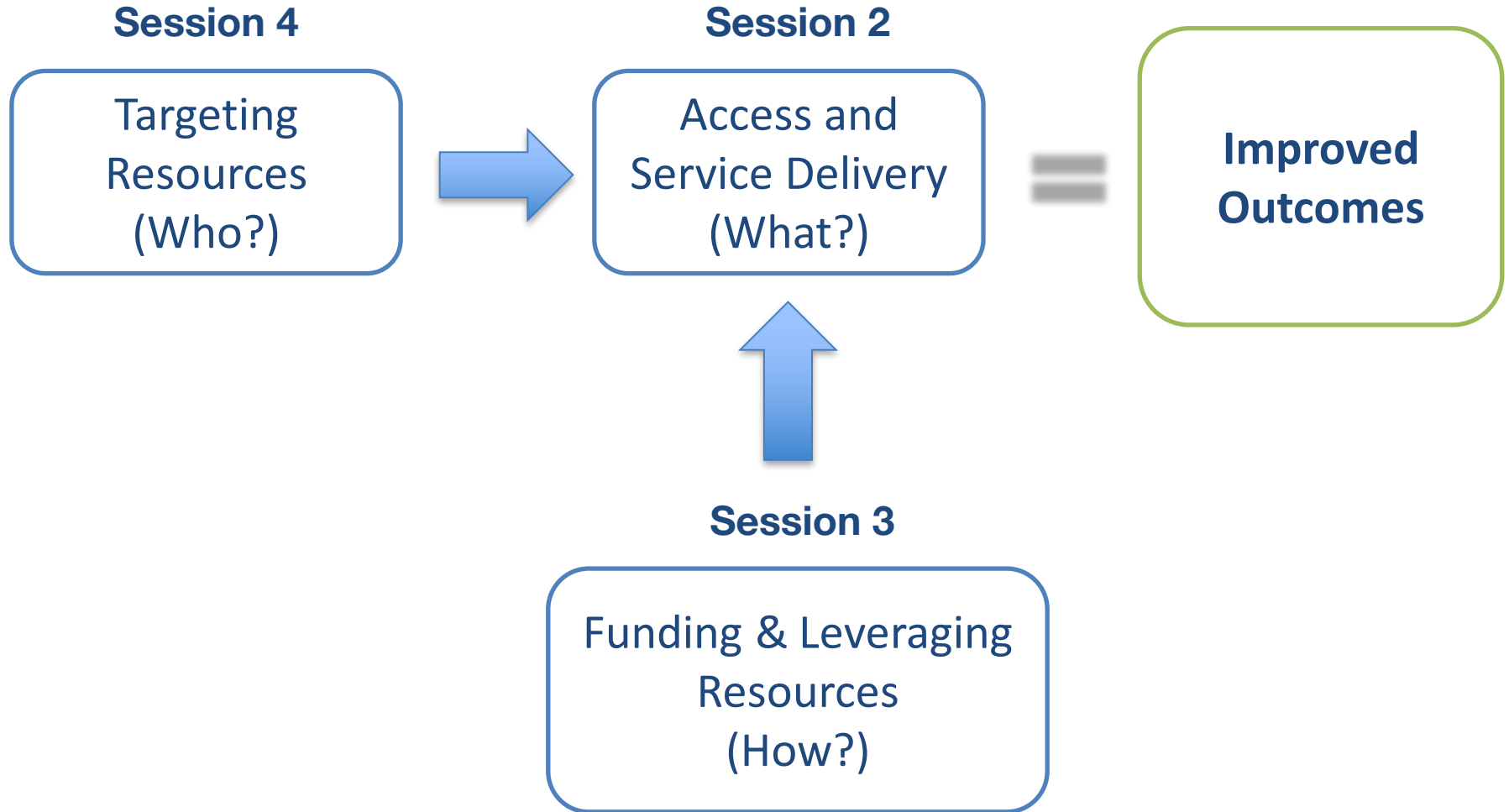
Session 4

Target Resources to Needs

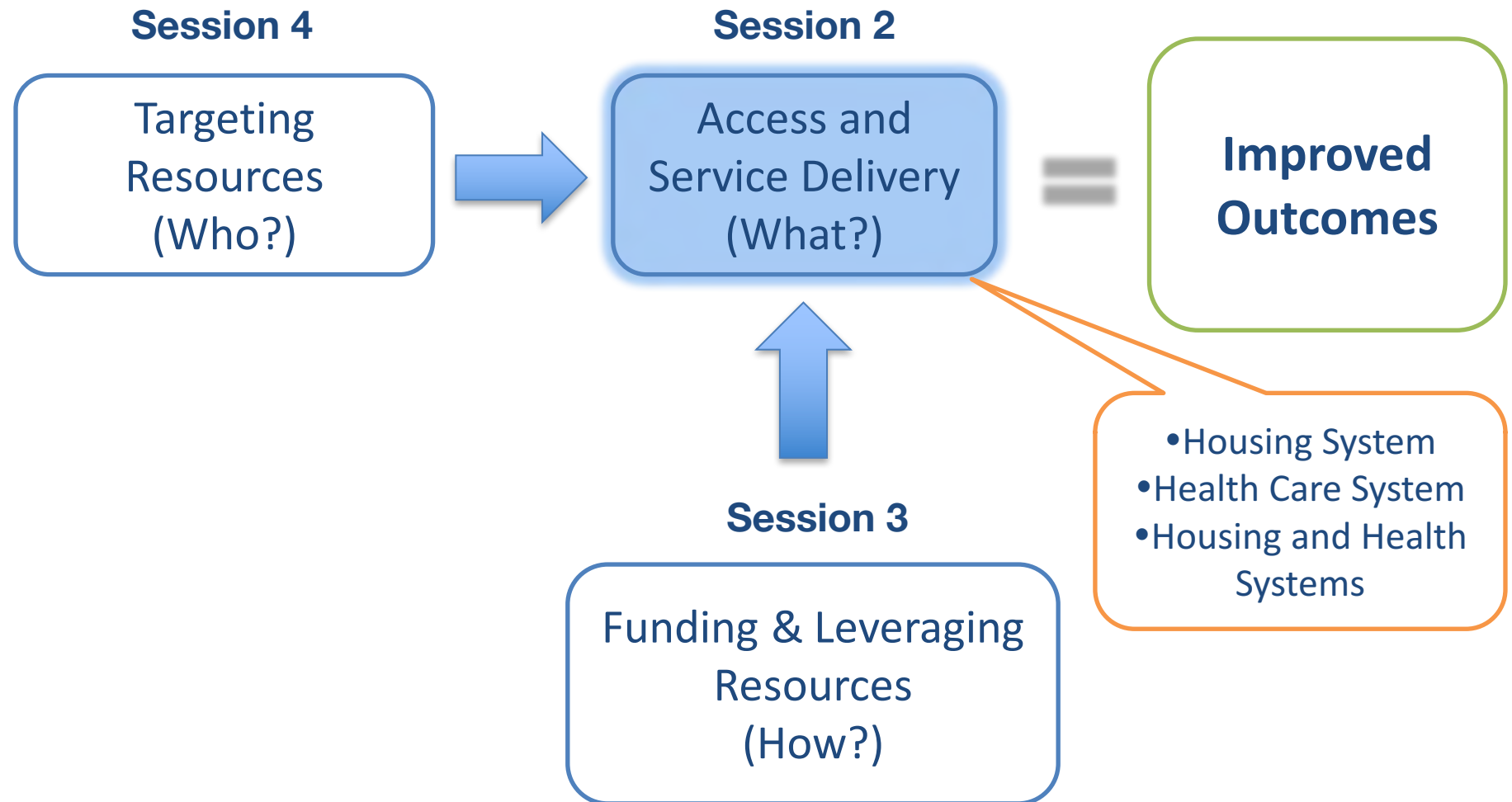
Outcomes & Measurement

If Yes

Process Map for Systems Integration



Process Map for Systems Integration



Session 2: Service Delivery (What)

Housing (2A)

- **HUD Resources**
- **Other Federal Resources**
- **Montana Resources**

Health Care (2B)

- **FQHCs**
- **Medicaid**
- **Managed Care**
- **Montana Resources**

- What housing and healthcare services are currently provided and how?
- ' What are the barriers to our target populations accessing and navigating the housing and health care systems?
 - ' Where does the system break down in terms of getting our clients access to care and/or housing? How do we address these challenges?
- What are promising strategies and potential solutions for improving access to care?

Process Map for Systems Integration

Session 4

Targeting
Resources
(Who?)



Session 2

Access and
Service Delivery
(What?)



**Improved
Outcomes**



Session 3

Funding & Leveraging
Resources
(How?)

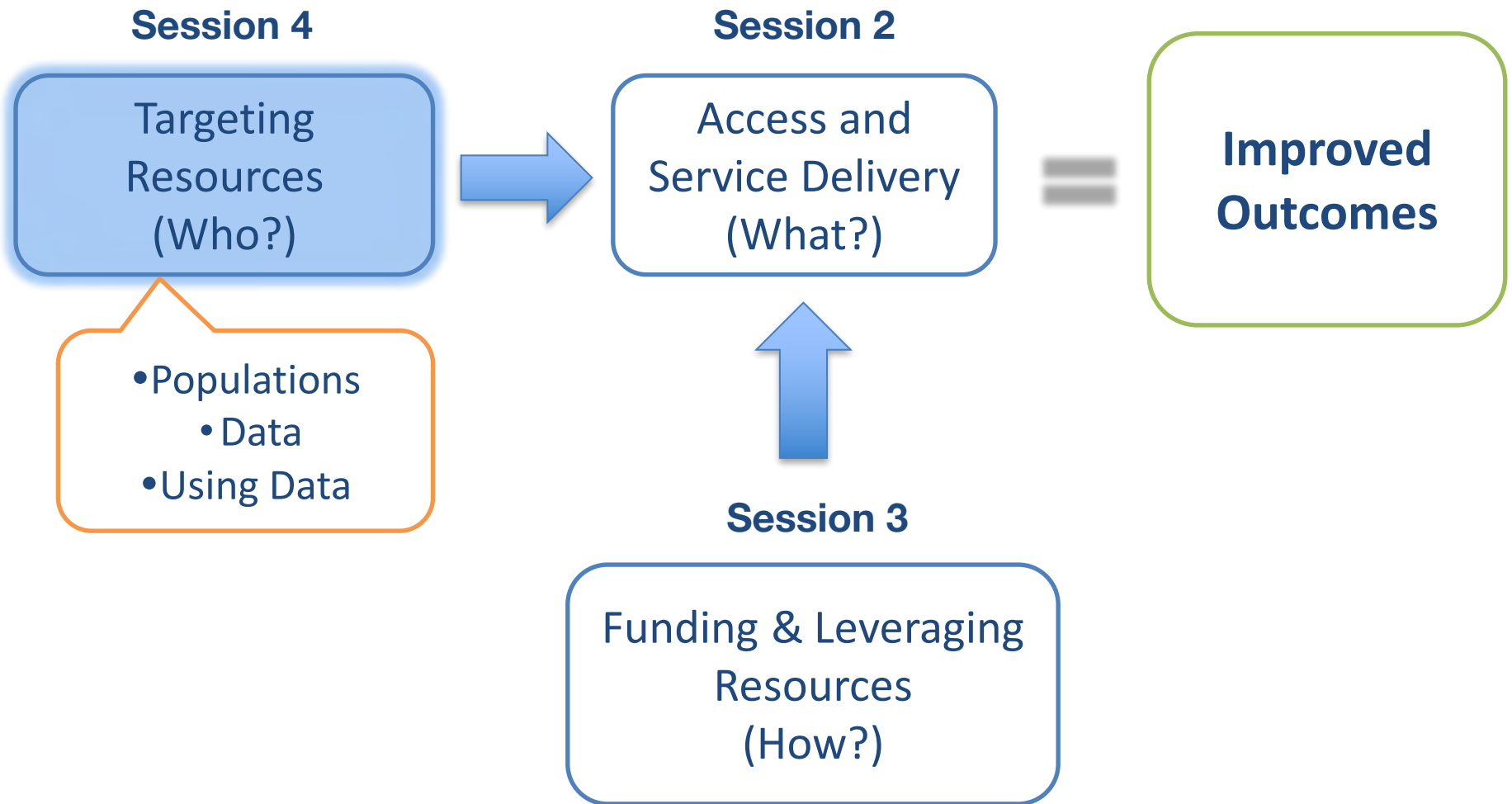
- Innovative Partnerships and Program Models
- Innovative Funding
- Cross-Systems Innovations

Session 3: Funding and Leveraging Resources to Support Systems Integration (How)

- Innovative Partnerships (3A)
 - Innovative Funding (3B)
- Montana Healthcare Innovation (3C)

- What kinds of resources are needed?
- What are the current funding gaps and barriers? How can Medicaid help?
- How do we form partnerships? What are new ways to develop relationships?
 - What capacity needs to be built on the ground?

Process Map for Systems Integration

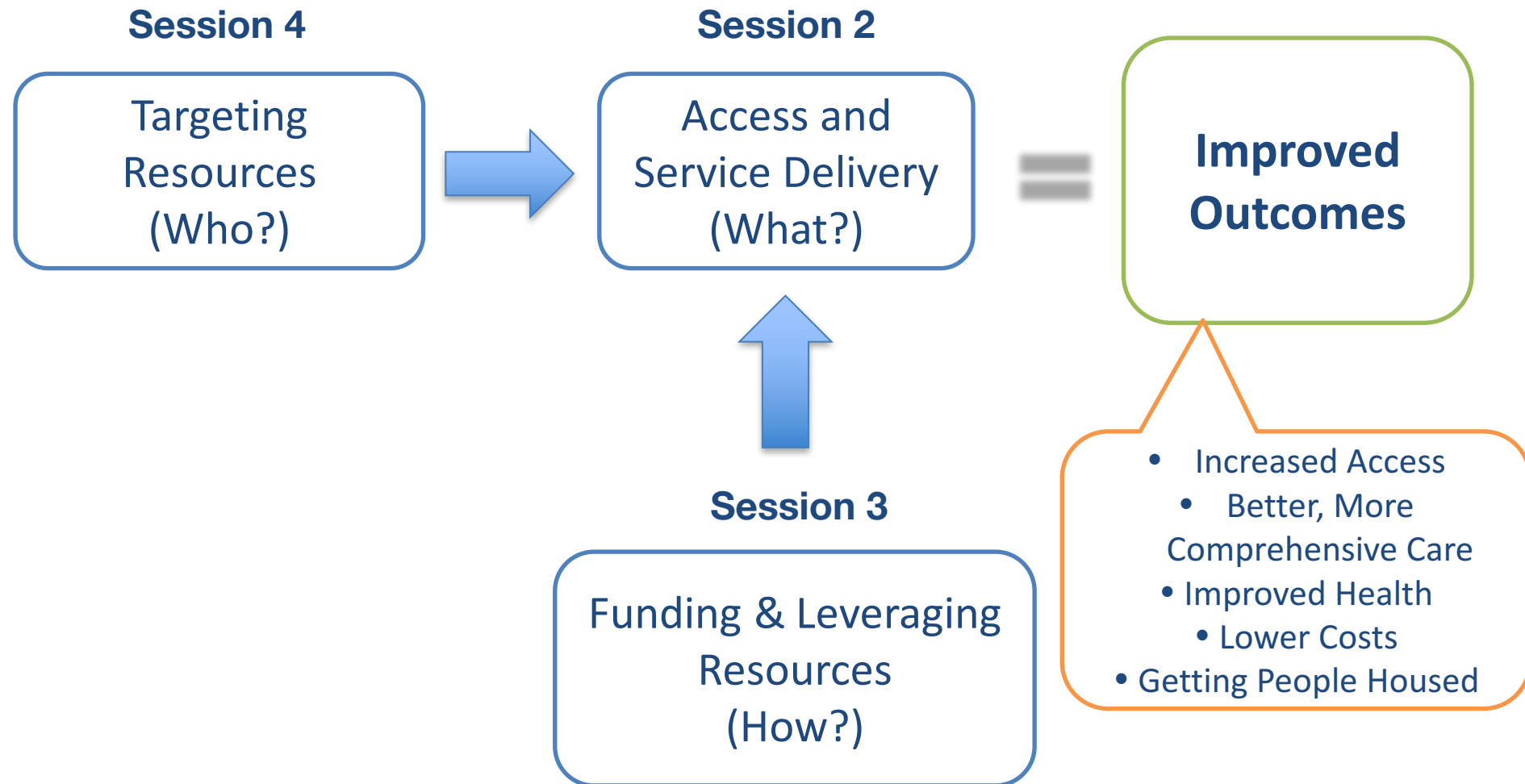


Session 4: Targeting Resources (Who)

- Defining Populations (4A)
- What is the Data? (4A)
- How to Use Data (4B)

- Who are the members of these populations?
- What more do we need to know? How can we find out?
- ' What challenges do we face in collecting/sharing data across different systems and their databases?

Process Map for Systems Integration



Improved Outcomes

Greater integration of the housing and health care systems, leading to...

- ✧ Increased Access to Care
- ✧ Better, More Comprehensive Care
 - ✧ Improved Health
 - ✧ Lower Costs
- ✧ Getting and Keeping People Housed

APPENDIX F: HOUSING RESOURCES

The following is a brief guide to homeless assistance and affordable housing programs and resources, including resources and programs funded by the U.S. Department of Housing and Urban Development and other federal resources.

HOMELESS HOUSING RESOURCES

The information in this document is intended primarily to provide people working in health care with basic information about homeless assistance and housing programs and resources. It is also intended to provide context for housing, health care, and service providers for discussions on gaps in needed housing and services that support housing stability. The following resources are covered:

- **HUD Resources**
 - Vouchers
 - HOME Program
 - Housing Trust Fund
 - Continuum of Care (CoC) Program
 - Emergency Solutions Grants (ESG)
 - Housing Opportunities for Persons with AIDS (HOPWA) Program
 - Office of Native American Programs (ONAP) Programs
 - VA Supportive Housing (VASH) Programs
- **Other Federal Resources**
 - Supportive Services for Veteran Families (SSVF)
 - USDA Rural Development, Rural Housing Service
 - SSI/SSDI Outreach, Access, and Recovery (SOAR) Program
 - Low Income Housing Tax Credit (LIHTC) Program
- **Local Housing Resources, including Permanent Supportive Housing (PSH) Programs**

Financial support for housing for low-income people tends to fall into categories: support to help cover “hard” costs (such as construction and rehabilitation) and support to cover more flexible “soft” costs, such as vouchers, operating costs, and services. Resources are often focused on a particular population (e.g. people with disabilities, people living with HIV/AIDS, people experiencing homelessness, veterans).

HUD Resources

HUD provides a variety of resources to states, local governments, and nonprofit housing agencies to provide access to or in order to develop affordable housing.

Housing Choice Voucher (HCV) Program¹

The Housing Choice Voucher (HCV) program provides rental assistance for low-income individuals and families. The HCV Program provides “tenant-based” rental assistance under Section 8 by providing low-income households with a voucher they can use to rent any private apartment that meets program guidelines. Section 8 also offers “project-based” rental assistance, which provides rental housing to low-income households in privately owned and managed rental units, but in which the subsidy stays with the building.

Special Purpose Vouchers²

Special purpose vouchers have been appropriated by Congress exclusively for people with disabilities. They are an invaluable resource for meeting the housing needs of people with disabilities

¹ U.S. Department of Housing and Urban Development, “Housing Choice Vouchers Fact Sheet,” 2015, http://portal.hud.gov/hudportal/HUD?src=/program_offices/public_indian_housing/programs/hcv/about/fact_sheet.

² The United States Interagency Council on Homelessness, “PHA Guide to Using Special Purpose Vouchers to End Homelessness,” http://usich.gov/resources/uploads/asset_library/PHA_SpecialPurposeVouchers.pdf.

because they must be set aside for people with disabilities even when they turn over and are re-issued. Vouchers are targeted exclusively to people with disabilities through the following programs:

Five-Year Mainstream Housing Opportunities for Persons with Disabilities

These vouchers are set aside exclusively for people with disabilities. They are funded through the Section 811 tenant-based rental assistance program (25% of the program's appropriations have been used for tenant-based rental assistance). PHAs³ receive 5-year annual contributions contracts.

Rental Assistance for Non-Elderly Persons with Disabilities ("NED" Vouchers)

Over the past decade, HUD has also awarded over 55,000 other vouchers targeted to non-elderly people with disabilities, now referred to as NED vouchers.

Although vouchers are an invaluable resource for helping homeless and low-income individuals with disabilities, PHAs often have substantial waiting lists for applicants to receive HCV and special purpose vouchers; lists may be also closed when the wait for housing becomes unreasonable.

HOME Investment Partnerships Program⁴

The federal government created the HOME Investment Partnerships Program (HOME) in 1990. The HOME program is a formula grant of federal housing funds given to states and localities (referred to as "participating jurisdictions" or PJs).

HOME funds can be used to:

- Build, buy, and renovate rental housing;
- Finance homeownership opportunities;
- Repair homes, including making buildings physically accessible; or
- Provide rental subsidies to eligible households.

National Housing Trust Fund (NHTF)⁵

The federal government created the NHTF in 2008, but it has not been operating due to insufficient funding. Funds are now being set aside, and HUD anticipates that allocations will begin mid-2016. The NHTF program is a formula grant of federal funds given to states and state-designated entities. Each state determines its priority housing need for production or preservation, primarily of rental housing, that is affordable and available to extremely low-income households. A state must use at least 80 percent of each annual grant for rental housing; up to 10 percent for homeownership; and up to 10 percent for the grantee's reasonable administrative and planning costs.

NHTF funds can be used for:

- New construction of rental and homebuyer units;
- Acquisition or acquisition/rehabilitation of rental and homebuyer units; or
- Operating costs for rental projects (up to one third of annual grant).

To receive its share of the NHTF, a state must submit an allocation plan as part of its annual action plan. The HUD Office of Community Planning and Development issued a Notice on January 28, 2016 outlining the timing for states and entitlement jurisdictions to submit their FY16 consolidated plans, action plans, and NHTF allocation plans. On April 4, 2016, HUD announced that \$174 million will soon be made available through first-ever allocations of the NHTF.

³ Non-profit disability organizations were also eligible to apply for Section 811-funded Mainstream vouchers.

⁴ U.S. Department of Housing and Urban Development, "HOME Investment Partnerships Program," http://portal.hud.gov/hudportal/HUD?src=/program_offices/comm_planning/affordablehousing/programs/home/.

⁵ HUD Exchange, Housing Trust Fund <https://www.hudexchange.info/programs/htf/> and Federal Register, Vol. 81, No. 87, May 5, 2016, "Housing Trust Fund Federal Register Allocation Notice", <https://www.gpo.gov/fdsys/pkg/FR-2016-05-05/pdf/2016-10508.pdf>

Continuum of Care (CoC) Program⁶

The Continuum of Care (CoC) Program is designed to promote communitywide commitment to the goal of ending homelessness; provide funding for efforts by nonprofit providers, and State and local governments to quickly rehouse homeless individuals and families while minimizing the trauma and dislocation caused to homeless individuals, families, and communities by homelessness; promote access to and effect utilization of mainstream programs by homeless individuals and families; and optimize self-sufficiency among individuals and families experiencing homelessness.

Emergency Solutions Grants (ESG)⁷

The Emergency Solutions Grant (ESG) Program provides grants to states and localities for emergency shelter, transitional housing, and permanent housing for the homeless. ESG funds can be used for street outreach, emergency shelter, homelessness prevention, rapid re-housing assistance, and HMIS, as well as administrative activities. ESG funds may also be used to fund Homeless Prevention and Rapid Re-Housing Programs (HPRP).

Housing Opportunities for Persons with AIDS Program (HOPWA)⁸

HOPWA funding provides housing assistance and related supportive services by grantees who are encouraged to develop community strategies and form partnerships with nonprofit organizations. Funds may be used for a range of housing, social services, program planning, & development costs.

HOPWA funds are awarded through the Consolidated Plan as a block grant to states and larger metropolitan areas based on the incidences of AIDS, and competitively through an annual Notice of Funding Availability (NOFA).

Office of Native American Programs (ONAP) Resources⁹

As sovereign nations, tribes are the direct recipients of HUD funding. Each tribe designates an entity to administer its housing programs with these federal dollars. Referred to as a Tribally Designated Entity (TDHE), the organization may be a department within the tribe, tribal housing authority with separate board of commissioners, or a nonprofit organization.

Regional ONAP offices administer the following programs:

Indian Housing Block Grant (IHBG): Formula-based grant program. Eligible activities include: housing development, assistance to housing developed under the Indian Housing Program, housing services to eligible families and individuals, crime prevention and safety, and model activities that provide creative approaches to solving affordable housing problems.

Section 184 Indian Home Loan Guarantee Program: Created in 1992 to help increase Native access to homeownership by providing a guarantee to lenders on mortgage loans made to Native borrowers. Section 184 loans can be used both on and off native lands for new construction, rehabilitation, purchase of an existing home, or refinancing.

⁶ U.S. Department of Housing and Urban Development, "Continuum of Care (CoC) Program," <https://www.hudexchange.info/programs/coc/>

⁷ U.S. Department of Housing and Urban Development, "Emergency Solutions Grant (ESG) Program Fact Sheet," <https://www.hudexchange.info/resources/documents/EmergencySolutionsGrantsProgramFactSheet.pdf>.

⁸ ICF International and Collaborative Solutions, Inc., "Housing Opportunities for Persons with AIDS (HOPWA) Rental Assistance Guidebook," U.S. Department of Housing and Urban Development's Office of HIV/AIDS Housing, January 2013. <https://www.hudexchange.info/resources/documents/HOPWARentalAssistanceGuidebook.pdf>.

⁹ U.S. Department of Housing and Urban Development, "Office of Native American Programs (ONAP)," http://portal.hud.gov/hudportal/HUD?src=/program_offices/public_indian_housing/ih and U.S. Department of Housing and Urban Development, Office of Native American Programs (ONAP), "Grants," http://portal.hud.gov/hudportal/HUD?src=/program_offices/public_indian_housing/ih/grants

Indian Community Development Block Grant (ICDBG): Awarded under an annual competition. Provide single purpose grants for housing rehabilitation, land acquisition, community facilities, infrastructure construction, and economic development activities that benefit primarily people with low and moderate incomes.

Title VI Loan Guarantee Program: Assists Indian Housing Block Grant recipients who want to finance eligible affordable housing activities, but are unable to secure financing without the assistance of a federal guarantee.

VA Supportive Housing Program (VASH)¹⁰

VASH is a joint project between the Department of Veteran Affairs (VA) and the Department of Housing and Urban Development (HUD). The goal of the program is to transition veterans from homelessness to having permanent, secure, safe housing so that they may rebuild their lives. This program is administered with a housing voucher from HUD for veterans to rent a home or an apartment, and intensive case management services provided by the VA for five years.

Other Federal Resources

Supportive Services for Veteran Families (SSVF)¹¹

The SSVF Program is a VA program that awards grants to private nonprofit organizations and consumer cooperatives that will provide supportive services to very low-income Veterans and their families residing in or transitioning to permanent housing. The grantees will provide a range of supportive services designed to promote housing stability.

USDA Rural Development, Rural Housing Service¹²

USDA Rural Development offers a variety of programs to build or improve housing and essential community facilities in rural areas. The Rural Housing Service in particular offers loans, grants and loan guarantees for single- and multi-family housing, child care centers, fire and police stations, hospitals, libraries, nursing homes, schools, first responder vehicles and equipment, housing for farm laborers and much more. The USDA also provide technical assistance loans and grants in partnership with non-profit organizations, Indian tribes, state and federal government agencies, and local communities.

SSI/SSDI Outreach, Access, and Recovery Program (SOAR)¹³

Through its SOAR program, the Substance Abuse and Mental Health Services Administration (SAMHSA) seeks to end homelessness through increased access to Supplemental Security Income (SSI) and Social Security Disability Income (SSDI) support. Nationally, 37 percent of all applications for SSI/SSDI are approved upon first application. However, for people who are homeless, initial SSI/SSDI application approval is only 15 percent. When homeless people apply for SSI/SSDI through the SOAR Initiative, initial application approval is greatly increased – 93 percent of persons thought to be eligible are approved within 3 months.

¹⁰ U.S. Department of Veterans Affairs, "The Department of Housing and Urban Development and VA's Supportive Housing (HUD-VASH) Program," <http://www.va.gov/homeless/hud-vash.asp>.

¹¹ U.S. Department of Veterans Affairs, "Supportive Services for Veteran Families Program," <http://www.va.gov/homeless/ssvf.asp>.

¹² U.S. Department of Agriculture, Rural Development, "Rural Housing Service," <http://www.rd.usda.gov/about-rd/agencies/rural-housing-service>

¹³ North Carolina Department of Health and Human Services, "SSI/SSDI Outreach, Access, and Recovery Program (SOAR)," January 28, 2011, <http://www2.ncdhhs.gov/homeless/soar.htm>.

Federal Low Income Housing Tax Credit (LIHTC) Program¹⁴

The LIHTC program is administered by the U.S. Department of Treasury. The program provides competitive awards of federal tax credits to developers to assist in the creation of affordable rental housing including supportive housing. It requires that 20 percent of LIHTC units be made available for households at or below 50 percent of area median income (AMI) or that 40 percent of LIHTC units be

¹⁴ Ed Gramlich, "Low Income Housing Tax Credit Program," *National Low Income Housing Coalition Advocates' Guide*, 2013, <http://nlihc.org/sites/default/files/2014AG-254.pdf>.

APPENDIX G: HEALTHCARE RESOURCES

The following is a brief guide to healthcare resources for people with low incomes and people experiencing homelessness – including Medicaid, Veteran health resources, HIV/AIDS health resources, and behavioral health resources – and information about health system changes underway that may benefit people with low incomes and people experiencing homelessness.

HEALTH CARE RESOURCES

The information in this document is intended primarily to provide people working in subsidized housing and homeless assistance systems basic information about available health care resources. It is also intended to provide context for a discussion on gaps in needed health care services and treatment. Finally, information is included to inform housing, health care, and service providers about some current health-related efforts that may benefit their clients through and to facilitate strategic discussions about ways to creatively take advantage of existing and emerging healthcare resources. The following resources are covered:

Healthcare Resources and Medicaid Coverage

- Federally Qualified Health Centers: Community Health Centers; Health Care for the Homeless
- Rural Health Resources
- Indian Health Resources
- Veteran Health Resources
- HIV/AIDS Health Resources
- Behavioral Health Resources
- Other Resources for the Uninsured
- Medicaid
- Managed Care

Healthcare Changes Underway

- State Innovation Model (SIM) Awards
- 1115 Waivers
- Accountable Care Organizations (ACOs)
- Patient-Centered Medical Homes
- Health Homes

A variety of health care resources for low-income people exist at the federal and state level. These resources can take the form of health care directly accessible by individuals or funding that flows through organizations that provide health care and related services. Accessing certain resources requires enrollment (and re-certification) based on specific, documented eligibility criteria. As with housing resources, many health care resources focus on particular populations, such as people experiencing homelessness, people living with HIV/AIDS, veterans, or people with disabilities.

HEALTH CARE RESOURCES AND MEDICAID

Federally Qualified Health Centers (FQHCs)¹

The Federal Health Center Program serves medically underserved populations or areas, works with special populations, and provides for enhanced Medicaid reimbursement. The four types of health centers are: (1) Community Health Centers; (2) Health Care for the Homeless; (3) Migrant Health Centers; and (4) Public Housing Primary Care Health Centers. Details about Community Health Centers and Health Care for the Homeless Programs are below.

¹ National Association of Community Health Centers, “So You Want to Start a Health Center...? A Practical Guide for Starting a Federally Qualified Health Center,” July 2011: 1, <http://www.nachc.com/client/documents/Starting%20a%20FQHC%20Manual-September%202011.pdf>.

Community Health Centers²

Community Health Centers (CHCs) deliver comprehensive, high-quality preventative and primary health care to patients regardless of their ability to pay. They also provide oral health and behavioral health care tailored to the needs of the communities they serve. CHCs offer a sliding fee discount based on income.

Health Care for the Homeless (HCH) Programs³

HCH Programs emphasize a multi-disciplinary approach to delivering care to homeless persons, combining aggressive street outreach with integrated systems of primary care, mental health and substance abuse services, case management, and clinical advocacy. Emphasis is placed on coordinating efforts with other community health providers and social service agencies.

Rural Health Resources

Critical Access Hospitals (CAHs) and Rural Health Clinics (RHCs) are the safety net providers for rural and remote communities.

Critical Access Hospitals (CAHs)⁴

“Critical Access Hospital” is a designation given to certain rural hospitals by the Centers for Medicare and Medicaid Services (CMS). The CAH designation is designed to reduce the financial vulnerability of rural hospitals and improve access to healthcare by keeping essential services in rural communities. This is accomplished through cost-based Medicare reimbursement.

To ensure that CAHs deliver services to improve access to rural areas that need it most, restrictions exist concerning what types of hospitals are eligible for the CAH designation. The primary eligibility requirements for CAHs are:

- 25 or fewer acute care inpatient beds
- Location more than 35 miles from another hospital
- Maintained annual average length of stay of 96 hours or less for acute care patients
- 24/7 emergency care services

Rural Health Clinics (RHCs)⁵

A Rural Health Clinic is a federally qualified health clinic (but not a part of the FQHC Program) that is certified to receive special Medicare and Medicaid reimbursement. CMS provides advantageous reimbursement to increase rural Medicare and Medicaid patients' access to primary care services.

CMS reimburses RHCs differently than it does other facilities. CMS is required to pay RHCs using a prospective payment system (PPS) rather than a cost-based reimbursement system. RHCs receive an interim payment from Medicare, and at the end of the year, this payment is reconciled using the clinic's cost reporting. For services provided to Medicaid patients, states can reimburse using PPS or by an alternative payment methodology that results in a payment equal to what the RHC would receive under PPS. Regardless of whether the patient sees a mid-level provider or a physician, the RHC must receive the same amount for its services.

² Idaho Primary Care Association, “What is a Community Health Center?”, 2015, <http://www.idahopca.org/community-health-centers#what-are-community-health-centers>.

³ National Association of Community Health Centers, “Health Care for the Homeless,” <http://www.nachc.com/homeless-healthcare.cfm>.

⁴ Rural Health Information Hub, “Critical Access Hospitals (CAHs),” <https://www.ruralhealthinfo.org/topics/critical-access-hospitals>.

⁵ U.S. Department of Health and Human Services Health Resources and Services Administration, “What are Rural Health Clinics (RHCs)?”, 2015, <http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Introduction/ruralclinics.html>.

Indian Health Services⁶

The Indian Health Service (IHS), an agency within the Department of Health and Human Services, is responsible for providing federal health services to American Indians and Alaska Natives. The provision of health services to members of federally-recognized tribes grew out of the special government-to-government relationship between the federal government and Indian tribes. The IHS is the principal federal health care provider and health advocate for Indian people, and its goal is to raise their health status to the highest possible level. The IHS provides a comprehensive health service delivery system for approximately 1.9 million American Indians and Alaska Natives who belong to 567 federally recognized tribes in 35 states.

Veteran Health Resources

Veterans Health Administration⁷

The Veterans Health Administration is the largest integrated health care system in the United States, providing care at 1,233 health care facilities, including 168 VA Medical Centers and 1,053 outpatient sites of care of varying complexity (VHA outpatient clinics), serving more than 8.9 million Veterans each year.

The following programs may be offered at VA medical facilities, including community-based outpatient clinics, to provide healthcare to homeless Veterans.

Health Care for Homeless Veterans (HCHV) Program

The HCHV program serves as the hub for a myriad of housing and other services which provide the VA a way to outreach and assist homeless Veterans by offering them entry to VA care. The central goal is to reduce homelessness among veterans by conducting outreach to those who are the most vulnerable and are not currently receiving services and engaging them in treatment and rehabilitative programs. HCHV's Contract Residential Treatment Program ensures that Veterans with serious mental health diagnoses can be placed in community-based programs that provide quality housing and services.

Homeless Patient Aligned Care Teams (H-PACTs) Program

The Homeless Patient Aligned Care Teams (H-PACTs) Program implements a coordinated homeless primary care model that focuses on improving access, care coordination, and quality of treatment for alcohol and other substance use for veterans experiencing or at risk of homelessness. H-PACTs provide a coordinated "medical home" specifically tailored to the needs of homeless Veterans, integrating clinical care with the delivery of social services.

Health Care for Re-Entry Veterans Program

The Health Care for Re-Entry Veterans Program helps incarcerated Veterans successfully rejoin the community through supports including those addressing mental health and substance use problems.

Homeless Veterans Dental Initiative

The Homeless Veterans Dental Initiative provides dental treatment for eligible Veterans in a number of programs: Domiciliary Residential Rehabilitation Treatment, VA Grant and Per Diem, Compensated

⁶ Indian Health Services, "About IHS," <https://www.ihs.gov/aboutihs/>

⁷ U.S. Department of Veterans Affairs, "Veterans Health Administration," www.va.gov/health/aboutVHA.asp and U.S. Department of Veterans Affairs, "Homeless Veterans – Health Care," http://www.va.gov/homeless/health_care.asp

Work Therapy/Transitional Residence, Healthcare for Homeless Veterans (contract bed), and Community Residential Care.

HIV/AIDS Health Resources

Ryan White HIV/AIDS Program⁸

The Ryan White HIV/AIDS Program provides a comprehensive system of care that includes primary medical care and essential support services for people living with HIV who are uninsured or underinsured. The Program works with cities, states and local community-based organizations to provide HIV care and treatment services to more than 512,000 clients in the U.S. each year.

Part A

Part A provides assistance to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs) that are most severely impacted by the HIV epidemic.

Part B

Part B provides grants to State departments of health or other State and U.S. Territories which administer public health programs and services. Part B grants include a base grant, the AIDS Drug Assistance Program (ADAP) award, ADAP supplemental grants, grants to State for Emerging Communities and an award for Minority AIDS initiative activities.

The AIDS Drug Assistance Program (ADAP) provides free medications for the treatment of HIV/AIDS and opportunistic infections. The drugs provided through ADAP can help people with HIV/AIDS to live longer and treat the symptoms of HIV infection. ADAP can help people with partial insurance and those who have a Medicaid spend down requirement.

Part C

The Part C Early Intervention Services (EIS) component funds comprehensive primary health care in outpatient settings for people living with HIV disease.

Part D

Ryan White HIV/AIDS Program Part D grant recipients provide outpatient ambulatory family-centered primary and specialty medical care and support services for women, infants, children, and youth living with HIV.

Behavioral Health Resources

Projects for Assistance in Transition from Homelessness (PATH)⁹

The Substance Abuse and Mental Health Services administration (SAMHSA) operates the grant program Projects for Assistance in Transition from Homelessness (PATH), which provides assistance to individuals who are homeless and have serious mental illnesses. PATH funds are distributed to states, which then contract with local public or non-profit organizations to fund services for homeless individuals.

⁸ U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), HIV/AIDS Program, “Ryan White HIV/AIDS Program Parts,” <http://hab.hrsa.gov/abouthab/partd.html>

⁹ Benefit.gov, “Projects for Assistance in Transition from Homelessness (PATH),” <https://www.benefits.gov/benefits/benefit-details/728>

Among the services eligible for funding under PATH are outreach services, screening and diagnostic treatment services, habilitation and rehabilitation services, community mental health services, alcohol and drug treatment services staff training, case management services, supportive and supervisory services in residential settings, referrals for primary health services, job training, educational services, and relevant housing services.

Other Health Resources for Uninsured Residents

Free Clinics¹⁰

Free health and medical clinics offer services free of cost or for a nominal fee to persons who have limited income, no health insurance, or do not qualify for Medicaid or Medicare.

Medicaid

State Medicaid Plan¹¹

Overview: Historically, Medicaid eligibility was restricted to specific categories of low-income individuals, such as children, their parents, pregnant women, the elderly, or individuals with disabilities. In most states, adults without dependent children were ineligible for Medicaid, regardless of their income, and income limits for parents were very low. The Affordable Care Act (ACA) extended Medicaid to nearly all nonelderly adults with incomes at or below 138% of poverty (about \$32,500 for a family of four in 2013). All states previously expanded eligibility for children to higher levels than adults through Medicaid and the Children's Health Insurance Program (CHIP).

Home and Community Based Services Waiver Programs¹²

The 1915(c) waivers are one of many options available to states to allow the provision of long term care services in home and community based settings under the Medicaid Program. States can offer a variety of services under an HCBS Waiver program. Programs can provide a combination of standard medical services and non-medical services. Standard services include but are not limited to: case management (i.e. supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care. States can also propose "other" types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community.

Managed Care¹³

Managed Care is a health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services.

By contracting with various types of MCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health

¹⁰ Mental Health America, "Paying for Care," <http://www.mentalhealthamerica.net/paying-care>

¹¹ The Henry J. Kaiser Family Foundation, "How Will the Uninsured Fare Under the Affordable Care Act?", April 7, 2014, <http://kff.org/health-reform/fact-sheet/how-will-the-uninsured-fare-under-the-affordable-care-act/>.

¹² Medicaid.gov, "1915(c) Home & Community-Based Waivers," <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Home-and-Community-Based-1915-c-Waivers.html>

¹³ Medicaid.gov, "Managed Care," <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html>

services. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care.

Some states are implementing a range of initiatives to coordinate and integrate care beyond traditional managed care. These initiatives are focused on improving care for populations with chronic and complex conditions, aligning payment incentives with performance goals, and building in accountability for high quality care.

HEALTH CARE CHANGES UNDERWAY

State Innovation Models¹⁴

Background

The State Innovation Models (SIM) Initiative is providing financial and technical support to states for the development and testing of state-led, multi-payer health care payment and service delivery models that will improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid and Children's Health Insurance Program (CHIP) beneficiaries—and for all residents of participating states. The Center for Medicare and Medicaid Innovation (CMMI) periodically issues RFPs for demonstration projects: innovative health care delivery approaches that may achieve better health outcomes and cost efficiencies.

Health Care Innovation Awards: to organizations implementing the most compelling new ideas to deliver better health, improved care and lower costs to people enrolled in Medicare, Medicaid and Children's Health Insurance Program (CHIP), particularly those with the highest health care needs.

Health Care Innovation Awards Round Two: to applicants testing new payment and service delivery models that will deliver better care and lower costs for Medicare, Medicaid, and/or CHIP enrollees.

1115 Waivers¹⁵

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs. The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate policy approaches such as:

- Expanding eligibility to individuals who are not otherwise Medicaid or CHIP eligible;
- Providing services not typically covered by Medicaid; or
- Using innovative service delivery systems that improve care, increase efficiency, and reduce costs.

Accountable Care Organizations (ACO)¹⁶

- Typically include 3 key elements:
 - (1) Provider-run organization at base

¹⁴ Centers for Medicare & Medicaid Services, "State Innovation Models Initiative: General Information," <https://innovation.cms.gov/initiatives/state-innovations>

¹⁵ Medicaid.gov, "Section 1115 Demonstrations," <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/section-1115-demonstrations.html>

¹⁶ The Henry J. Kaiser Family Foundation, "Medicaid Delivery System and Payment Reform: A Guide to Key Terms and Concepts," June 22, 2015, <http://kff.org/medicaid/fact-sheet/medicaid-delivery-system-and-payment-reform-a-guide-to-key-terms-and-concepts/>.

- (2) Accountability for shared outcomes
- (3) Potential for shared savings
- Provider-run organizations that consist of a network of health care providers and organizations like hospitals, managed health care plans, and doctors, which come together voluntarily to give coordinated care to their patients.
- Relatively new payment model for delivering health care that coordinates all the different health care services a patient receives, breaking down traditional health care silos. Focuses on containing the overall cost of overall care.
- Participating providers are collectively responsible for the care of an enrolled population and may share in any savings associated with improvements in the quality and efficiency of the care they provide. Medicaid ACOs must meet quality of care standards, and receive a share of any savings achieved when they deliver health care at lower costs than budgeted for per-member payments. These payments create a strong incentive for ACOs to invest in preventative care for their patients.
- Patient-centered care management and coordination directed by providers:
 - Targeted and intensive complex care management, tailored to high-need/high-cost patients with cross-functional care teams
 - Data infrastructure and analytics
 - Motivated and mission-driven leadership and providers empowered to transform care delivery, build cross-functional teams/structure for meaningful patient and community partnerships
 - Capacity to address social needs

ACOs have incentives to reduce costs. Housing providers would make excellent members of care teams and can partner with ACO provider groups. If affordable housing providers can demonstrate ability to support the health of patients, ACOs may provide funding to housing providers to deliver non-medical services such as health education and hospital discharge planning. Housing providers can also help ACOs conduct outreach to inform low-income households about their eligibility to enroll in ACOs, since outreach to Medicaid enrollees is often a major challenge for ACOs.

However, ACOs come with the following challenges:

- Require substantial initial investments in capacity-building and infrastructure development.
- States or purchasers/providers must negotiate payment models aligning financial incentives to serve patients with greatest needs and risks.
- Existing risk-adjustment methodologies do not capture factors associated with social determinants of health.

Patient-Centered Medical Homes¹⁷

A patient-centered medical home (PCMH) is a coordinated care model focused on acute care for all populations. They are typically defined as physician-led primary care practices, which bring together a team of medical professionals (including nurses, nurse care managers, medical assistants, office support staff, and often pharmacists and social workers) to coordinate and personalize medical care.

¹⁷ U.S. Department of Health & Human Services, Agency for Healthcare Research and Quality (AHRQ), "Defining the PCMH," <https://pcmh.ahrq.gov/page/defining-pcmh>

Health Homes¹⁸

A health home offers coordinated care to individuals with multiple chronic health conditions, including mental health and substance use disorders. The health home is a team-based clinical approach that includes the consumer, his or her providers, and family members, when appropriate. The health home builds linkages to community supports and resources as well as enhances coordination and integration of primary and behavioral health care to better meet the needs of people with multiple chronic illnesses.

¹⁸ SAMHSA-HRSA Center for Integrated Health Solutions, "Health Homes and Medical Homes," <http://www.integration.samhsa.gov/integrated-care-models/health-homes>

APPENDIX H: DATA SNAPSHOTS

The following is a guide to publicly available data relating to homelessness, poverty, and certain types of health resources accessed by people with low incomes and people experiencing homelessness.

DATA SNAPSHOTS

The information in this document is intended to present housing, healthcare, and social service providers with descriptions of and links to publicly available data about people living with low incomes and people experiencing homelessness. The data referenced may be helpful in a variety of ways on its own, but is also presented to provide housing and healthcare stakeholders with an overview of what information is available to help facilitate conversations about how such information can be used and what other information is needed to further system integration. The following topics are covered:

Population: Persons Experiencing Homelessness

- Homeless Point-in-Time (PIT) Count
- Housing Wage

Population: Individuals with Low Incomes and People Living in Poverty

- Estimated Percentage of U.S. Population Living in Poverty
- Health Insurance Coverage of U.S. Residents with Low Incomes

Population: Persons Living with HIV/AIDS

- HIV Surveillance Reports
- Ryan White Program Statistics

Population: HRSA Health Center Patients

Appendices

- Appendix A: Healthcare Data Collected by Housing Providers and Housing Data Collected by Healthcare Providers
- Appendix B: VI-SPDAT Vulnerability Index/Assessment Tool

Population: Persons Experiencing Homelessness

Homeless Point-in-Time (PIT) Count¹

The Point-in-Time (PIT) count is a count of sheltered and unsheltered homeless persons on a single night in January. HUD requires that Continuums of Care conduct an annual count of homeless persons who are sheltered in emergency shelter, transitional housing, and Safe Havens on a single night. Continuums of Care also must conduct a count of unsheltered homeless persons every other year (odd numbered years). Each count is planned, coordinated, and carried out locally.

State/Local Resources: 2015 PIT Count information available at:

<https://www.hudexchange.info/resource/3031/pit-and-hic-data-since-2007/> and
https://www.hudexchange.info/resource/reportmanagement/published/CoC_PopSub_CoC_ND-500-2015_ND_2015.pdf

¹ HUD Exchange, "PIT and HIC Guides, Tools, and Webinars," <https://www.hudexchange.info/programs/hdx/guides/pit-hic/>

Housing Wage²

"Housing wage" is the hourly wage needed to afford a two-bedroom apartment at Fair Market Rent without paying more than 30% of income on housing. It assumes a 40-hour work week, 52 weeks per year.

State/Local Resources: National Low-Income Housing Coalition, Housing Wage Calculator, <http://nlihc.org/library/wagecalc>

Population: Individuals with Low Incomes and Those Living in Poverty³

The Henry J. Kaiser Family Foundation (www.kff.org) provides national and state information on health issues, including the following:

Estimated Percentage of U.S. Population Living in Poverty (2015)

Household Income Level	Percentage of Total Population
Under 100% Federal Poverty Level (FPL)	14%
100-199% FPL	18%
200-399% FPL	29%
400% + FPL	40%

Current Federal Poverty Level (FPL) guidelines:

- Individual: \$11,880 (\$11,770 in 2015)
- 2-person family: \$16,020 (\$15,930 in 2015)
- 3-person family: \$20,160 (\$20,090 in 2015)
- 4-person family: \$24,300 (\$24,250 in 2015)

Health Insurance Coverage of U.S. Residents with Low Incomes (ages 0-64 (2015))

Income Level	Uninsured		Medicaid	
	Number	Percent of population subgroup	Number	Percent of population subgroup
Under 100% FPL	7,383,000	19%	21,336,800	54%
Up to 200% FPL	15,113,600	17%	39,077,100	45%

Population: Persons Living With HIV/AIDS

HIV Surveillance Reports⁴

HIV Surveillance is the ongoing collection, analysis, interpretation, dissemination, and evaluation of population-based information about persons with HIV infections. HIV Surveillance Reports provide an overview on the current epidemiology of HIV disease in a state.

² National Low-Income Housing Coalition, "Out of Reach 2016," http://nlihc.org/sites/default/files/oor/OOR_2016.pdf

³ The Henry J. Kaiser Family Foundation, www.kff.org

⁴ Michigan Department of Health and Human Services, "Annual HIV Surveillance Report, Michigan," July 2015, http://www.michigan.gov/documents/mdch/Statewide_496827_7.pdf and The Centers for Disease Control and Prevention, "HIV Surveillance Report," <http://www.cdc.gov/hiv/library/reports/surveillance/>

State/Local Resources: Surveillance Reports may be made available by the Department of Health & Human Services or Department of Public Health in your state.

Ryan White Program Statistics⁵

Ryan White HIV/AIDS Programs collect client level data and other information: demographics, services delivered and expenditures.

State/Local Resources: Ryan White HIV/AIDS Program State Profiles from 2013 are available at <http://hab.hrsa.gov/stateprofiles/Default.aspx>

Population: HRSA Health Center Patients

Each year HRSA-funded Health Center Grantees are required to report core set of information, including data on patient demographics, services provided, clinical indicators, utilization rates, costs, and revenues.

State/Local Resources: Health Center Program Grantee Data by state for 2015 is available at <http://bphc.hrsa.gov/uds/datacenter.aspx?q=d>

⁵ U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Programs, "Program Data," <http://www.hab.hrsa.gov/data/index.html>

APPENDIX A: HEALTHCARE DATA COLLECTED BY HOUSING PROVIDERS AND HOUSING DATA COLLECTED BY HEALTHCARE PROVIDERS

HEALTHCARE-RELATED QUESTIONS BY HOUSING PROVIDERS

Homeless Management Information System (HMIS)⁶

Each community is required to maintain client-level data in a Homeless Management Information System (HMIS) as defined in the HUD Data Standards. Individual CoCs may also add standards beyond those the HUD Data Standards require. Housing providers enter data to the HMIS at various points over the client's interaction with the program, including entry, departure, and updates.

Data Categories

Standard 3.8: Disabling Condition (Y/N)

Standard 4.4: Covered by Health Insurance (Y/N)

- Medicaid
- Medicare
- State Children's Health Insurance Program
- Veteran's Administration (VA) Medical Services
- Employer-Provided Health Insurance
- Reason if "No" (for Housing Opportunities for Persons with AIDS (HOPWA) only)

Standard 4.5: Physical Disability (Y/N)

- Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently
- Documentation of the disability and severity on file
- Currently receiving services/treatment for this disability

Standard 4.6: Developmental Disability (Y/N)

- Expected to substantially impair ability to live independently
- Documentation of the disability and severity on file
- Currently receiving services/treatment for this disability

Standard 4.7: Chronic Health Condition (Y/N)

- Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently
- Documentation of the disability and severity on file
- Currently receiving services/treatment for this condition

Standard 4.8: HIV/AIDS (Y/N)

- Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently
- Documentation of the disability and severity on file
- Currently receiving services/treatment for this condition

Standard 4.9: Mental Health Problem (Y/N)

- Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently
- Documentation of the disability and severity on file

⁶ U.S. Department of Housing and Urban Development, "2014 HMIS Data Standards Manual," July 2015, <https://www.hudexchange.info/resources/documents/HMIS-Data-Standards-Manual.pdf>.

- Currently receiving services/treatment for this condition
- How confirmed (for PATH only)
- Serious mental illness (SMI) and, if SMI, how confirmed (for PATH only)

Standard 4.10: Substance Abuse (Y/N)

- Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently
- Documentation of the disability and severity on file
- Currently receiving services/treatment for this condition
- How confirmed (for PATH only)

Standard 4.14A: Services Provided: PATH funded

- Type of PATH funded Services response categories include “community mental health” and “substance use treatment”

Standard 4.14B Services Provided: RHY (checkbox), including:

- Dental care
- Post-natal care
- Pre-natal care
- Health/medical care
- Psychological or psychiatric care
- Substance abuse assessment and/or treatment
- Substance abuse prevention
- Street Outreach – health and hygiene products distributed

Standard 4.14C Services Provided: Housing for People with AIDS (HOPWA)

- Date of service
- Type of service response categories include:
 - Health/medical care
 - Mental health care/counseling
 - Substance abuse services/treatment

Standard 4.14D: Services Provided: Supportive Services for Veteran Families Program (SSVF)

- Type of Assistance response categories include “assistance obtaining VA benefits” and “assistance obtaining/coordinating other public benefits”

Standard 4.16A: Referrals Provided: Projects for Assistance in Transition from Homelessness (PATH)

- Date of Referral
- Type of Referral: Community Mental Health, Substance Use Treatment, Primary Health Services, Medical Assistance
- Select Outcome for each: Attained, Not Attained, Unknown

Standard 4.16A: Referrals Provided: Runaway and Homeless Youth Program (RHY)

- Date of Referral
- Type of Referral: Medicaid, Non-Residential Substance Abuse or Mental Health Program

Standard 4.20: PATH Status: PATH

- Date of Status Determination
- Client Became Enrolled in PATH (Y/N)
- Reason Not Enrolled

Standard 4.27 General Health Status: RHY

- General Health Status: Excellent, Very good, Good, Fair, Poor

Standard 4.28 Dental Health Status: RHY

- Dental Health Status: Excellent, Very good, Good, Fair, Poor

Standard 4.29 Mental Health Status: RHY

- Mental Health Status: Excellent, Very good, Good, Fair, Poor

Standard 4.30 Pregnancy Status: RHY (Y/N)

- Due Date

Standard 4.33 Young Person's Critical Issues: RHY (Y/N), including

- Mental Health Issues – Youth
- Mental Health Issues – Family member
- Health Issues – Youth
- Health Issues – Family member
- Mental Disability – Youth
- Mental Disability – Family member
- Alcohol or other drug abuse – Youth
- Alcohol or other drug abuse – Family member

Standard 4.34 Referral Source: RHY, including:

- Residential Project: Drug Treatment Center
- Residential Project: Treatment Center
- Mental hospital
- Number of times approached by outreach prior to entering the project

Standard 4.39: Medical Assistance: HOPWA

- Receiving Public HIV/AIDS Medical Assistance? If no, reason.
- Receiving AIDS Drug Assistance Program (ADAP)? If no, reason.

Annual Performance Report (APR)⁷

HUD requires CoC-funded programs to provide an APR that analyzes certain data in HMIS to respond to specific questions. These questions are outlined in the CoC APR Guidebook and are not inclusive of all of the information in HMIS.

Data Categories

Q18a, Q22a: Number of Households with Specified Physical and Mental Health Conditions at Entry and Exit:

- Mental Illness
- Alcohol Abuse
- Drug Abuse
- Chronic Health Condition
- HIV/AIDS and Related Diseases
- Developmental Disability
- Physical Disability

Q18b, Q22b: Number of Physical and Mental Health Known Conditions at Entry and Exit:

- 1 Condition
- 2 Conditions
- 3+ Conditions

Q26a1, 26b2: Number of Adults and Children (leavers and stayers) Receiving Specified Non-cash Benefit Sources at exit/follow up, including:

- Medicaid Health Insurance

⁷ U.S. Department of Housing and Urban Development, "e-snaps CoC APR Guidebook for CoC Grant Funded Programs," March 2015, Version 8, <https://www.hudexchange.info/resources/documents/e-snaps-CoC-APR-Guidebook-for-CoC-Grant-Funded-Programs.pdf>.

- Medicare Health Insurance
- State Children's Health Insurance
- VA Medical Services

Q26a2, Q26b2: Number of non-cash benefits for each adult or head of household (leavers and stayers, at exit/follow up):

- No Sources
- 1+ source
- Don't know/refused
- Information missing

HOUSING-RELATED QUESTIONS BY HEALTHCARE PROVIDERS

International Classification of Diseases (ICD-10)⁸

The International Classification of Diseases, or ICD-10, is a healthcare classification system that provides diagnostic codes for classifying information relating to a patient's condition and inpatient procedures, including specific diseases, symptoms, causes, abnormal findings, and social circumstances. The United States transitioned from the ICD-9 to the ICD-10 on October 1, 2015.

Data Categories

Z59.0 Homelessness

Z59.1 Inadequate Housing

Z59.5 Extreme Poverty

Z59.8 Other Problems Related to Housing and Economic Circumstances

Z59.9 Problems Related to Housing and Economic Circumstances, Unspecified

Federally Qualified Health Centers (FQHC) Patient Data⁹

FQHCs maintain patient-level data necessary to report annually to the Health Resources and Services Administration (HRSA) through the Uniform Data System. All health centers report on selected patient characteristics for all patients that receive at least one face-to-face visit during the calendar year.

Data Categories

Homeless

Public Housing

IncomeMedicaid/CHIP, Medicare, Other Third Party

Place of Service Codes for Professional Claims¹⁰

Place of Service Codes are used throughout the healthcare industry to indicate the setting where services were rendered. These codes are maintained by CMS and required for use by the national standards for electronic transmission of professional health care claims under HIPAA.

⁸ UnitedHealthcare, "ICD-10-CM Code Lookup Tool," <https://icd10codelookup.smartbaselink.com/>

⁹ U.S. Health Resources and Services Administration (HRSA) Bureau of Primary Health Care, "UDS Reporting Instructions for Health Centers," December 31, 2014, <http://bphc.hrsa.gov/datareporting/reporting/2014udsmanual.pdf>.

¹⁰ U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services, "Place of Service Codes for Professional Claims Database," August 6, 2015, <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Website-POS-database.pdf>.

Data Categories

04 Homeless Shelter

HOUSING-RELATED DATA COLLECTED BY OTHER ENTITIES

Medicaid Encounter Data¹¹

Encounter data are the records of services delivered to Medicaid beneficiaries enrolled in managed care plans that receive a capitated, per-member-per-month payment. These records allow the Medicaid agency to track the services received by members enrolled in managed care. Encounter data typically come from billed claims that providers submit to managed care plans to be paid for their services. In response to the increase in homeless and at-risk members since Medicaid expansion, some MCOs have been using encounter data, among other data sources, to develop a homelessness predictor tool.

Department of Education Data¹²

The Consolidated State Performance Report (CSPR) is a data collection tool administered annually by The U.S. Department of Education's Office of Elementary and Secondary Education (OESE). EDFacts is an initiative to establish one federally coordinated, K through 12 education data repository, located in the Department of Education. EDFacts collects aggregate statistical information from administrative systems in state employment agencies and local education agencies. Beginning SY 2004-2005, the OESE began using the Education Data Exchange Network (EDEN) and EDEN Submission System (ESS) for data submission. The ESS is a centralized portal through which states electronically submit their education data to the data repository.

Every local education agency in the U.S. is required to submit homeless education data for inclusion in the EDFacts system. State Coordinators are responsible for overseeing the collection and submission of homeless education data.

Data Categories

CSPR Question 1.9.1.1 – Number of homeless children and youths by grade level enrolled in public school at any time during the school year

CSPR Question 1.9.1.2 – Primary nighttime residence of homeless children and youths

CSPR Question 1.9.2.1 – Number of homeless children and youths by grade level served by McKinney-Vento subgrants

CSPR Question 1.9.2.2 Subgroups of homeless students served by McKinney-Vento subgrants

¹¹ U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services, "Encounter Data Toolkit," November 30, 2013, <http://www.medicare.gov/medicaid-chip-program-information/by-topics/data-and-systems/downloads/medicaid-encounter-data-toolkit.pdf>.

¹² National Center for Homeless Education at the SERVE Center, "Consolidated State Performance Report: Federal Data Collection Guide for State Coordinators of Homeless Education School Year 2011-2012," Updated September 2012, https://www.sde.idaho.gov/site/homeless_edu/docs/data/data_guide_11-12.pdf.

APPENDIX B: VI-SPDAT¹³

The VI-SPDAT is a “supertool” that combines the strengths of two widely used existing assessments:

- The Vulnerability Index (VI), a street outreach tool currently in use in more than 100 communities. Rooted in leading medical research, the VI helps determine the chronicity and medical vulnerability of homeless individuals.
- The Service Prioritization Decision Assistance Tool (SPDAT), an intake and case management tool in use in more than 70 communities. Based on a wide body of social science research and extensive field testing, the tool helps service providers allocate resources in a logical, targeted way.

The VI-SPDAT is designed to help homeless housing and service providers calibrate their response based on the individual, not merely the general population category into which they may fall (e.g., vulnerable, chronically homeless, etc.). The tool helps identify the best type of support and housing intervention for an individual by relying on three categories of recommendation:

- **Permanent Supportive Housing:** Individuals or families who need permanent housing with ongoing access to services and case management to remain stably housed.
- **Rapid Re-Housing:** Individuals or families with moderate health, mental health and/or behavioral health issues, but who are likely to be able to achieve housing stability over a short time period through a medium or short-term rent subsidy and access to support services.
- **Affordable Housing:** Individuals or families who do not require intensive supports but may still benefit from access to affordable housing. In these cases, the tool recommends affordable or subsidized housing but no specific intervention drawn uniquely from the homeless services world (In most cases, this amounts to no case management).

The VI-SPDAT helps identify who should be recommended for each housing and support intervention, moving the discussion from simply who is eligible for a service intervention to who is eligible and in greatest need of that intervention.

There are three versions of the VI-SPDAT to account for variations between different homeless single adults, families, and youth. A copy of the VI-SPDAT for Single Adults follows. For a copy of the Family or Youth VI-SPDAT, as well as the most up-to-date version of all VI-SPDAT forms, please visit <http://www.orgcode.com/product/vi-spdatt/>.

¹³ Jake Maguire, “Introducing the VI-SPDAT Pre-Screen Survey,” *100,000 Homes Blog*, February 7, 2013, <http://100khomes.org/blog/introducing-the-vi-spdatt-pre-screen-survey>; Community Solutions and OrgCode, “Vulnerability Index- Service Prioritization Decision Assistance Tool (VI-SPDAT),” 2015, American Version 2.0: 11.

VULNERABILITY INDEX - SERVICE PRIORITIZATION DECISION ASSISTANCE TOOL (VI-SPDAT)

SINGLE ADULTS

AMERICAN VERSION 2.0

Administration

Interviewer's Name	Agency	<input type="checkbox"/> Team <input type="checkbox"/> Staff <input type="checkbox"/> Volunteer
Survey Date DD/MM/YYYY ____/____/____	Survey Time ____ : ____ AM/PM	Survey Location _____

Opening Script

Every assessor in your community regardless of organization completing the VI-SPDAT should use the same introductory script. In that script you should highlight the following information:

- the name of the assessor and their affiliation (organization that employs them, volunteer as part of a Point in Time Count, etc.)
- the purpose of the VI-SPDAT being completed
- that it usually takes less than 7 minutes to complete
- that only "Yes," "No," or one-word answers are being sought
- that any question can be skipped or refused
- where the information is going to be stored
- that if the participant does not understand a question or the assessor does not understand the question that clarification can be provided
- the importance of relaying accurate information to the assessor and not feeling that there is a correct or preferred answer that they need to provide, nor information they need to conceal

Basic Information

First Name	Nickname	Last Name
_____	_____	_____
In what language do you feel best able to express yourself? _____		
Date of Birth DD/MM/YYYY ____/____/____	Age _____	Social Security Number _____
		Consent to participate <input type="checkbox"/> Yes <input type="checkbox"/> No

IF THE PERSON IS 60 YEARS OF AGE OR OLDER, THEN SCORE 1.

SCORE:

VULNERABILITY INDEX - SERVICE PRIORITIZATION DECISION ASSISTANCE TOOL (VI-SPDAT)

SINGLE ADULTS

AMERICAN VERSION 2.0

A. History of Housing and Homelessness

1. Where do you sleep most frequently? (check one)

- ☐ Shelters
☐ Transitional Housing
☐ Safe Haven
☐ **Outdoors**
☐ **Other (specify):** _____
☐ **Refused**

IF THE PERSON ANSWERS ANYTHING OTHER THAN SHELTER, "TRANSITIONAL HOUSING", OR SAFE HAVEN, THEN SCORE 1.

SCORE:

2. How long has it been since you lived in permanent stable housing? _____

☐ Refused

3. In the last three years, how many times have you been homeless? _____

☐ Refused

IF THE PERSON HAS EXPERIENCED 1 OR MORE CONSECUTIVE YEARS OF HOMELESSNESS, AND/OR 4+ EPISODES OF HOMELESSNESS, THEN SCORE 1.

SCORE:

B. Risks

4. In the past six months, how many times have you...

a) Received health care at an emergency department/room? _____

☐ Refused

b) Taken an ambulance to the hospital? _____

☐ Refused

c) Been hospitalized as an inpatient? _____

☐ Refused

d) Used a crisis service, including sexual assault crisis, mental health crisis, family/intimate violence, distress centers and suicide prevention hotlines? _____

☐ Refused

e) Talked to police because you witnessed a crime, were the victim of a crime, or the alleged perpetrator of a crime or because the police told you that you must move along? _____

☐ Refused

Stayed one or more nights in a holding cell, jail or prison, whether that was a short-term stay like the drunk tank, a longer stay for a more serious offence, or anything in between? _____

☐ Refused

IF THE TOTAL NUMBER OF INTERACTIONS EQUALS 4 OR MORE, THEN SCORE 1 FOR EMERGENCY SERVICE USE.

SCORE:

5. Have you been attacked or beaten up since you've become homeless? ☐ Y ☐ N ☐ Refused

6. Have you threatened to or tried to harm yourself or anyone else in the last year? ☐ Y ☐ N ☐ Refused

IF YES TO ANY OF THE ABOVE, THEN SCORE 1 FOR RISK OF HARM.

SCORE:

VULNERABILITY INDEX - SERVICE PRIORITIZATION DECISION ASSISTANCE TOOL (VI-SPDAT)

SINGLE ADULTS

AMERICAN VERSION 2.0

7. Do you have any legal stuff going on right now that may result in you being locked up, having to pay fines, or that make it more difficult to rent a place to live? ☐ Y ☐ N ☐ Refused

IF YES, THEN SCORE 1 FOR **LEGAL ISSUES**.

SCORE:

8. Does anybody force or trick you to do things that you do not want to do? ☐ Y ☐ N ☐ Refused

9. Do you ever do things that may be considered to be risky like exchange sex for money, run drugs for someone, have unprotected sex with someone you don't know, share a needle, or anything like that? ☐ Y ☐ N ☐ Refused

IF YES TO ANY OF THE ABOVE, THEN SCORE 1 FOR **RISK OF EXPLOITATION**.

SCORE:

C. Socialization & Daily Functioning

10. Is there any person, past landlord, business, bookie, dealer, or government group like the IRS that thinks you owe them money? ☐ Y ☐ N ☐ Refused

11. Do you get any money from the government, a pension, an inheritance, working under the table, a regular job, or anything like that? ☐ Y ☐ N ☐ Refused

IF YES TO QUESTION 10 OR NO TO QUESTION 11, THEN SCORE 1 FOR **MONEY MANAGEMENT**.

SCORE:

12. Do you have planned activities, other than just surviving, that make you feel happy and fulfilled? ☐ Y ☐ N ☐ Refused

IF NO, THEN SCORE 1 FOR **MEANINGFUL DAILY ACTIVITY**.

SCORE:

13. Are you currently able to take care of basic needs like bathing, changing clothes, using a restroom, getting food and clean water and other things like that? ☐ Y ☐ N ☐ Refused

IF YES, THEN SCORE 1 FOR **SELF CARE**.

SCORE:

14. Is your current homelessness in any way caused by a relationship that broke down, an unhealthy or abusive relationship, or because family or friends caused you to become evicted? ☐ Y ☐ N ☐ Refused

IF YES, THEN SCORE 1 FOR **SOCIAL RELATIONSHIPS**.

SCORE:

VULNERABILITY INDEX - SERVICE PRIORITIZATION DECISION ASSISTANCE TOOL (VI-SPDAT)

SINGLE ADULTS

AMERICAN VERSION 2.0

D. Wellness

15. Have you ever had to leave an apartment, shelter program, or other place you were staying because of your physical health? ☐ Y ☐ N ☐ Refused
16. Do you have any chronic health issues with your liver, kidneys, stomach, lungs or heart? ☐ Y ☐ N ☐ Refused
17. If there was space available in a program that specifically assists people that live with HIV or AIDS, would that be of interest to you? ☐ Y ☐ N ☐ Refused
18. Do you have any physical disabilities that would limit the type of housing you could access, or would make it hard to live independently because you'd need help? ☐ Y ☐ N ☐ Refused
19. When you are sick or not feeling well, do you avoid getting help? ☐ Y ☐ N ☐ Refused
20. **FOR FEMALE RESPONDENTS ONLY:** Are you currently pregnant? ☐ Y ☐ N ☐ N/A or Refused

IF YES TO ANY OF THE ABOVE, THEN SCORE 1 FOR **PHYSICAL HEALTH**.

SCORE:

21. Has your drinking or drug use led you to being kicked out of an apartment or program where you were staying in the past? ☐ Y ☐ N ☐ Refused
22. Will drinking or drug use make it difficult for you to stay housed or afford your housing? ☐ Y ☐ N ☐ Refused

IF YES TO ANY OF THE ABOVE, THEN SCORE 1 FOR **SUBSTANCE USE**.

SCORE:

23. Have you ever had trouble maintaining your housing, or been kicked out of an apartment, shelter program or other place you were staying, because of:
- a) A mental health issue or concern? ☐ Y ☐ N ☐ Refused
- b) A past head injury? ☐ Y ☐ N ☐ Refused
- c) A learning disability, developmental disability, or other impairment? ☐ Y ☐ N ☐ Refused
- d) Do you have any mental health or brain issues that would make it hard for you to live independently because you'd need help? ☐ Y ☐ N ☐ Refused

IF YES TO ANY OF THE ABOVE, THEN SCORE 1 FOR **MENTAL HEALTH**.

SCORE:

IF THE RESPONDENT SCORED 1 FOR **PHYSICAL HEALTH** AND 1 FOR **SUBSTANCE USE** AND 1 FOR **MENTAL HEALTH**, SCORE 1 FOR **TRI MORBIDITY**.

SCORE:

APPENDIX I: MODEL STRATEGIES AND FRAMEWORK

The following document presents an overview of five key health-care related model strategies to consider in developing an Action Plan to improve health outcomes and housing stability for people experiencing homelessness.

Healthcare and Housing (H²) Initiative

Model Strategies

Working Together to Meet Unmet Housing and Healthcare Needs

OVERVIEW

Addressing health-related needs of people who are homeless or at-risk has long been recognized as a key component of efforts to prevent and end homelessness. Opening Doors, the Federal Strategic Plan to Prevent and End Homelessness, identifies *Improving Health and Stability* as one of its five themes, and includes an objective calling for integration of primary and behavioral health care with housing and other homeless services.¹ Likewise, HUD's Strategic Plan includes a focus on improving health outcomes as part of its goal to *Utilize Housing as a Platform for Improving Quality of Life*.²

The passage of the Affordable Care Act (ACA), with its expansion of eligibility to include most people who are homeless, has changed the landscape within which CoCs are operating, providing significant opportunities to advance efforts to address homelessness. With access to preventative, acute and chronic care as well as to mental health and substance abuse services, more people will be able to achieve housing stability and ongoing wellness. With more of their clients receiving Medicaid, permanent supportive housing and other homeless programs may be able to claim Medicaid reimbursements for services they provide, thus offering access to a new source of badly needed funding. The possibility of greater integration between the homeless and health care systems also raises potential opportunities for data sharing regarding client eligibility, service utilization and costs, and outcomes achieved. This information has the potential to inform and improve existing practices. Service delivery will also likely evolve due to a stronger focus on outcomes rather than volume.

The following is an overview of **five health-care related model strategies to consider in developing an Action Plan**:

1. Facilitate Enrollment of People Who Are Homeless and At-Risk in Medicaid
2. Facilitate Access to Care, Engagement with Providers, and Appropriate Use of Health Services
3. Integrate Housing, Health and Other Services to Facilitate Housing Retention and Ongoing Wellness
4. Develop Data-Driven Service Interventions Targeted to Priority Sub-Populations
5. Maximize Use of Medicaid to Finance Services that Support Housing Stability, including Permanent Supportive Housing (PSH) services and Recuperative / Transition Care.

Additionally, the following are **cross-cutting issues** to be considered as part of the implementation:

- Training: What training will be needed for staff?
- Partnerships: What partnerships are needed and how can they be forged?
- Targeting: Should particular sub-populations be targeted and how should they be identified?
- Scale: What will be needed to bring the strategy to a scale appropriate to meet the need?
- Systems: How can individual programmatic efforts be aligned into a unified system working toward shared outcomes?

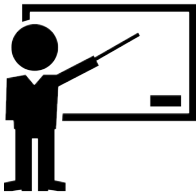
Note: This document was generated by TA providers to support direct TA for H² Initiative communities. This is not a HUD-endorsed document, and contains suggested strategies, not requirements.

¹ United States Interagency Council on Homelessness, "Opening Door: Federal Strategic Plan to Prevent and End Homelessness," as amended in June 2015: 9. http://usich.gov/resources/uploads/asset_library/USICH_OpeningDoors_Amendment2015_FINAL.pdf.

² U.S. Department of Housing and Urban Development, "FY 2010-2015 HUD Strategic Plan," June 25, 2010: 25, http://portal.hud.gov/hudportal/documents/huddoc?id=DOC_4436.pdf.

MODEL STRATEGY 1: MEDICAID ENROLLMENT

Awareness & Education



Identify Clients in Need



Assist with Enrollment



Advocate for Homeless Enrollment



MODEL STRATEGY 2: ACCESS & ENGAGEMENT

Expand/Transform Activity



Reduce ER/Inpatient Use



MODEL STRATEGY 3: INTEGRATION OF SERVICES

Build Capacity & Partnerships



MODEL STRATEGY 4: DATA-DRIVEN INTERVENTIONS

Integrate Data Across Systems



MODEL STRATEGY 5: MEDICAID AND OTHER FINANCING OPTIONS

State/County Level Action



Transform Billing Structures



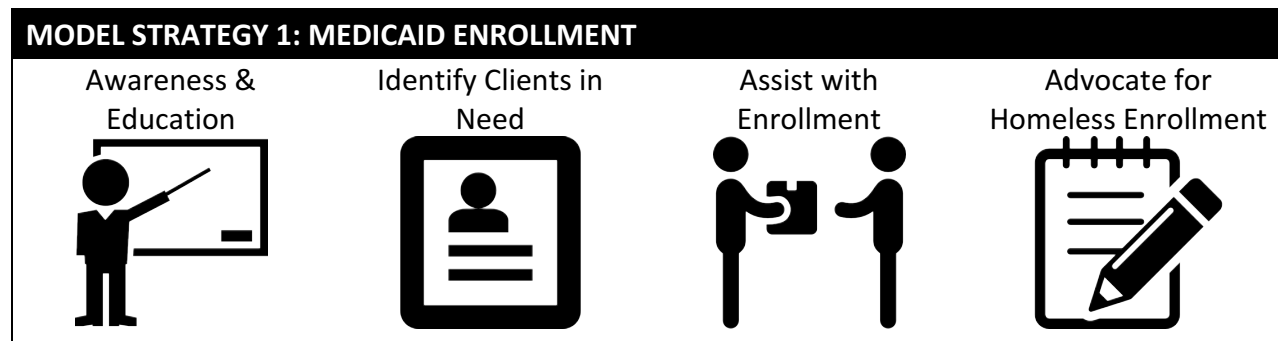
Pilot Different Payment Models



Identify Other Funding Sources



MODEL STRATEGY 1: FACILITATE ENROLLMENT OF PEOPLE WHO ARE HOMELESS AND AT-RISK IN MEDICAID



☐ A. PROMOTE CLIENT AWARENESS AND EDUCATION ABOUT EXPANDED MEDICAID ELIGIBILITY REQUIREMENTS AND ENROLLMENT RESOURCES.

- ☐ 1. Train staff directly working with clients on Medicaid eligibility and how to enroll.
- ☐ 2. Disseminate eligibility and enrollment information to clients, including through newsletters and other communications with clients/resident, by posting information and providing materials at locations frequented by clients, and through community education and outreach events (See Strategy 1.B.3. below).

☐ B. IDENTIFY CLIENTS IN NEED OF ENROLLMENT OR RENEWAL ASSISTANCE.

- ☐ 1. Include questions about health insurance/Medicaid in the coordinated assessment process, all individual agency assessments, and through outreach staff.
- ☐ 2. Flag client files with information about next steps required in enrollment or renewal process, unresolved administrative issues, etc., so staff can provide reminders during regular sessions with clients (case management, clinical, etc.).
- ☐ 3. Host enrollment events to facilitate client identification, including at existing events such as Project Homeless Connect.

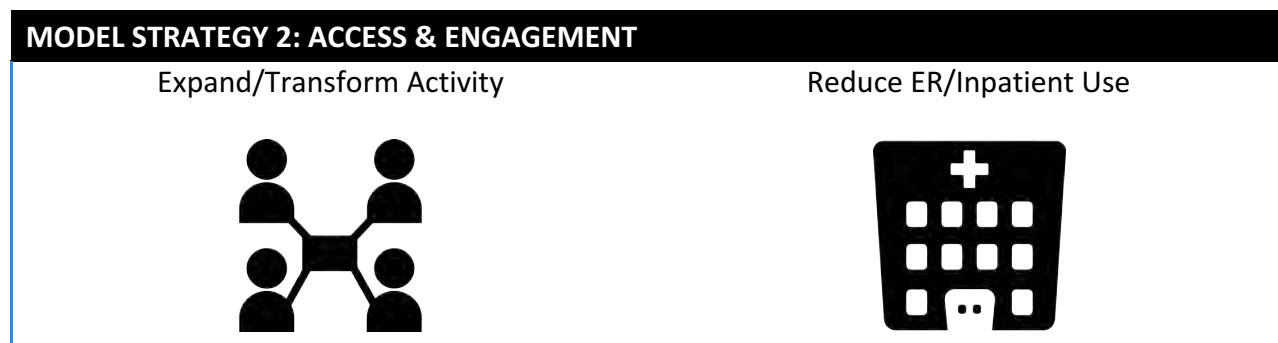
☐ C. ASSIST UNINSURED CLIENTS WITH ENROLLMENT.

- ☐ 1. Form referral partnerships with designated enrollment agencies.
 - a. Refer clients to off-site enrollment locations.
 - b. Provide assistance through out-stationed enrollment staff at homeless agencies.
 - c. Assist clients in completing referrals and enrollment requirements, through case management, transportation and other types of assistance.
- ☐ 2. Develop CoC-based enrollment capacity.
 - a. Have CoC-member agency staff, including HCH, trained and certified to provide enrollment assistance to homeless clients. Access federal and state funding for these positions.
 - b. Implement SOAR-type models to facilitate enrollment in health insurance/Medicaid as well as other benefits.

☐ D. ADVOCATE FOR ENROLLMENT PROCEDURES THAT FACILITATE HOMELESS ENROLLMENT.

- ☐ 1. Promote development of applications and procedures that facilitate homeless enrollment, including presumptive eligibility, streamlined applications, etc. Encourage pursuit of all funding opportunities to facilitate enrollment (federal, state, local and private).

MODEL STRATEGY 2: FACILITATE ACCESS TO CARE, ENGAGEMENT WITH PROVIDERS, AND APPROPRIATE USE OF HEALTH SERVICES



☐ A. FACILITATE ACCESS TO SERVICES AND EFFECTIVE MANAGEMENT OF HEALTH CONDITIONS – EXPAND OR TRANSFORM EXISTING ACTIVITY AND/OR INITIATE NEW EFFORTS.

- ☐ 1. Assist clients to access needed health care services and to manage their health conditions.
 - a. Community Health Workers
 - b. Peer Paraprofessionals
 - c. System Navigators
 - d. Mobile Teams (e.g., HCH)
- ☐ 2. Facilitate positive engagement with providers, including development of provider relationships, use of “warm hand-offs”/personal introductions, and use of appointment reminders regarding continuing or follow-up care.

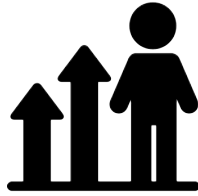
☐ B. REDUCE INAPPROPRIATE USE OF COSTLY EMERGENCY AND INPATIENT SERVICES.

- ☐ 1. Establish emergency room diversion and/or programs for people who frequently use high-cost emergency services so that those with non-urgent conditions access less costly care through health centers and other providers.
- ☐ 2. Educate clients about how to use health insurance and access care, i.e. by scheduling appointments with primary care provider rather than repeated use of emergency room services.
- ☐ 3. Put in place standardized discharge planning policies to help those with health and behavioral health conditions transition to community-based housing, treatment and services.
 - a. Hospitals
 - b. Criminal justice system
 - c. Substance abuse treatment facilities
 - d. Psychiatric hospitals
 - e. Other

MODEL STRATEGY 3: INTEGRATE HOUSING, HEALTH AND OTHER SERVICES TO FACILITATE HOUSING RETENTION AND ONGOING WELLNESS

MODEL STRATEGY 3: INTEGRATION OF SERVICES

Build Capacity & Partnerships



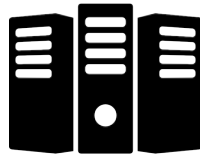
☐ A. BUILD CAPACITY FOR INTEGRATING HEALTH, BEHAVIORAL HEALTH, HOUSING AND SOCIAL SERVICES FOR HOMELESS PERSONS WITH MULTIPLE NEEDS.

- ☐ 1. Strengthen existing partnerships and integration models and test / pilot new ones.
 - a. HCH programs
 - b. Community health teams
 - c. FQHCs, private clinics, ERs, county public health clinics, and hospital-based partnerships
 - d. Care coordination teams and patient-centered medical homes
 - e. Accountable care organizations, coordinated care organizations, and managed care networks
- ☐ 2. Expand or pilot structures that promote connectivity and delivery of integrated care.
 - a. Blended funding
 - b. Co-location of services and service hubs
 - c. Shared staffing
 - d. Navigator staff positions
 - e. Case conferencing
 - f. Multidisciplinary teams
 - g. Staff cross-training
 - h. Other
- ☐ 3. Develop new and strengthen existing partnerships between PSH and health care providers.
 - a. Identify priority populations
 - b. Define services to be provided and identify which are Medicaid eligible
 - i. Targeted case management
 - ii. Individual housing transition services
 - iii. Individual housing and tenancy sustaining services
 - iv. Other
 - c. Define model, including how services will be provided: onsite, mobile and/or offsite
- ☐ 4. Develop recuperative care programs for medically fragile.
 - a. Define program structure and service delivery models.
- ☐ 5. Develop capacity for integrated electronic health records.
 - a. IT systems
 - b. Policies and procedures, including MOUs, ROIs, and HMIS- and HIPAA-compliant data privacy and security requirements
 - c. Staffing capacity

MODEL STRATEGY 4: DEVELOP DATA-DRIVEN SERVICE INTERVENTIONS TARGETED TO PRIORITY SUB-POPULATIONS

MODEL STRATEGY 4: DATA-DRIVEN INTERVENTIONS

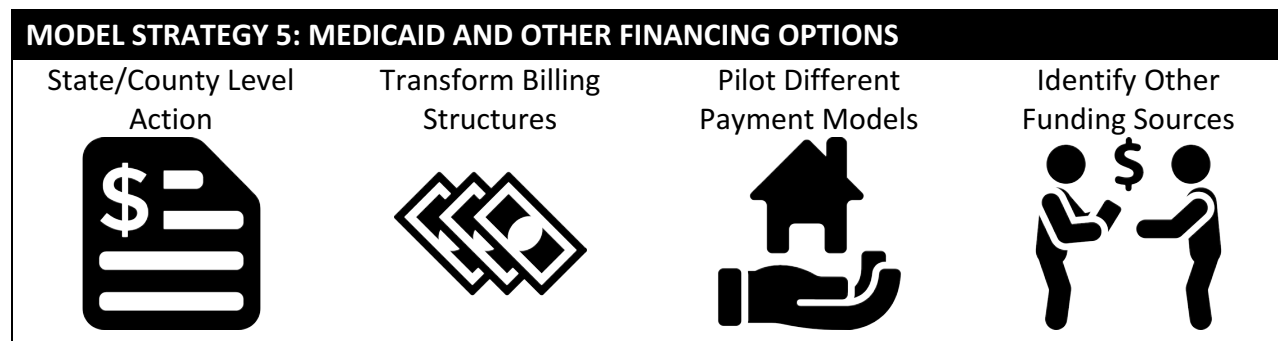
Integrate Data Across Systems



☐ A. Integrate Data Across Homeless, Health Care and Other Systems to Provide a Comprehensive Overview of Needs.

- ☐ 1. Based on data:
 - a. Identify priority sub-populations, neighborhoods and other groupings.
 - b. Craft changes in practice that will yield best outcomes within the target population.
- ☐ 2. Compare cross-system data (including EMS, jails, Medicaid, housing system) to identify individuals who frequently come into contact with two or more systems and/or frequently receive high-cost services. Create pilot programs to focus assistance from all systems on identified clients to get them connected to permanent housing and needed health and social services.
- ☐ 3. Track health outcomes, service utilization, and costs to facilitate continued quality improvement and make the case for additional funding for successful interventions.
- ☐ 4. Explore creation of data warehouse to allow for aggregate data analysis across systems.
- ☐ 5. Encourage data collection/sharing across not just housing and health care systems but Education, Criminal Justice, Public Libraries, and any other system likely to serve same population to create more comprehensive picture of homelessness.
- ☐ 6. Ensure hospitals are accurately and consistently using ICD codes that relate to homelessness and housing instability.

MODEL STRATEGY 5: MAXIMIZE USE OF MEDICAID TO FINANCE SERVICES THAT SUPPORT HOUSING STABILITY, INCLUDING PSH SERVICES AND RECUPERATIVE / TRANSITION CARE



☐ A. PROMOTE STATE AND COUNTY LEVEL ACTION TO FACILITATE ADEQUATE MEDICAID REIMBURSEMENT FOR MEDICAL AND SUPPORT SERVICES THAT PROMOTE STABLE HOUSING AND ONGOING WELLNESS.

- ☐ 1. Apply for Medicaid State Plan Options to allow funding for medical and support services that promote stable housing and ongoing recovery.
 - a. Medicaid Rehabilitation
 - b. Targeted Case Management
 - c. Section 1915(i) HCBS
 - d. Section 1915(k) Community First Choice
 - e. Health Homes
 - f. Section 1937 Alternative Benefit Plans
- ☐ 2. Apply for Demonstration Programs
 - a. Money Follows the Person (MFP)
 - b. Balancing Incentives Program (BIP)
 - c. Duals Demonstration/Integrating Care for people Enrolled in Medicare and Medicaid
- ☐ 3. Apply for Waivers
 - a. Section 1115 Research and Demonstration Projects
 - b. Section 1915(b) Managed Care Waivers
 - c. Section 1915(c) Home and Community-Based Services Waivers
- ☐ 4. Work with State Medicaid Agency to Align Financing and Incentives to Facilitate Provision of Services that Support Housing Retention and Overall Health for People Who Are Homeless and At Risk.
 - a. Ensure that payment methods, capitation rates, quality measures, service limitations and authorization requirements reflect the complex needs of people who are homeless.

☐ B. DEVELOP AND TRANSFORM AGENCY STRUCTURES AND OPERATIONS TO ENABLE MEDICAID BILLING.

- ☐ 1. Reconfigure agency operations, including:
 - a. Description of services provided
 - b. Staff training, licensure, credentialing and/or certification; supervision; case loads
 - c. Administration, data collection, record storage, paperwork, and billing capacity (in house or through an intermediary such as an Administrative Service Organization (ASO))
 - d. Health electronic records capability

- e. Quality performance measurement standards, with incentives and consequences, and regular reporting

☐ C. EXPLORE / PILOT DIFFERENT MEDICAID PAYMENT MODELS FOR SERVICES PROVIDED BY HOMELESS HOUSING AND SERVICE PROVIDERS.

- ☐ 1. PSH, recuperative care programs, case management, outreach and other services
 - a. Fee for service
 - b. Per diems
 - c. Bundled monthly rates
 - d. Risk adjusted case rates
 - e. Capitation
 - f. Other

☐ D. IDENTIFY OTHER SOURCES OF FUNDING FOR ESSENTIAL SERVICES NOT ELIGIBLE FOR MEDICAID REIMBURSEMENT.

- ☐ 1. Public, private, federal, state, local

APPENDIX J: DATA-DRIVEN STRATEGIES

The following is an overview of data-driven strategies for identifying homeless individuals across multiple service systems and effectively linking them to the range of housing, health, and supportive services they need.

DATA-DRIVEN STRATEGIES FOR CLIENT IDENTIFICATION, ENROLLMENT AND CROSS-SYSTEMS CARE COORDINATION

The information in this document is intended to present housing, healthcare, and social service providers with data-driven strategies for identifying homeless individuals across multiple systems and effectively linking them to the range of health, housing, and supportive services they need.

The following topics are covered in this worksheet:

- Coordinated Entry
- Data-Driven Targeting Tools and Vulnerability Assessments
- Cross-Systems Data Matching
- Data Warehousing
- Frequent User Programs
- Frequent User Systems Engagement (FUSE) Model

Homeless Management Information System (HMIS)¹

A Homeless Management Information System (HMIS) is a local information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness. Each CoC is responsible for selecting an HMIS software solution that complies with HUD's data collection, management, and reporting standards.

Coordinated Entry²

Background

- Under the HUD CoC Program interim rule, grant recipients and sub-recipients are required to use a coordinated system to initially assess the eligibility and needs of each individual or family who seeks homeless assistance, and to coordinate the entry and provision of referrals.
- A coordinated entry system will be developed and implemented by each Continuum of Care in accordance with minimum requirements established by HUD, including coverage of the geographic area, easy accessibility and entry by individuals and families seeking housing or services, good advertising, and a comprehensive and standardized assessment tool.

About Coordinated Entry

- Process for people to receive prevention, housing, and/or other related services.
- Increases likelihood families and individuals will be quickly served by the right intervention.
- Each system entry point uses the same assessment tool and makes decisions on which programs families and individuals are referred to based on a comprehensive understanding of each program's specific requirements, target population, and available beds and services.
- Coordinated entry paves the way for more efficient systems by:
 - Helping people move through the system faster (by reducing the amount of time people spend moving from program to program before finding the right match);
 - Reducing new entries into homelessness (by consistently offering prevention and diversion resources upfront, reducing the number of people entering the system unnecessarily); and
 - Improving data collection and quality and providing accurate information on what kind

¹ HUD Exchange, "Homeless Management Information System," <https://www.hudexchange.info/programs/hmis/>

² U.S. Department of Housing and Urban Development, "24 CFR Part 578: Interim Rule," *Federal Register*, July 31, 2012: 10, 15-16, 53. https://www.hudexchange.info/resources/documents/CoCProgramInterimRule_FormattedVersion.pdf.

Data-Driven Targeting Tools and Vulnerability Assessments³

Data-driven triage tools or evidence-based vulnerability assessments can help identify and prioritize individuals or families for supportive housing. The most sophisticated tools are based on statistical models or predictive algorithms that use information (demographics, homelessness, child welfare involvement) collected at the time of screening to identify families at highest risk for chronic child welfare involvement and long-term homelessness. Vulnerability assessments work in a similar fashion in that they collect information from respondents across a number of different domains (health/mental health, homelessness, child welfare involvement, etc.) to produce an aggregate vulnerability score or rating that is then used to prioritize families for services.

Case Study: Veterans Homeless Risk Assessment⁴

To improve the Department of Veterans Affairs (VA)'s ability to identify veterans who are at risk of homelessness—or experiencing homelessness but not accessing services—the VA National Center on Homelessness Among Veterans, in collaboration with the VA National Clinical Reminders Committee, developed a two stage **Homelessness Screening Clinical Reminder (HSCR)** to conduct an ongoing, universal screen for homelessness and risk among veterans accessing healthcare services. The objective of this national, health system-based screening instrument is to enhance the rapid identification of veterans who have very recently become homeless or are at imminent risk of homelessness, and to ensure that they are referred for the appropriate assistance to stabilize their housing crisis or to rapidly rehouse them if they have fallen into homelessness. The HSCR is comprised of two primary questions intended to assess current housing instability and imminent risk of housing instability:

1. In the past 2 months, have you been living in stable housing that you own, rent, or stay in as part of a household? (“No” response indicates veteran is positive for homelessness.)
2. Are you worried or concerned that in the next 2 months you may NOT have stable housing that you own, rent, or stay in as part of a household? (“Yes” response indicates Veteran is positive for risk.)

Veterans who screen positive are asked two additional questions: (1) Where they have lived for most of the previous two months, and (2) Whether they want to be referred to social work or homeless services to address their housing instability. Veterans' responses to the HSCR are stored in the VA's Corporate Data Warehouse along with additional information captured through their medical records, such as demographics, diagnoses, and services utilization.

Cross-Systems Data Matching⁵

Most public agencies have data collection systems and can identify families who have had contact with child welfare and homeless systems. However, these systems are largely uncoordinated. Cross-system administrative data matches (for example between child welfare agency data systems and Homeless Management Information Systems) may be used to identify families who overlap and have

³ Corporation for Supportive Housing (CSH), “Strategies for Identifying Families,” 2015, <http://www.csh.org/toolkit/keeping-families-together-a-guide-to-developing-supportive-housing-for-child-welfare-involved-families/targeting-high-need-families-for-supportive-housing/strategies-for-identifying-families/>.

⁴ Ann Montgomery, Ph.D. “Using a Universal Screener to Identify Veterans Experiencing Housing Instability,” VA National Center on Homelessness Among Veterans and U.S. Department of Veterans Affairs, March 2014: 1-2. http://www.endveteranhomelessness.org/sites/default/files/research/Universal%20Screener%20to%20Identify%20Veterans%20Experiencing%20Housing%20Instability_2014_03.04.pdf.

⁵ Corporation for Supportive Housing (CSH), “Strategies for Identifying Families,” 2015, <http://www.csh.org/toolkit/keeping-families-together-a-guide-to-developing-supportive-housing-for-child-welfare-involved-families/targeting-high-need-families-for-supportive-housing/strategies-for-identifying-families/>.

frequent contacts with multiple systems. Feasibility of a data match depends on the breadth of data collected, quality of the data, and the sophistication of data systems. In the most sophisticated data systems, a human services agency may be able to track families across multiple departments of the agency (e.g., child welfare, homeless, TANF, mental health, etc.). In this scenario, public agencies or departments have Memorandums of Understanding (MOUs) that allow staff from any of the partnering agencies to view all of the data pertaining to a family. If data and systems permit, this matching approach is particularly effective and efficient for identifying a community's highest-need/highest-cost families to target for intensive services.

Case Study: Utah Medicaid Data Match⁶

Following their H² Action Planning Session in March 2015, the Utah Department of Workforce Services (DWS) successfully conducted a match of the data available in the Homeless Management Information System (HMIS) and eREP (Medicaid eligibility system) for the state. Utah DWS is using this data match to create aggregate data to evaluate current performance, historical trends, and evaluate performance expectations at the time of contract renewals. This increase in Utah's cross-system integrated data capacity helps the state facilitate better understanding of system level operations, effectiveness, and efficiency, and supports their goal to engage in data-driven decision-making around homeless health and housing service provision.

Data Warehousing⁷

A data warehouse is a central database integrating information from more than one source of the same type of system (e.g., multiple Homeless Management Information Systems (HMIS)) and/or from more than one source of different systems (e.g., multiple mainstream systems such as healthcare, foster care, corrections, and education). A warehouse rearranges the data into a structure that allows for more effective and efficient reporting and analysis. Data warehouses have proven effective in the study of regional homelessness and the use of mainstream systems.

Case Study: Ohio Human Services Data Warehouse⁸

The Ohio Human Services Data Warehouse (OHSDW) involves the consolidation of multiple data sources into one centralized database to report a regional and statewide picture of homelessness. Ohio's data warehouse was initiated with the formation of a collaboration of homeless Continuums of Care and their respective Homeless Management Information Systems (HMIS). This HMIS Data Warehouse of consolidated statewide HMIS data will then be combined with data from other state agencies, including mental health providers, Medicaid, youth services, the foster care system, and TANF. The data warehouse will serve multiple purposes including, but not limited to, obtaining unduplicated regional counts of homeless persons, understanding client movement, and analyzing service usage.

Frequent User Programs⁹

"Frequent User" programs and partnerships use health service utilization data to identify the most frequent users of health services and engage them in more appropriate and cost-effective services, including primary and preventive health care, treatment services, social services and supports, and connections to stable housing (Similar programs also exist for individuals with frequent interaction

⁶ Utah H² Leadership Team, "Utah H² Action Plan," Draft 8, August 8, 2015.

⁷ U.S. Department of Housing and Urban Development, "HMIS Data Warehousing Curricula," October 2008, <https://www.hudexchange.info/resource/1696/hmis-data-warehousing-curricula/>.

⁸ Ohio Human Services Data Warehouse: <http://ohiodatawarehouse.org/index.html>.

⁹ United States Interagency Council on Homelessness, "Frequent Users of Health Services," 2015, http://usich.gov/usich_resources/solutions/explore/frequent_users_of_health_services.

with the criminal justice system). When care management and flexible services linked to stable housing are provided to “frequent users” who are experiencing homelessness, the results include housing stability, significant reductions in the utilization and costs of emergency health services, and better treatment for complex health issues.

Case Study: Community Care of North Carolina (CCNC) Priority Patients Program Medical Center Coordinated Care Clinic¹⁰

Community Care of North Carolina (CCNC) built a partnership between a large funder of health care (Medicaid), primary care physicians, and other local health care providers to achieve quality, utilization, and cost objectives in the management of care for Medicaid recipients across North Carolina. CCNC’s Priority Patient Program was initiated in 2011 and focuses on about 5% of the overall CCNC population who are considered “super-utilizers” based on potentially preventable inpatient admissions and/or Emergency Department visits. Priority patients are determined through the following data:

- Claims data to estimate expected spending for each beneficiary given his/her clinical history
- CCNC has an electronic data exchange that receives weekly updated statewide Medicaid claims data as well as real-time hospital admission data, laboratory results, and clinical data from the primary care medical record.
- Uses Clinical Risk Grouping software from 3M Health Information System to assign patients to a risk category, estimate average cost of care for patients in each category, and flag those with hospital spending at least \$1000 above the level expected for their category.

Priority patients are then connected with care managers who review their case histories and develop an individualized approach for outreach and intervention to prevent unnecessary hospital costs.

Frequent User Systems Engagement (FUSE) Model¹¹

FUSE identifies and works to engage and stabilize people who are high users of both the shelter system and the criminal justice system, using a Housing First model of permanent supportive housing. The program model focuses on providing housing stability and reducing the involvement of participants in the criminal justice system and other emergency service systems. A core component of the FUSE model is **Data-Driven Problem Solving**. Data is used to identify a specific target population of high-cost, high-need individuals who are shared clients of multiple systems, including jails, homeless shelters, and crisis health services. Data analysis is used to identify those individuals who are caught in a “revolving door” with repeated contacts with several systems. Cross system data is also used to track implementation progress and measure outcomes.

Case Study: FUSE 10th Decile Project, Los Angeles, CA¹²

Goal: To identify the 10% of homeless patients with the highest public and hospital costs, place them into permanent supportive housing (PSH), and surround them with supportive medical and mental health homes.

Data and Tools Used: A triage tool is used to screen for high cost, high need homeless individuals to differentiate homeless individuals with the highest public costs from other homeless individuals

¹⁰ HomeBase, “Breaking the Cycle: Data-Driven Interventions for Frequent Users of Public Systems; Community Care of North Carolina (CCNC) Priority Patients Program Medical Center Coordinated Care Clinic,” September 21, 2014.

¹¹ United States Interagency Council on Homelessness, “Frequent User Systems Engagement (FUSE),” 2015, http://usich.gov/usich_resources/solutions/explore/frequent_users_systems_engagement_fuse.

¹² HomeBase, “Breaking the Cycle: Data-Driven Interventions for Frequent Users of Public Systems: FUSE (Frequent Users Systems Engagement) 10th Decile Project, Los Angeles, CA,” September 21, 2014.

with less severe conditions. This cost spread is based on health conditions and history of using public services. The tool uses an array of variables (51 pieces of information are collected and combined) to determine the probability that the homeless individual is in the top cost-decile.

Intervention: Participating patients are enrolled with experienced community-based homeless service providers. The transition from the hospital or clinic to a navigator takes place through a warm handoff- health provider staff, usually a social worker, briefs the navigator on the patient's social and medical background, personal characteristics, history of hospital use, presenting issues, diagnoses, and underlying problems, and then personally introduces the navigator to the patient. The navigator assumes immediate responsibility for assisting the individual, including assessing what type of temporary housing is needed, providing transportation to the housing site, visiting a Federally Qualified Health Center to arrange immediate care, facilitating the process of obtaining the documentation and benefits needed to access PSH, linking those in PSH with a medical home, and providing post-housing follow-on support.

Outcomes:

- Total annual average public and hospital costs/person for those who obtained housing decreased from \$63,808 to \$16,913 (73%) – excluding housing subsidy costs.
- Total health care costs/person, including jail medical and mental health, for those housed declined from \$58,962 to \$16,474 (72%).
- Every \$1 spent on navigation, housing, and services produced a net savings of \$2 in the first year and \$6 in subsequent years through reduced public and hospital costs.



APPENDIX K: INNOVATIVE PARTNERSHIP STRATEGIES

The following is an overview of innovative, cross-system partnership and coordination strategies, including case studies and examples from communities around the country.

INNOVATIVE TREATMENT, HOUSING, AND SERVICE PARTNERSHIPS TO LINK HOUSING WITH HEALTH AND HUMAN SERVICES

The information in this document is intended to provide housing, health care, and social service providers with ideas for innovative, cross-system partnerships and coordination. The following topics are covered:

- Connection Between Homelessness and Health Outcomes
- Housing and Service Providers in Partnership
- Healthcare for the Homeless Programs as Housing Programs
- Housing Navigators
- Housing Transition and Support Services
- Managed Care Strategies

Connection Between Homelessness and Health Outcomes

- Homeless adults are more likely to suffer from chronic medical conditions and to suffer complications from their illnesses due to lack of housing stability and regular, uninterrupted treatment.¹
- Chronically homeless people tend to frequently use emergency services, crisis response, and public safety systems.²
- For those with complex chronic health conditions, homelessness or housing instability is among the most significant barriers to health care access, resulting in excessive use of emergency departments, inpatient treatment, and crises services.³
- Numerous studies have shown the correlation between homelessness and high health care costs:
 - A 2010 HUD study found that in Kalamazoo, Medicaid costs for children in a cohort of homeless families were 26% higher than the statewide average Medicaid cost for children; Medicaid costs for adults were 78% higher than the statewide average.⁴
 - A 2004 analysis of Duval County conservatively estimated taxpayers pay \$35,000,000 a year on providing services for the homeless, including healthcare system costs such as emergency rooms, untreated illnesses, unreimbursed expenses, ambulance service, and crisis stabilization units.⁵
 - A Philadelphia study found that the top 20% of individuals experiencing chronic homelessness plus substance abuse cost the City approximately \$22,000 per person per year in behavioral health services, prison, jail, and homeless services.⁶

¹ <http://www.cdc.gov/features/homelessness/> and Kaiser Commission on Medicaid and the Uninsured, "Medicaid Coverage and Care for the Homeless Population: Key Lessons to Consider for the 2014 Medicaid Expansion", September 2012, available at: <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8355.pdf>

² National Alliance to End Homelessness, "Chronic Homelessness," 2015, http://www.endhomelessness.org/pages/chronic_homelessness.

³ Deborah Canavan Theile, "Creating a Medicaid Supportive Housing Services Benefit: A Framework for Washington and Other States," *The Corporation for Supportive Housing for Washington Low Income Housing Alliance*, August 2014: 10, <http://wliha.org/sites/default/files/FINAL%20Creating%20a%20Medicaid%20Supportive%20Housing%20Services%20Benefit.pdf>.

⁴ U.S. Department of Housing and Urban Development, "Costs Associated with First-Time Homelessness for Families and Individuals," March 2010, https://www.huduser.gov/publications/pdf/Costs_Homeless.pdf.

⁵ Ability Housing, "Home is Where Our Heart Is," 2007 Annual Report, http://abilityhousing.org/docs/AH_07AnnualReport.pdf.

⁶ Stephen R. Poulin, Marcella Maguire, Stephen Metraux, and Dennis P. Culhane. "Service Use and Costs for Persons Experiencing Chronic Homelessness in Philadelphia: A Population-Based Study" *Psychiatric Services* 61.11 (2010): 1093-1098.

- A Clarke county study released in February 2007 found that Athens hospitals, which are required to treat everyone regardless of ability to pay, spent at least \$12.4 million in 2005 caring for the homeless, an average of almost \$20,000 per homeless patient.⁷
- According to a University of Texas two-year survey of homeless individuals, each person costs the taxpayers \$14,480 per year across public systems, primarily for overnight jail.⁸
- A New York study found that homeless patients are six times more likely than patients with stable housing to name an emergency department as their usual source of care or to report no usual source of care.⁹
- A 2012 study in Los Angeles found the estimated average annual public cost for 10th decile patients living in permanent supportive housing was \$63,808. These public costs included jail, probation, emergency medical services, and hospitalization.¹⁰
- 37 homeless men and women in Asheville, North Carolina, over a three-year period, cost the City and County over \$800,000 each year. The total costs included \$120,000 for 280 episodes of EMS services, and \$425,000 in hospitalization costs.¹¹
- A study conducted by West Virginia University (WVU) and the West Virginia Coalition to End Homelessness found that 267 persons experiencing homelessness who received care at WVU Ruby Memorial Hospital over a one-year period incurred \$5,979,463 in service costs, including 785 emergency department visits totaling \$1,128,036 in care costs and 257 inpatient stays totaling \$3,743,699 in care costs.¹²
- California study: Approximately 45% of high utilizers of emergency departments are homeless.¹³
- Hawaii study: The rate of psychiatric hospitalization of homeless people was over 100 times higher than for a non-homeless cohort.¹⁴
- AmeriHealth Washington D.C. member costs: A data query of 48 homeless members, listing a shelter as address in 2014, found that 54% had behavioral health issues; 19% made frequent use of the emergency room; 62.5% had costs significantly higher than average per member per year cost of \$3,307.¹⁵
- In 2009, the emergency department of St. Patrick Hospital in Missoula, MT was visited by 514 people identified as homeless. These individuals accounted for 1,219 separate visits to the ER and were provided with \$3,028,359 in charity care. Three years later in 2012, the cost was closer to \$4,000,000.¹⁶

⁷ "Cost Analysis of Medical Services to Homeless Persons" (2007) Athens-Clarke County Dept. of Human and Economic Development, as cited in "Addressing Homelessness through Collaboration," State Housing Trust Fund Annual Report, January 1, 2008, <http://www.dca.state.ga.us/housing/specialneeds/publications/2008HTFAAnnualReport.pdf>.

⁸ National Alliance to End Homelessness, "Cost of Homelessness," http://www.endhomelessness.org/pages/cost_of_homelessness.

⁹ California Department of Health Care Services Webinar, "Medi-Cal Managed Care Plans and Homeless Members," October 1, 2014. Available at: https://www.youtube.com/watch?v=32xyeUzTqys&feature=player_embedded

¹⁰ "Getting Home: Outcomes from Housing High Cost Homeless Hospital Patients," Conrad N. Hilton Foundation, UniHealth Foundation, the Corporation for National and Community Service, the Corporation for Supportive Housing, and the Economic Roundtable, http://www.csh.org/wp-content/uploads/2013/09/Getting_Home_2013.pdf

¹¹ From National Academy for State Health Policy, "Chronic Homeless and High Users of Health Services" available at http://nashp.org/sites/default/files/chronic_homelessness.pdf?q=Files/chronic_homelessness.pdf

¹² David Parker, "An inexpensive, interdisciplinary, methodology to conduct an impact study of homeless persons on hospital based services," as cited in the West Virginia Interagency Council on Homelessness 2014 Report, available at: http://www.wvcommerce.org/App_Media/assets/download/ndrc/WVICH_Progress_Report_2014.pdf.

¹³ Linkins, Brya, & Chandler, 2008, available at: <http://www.aidschicago.org/pdf/2009/hhrpn/FUHCs/1FrequentUsersofHealthServicesInitiative-FinalEvaluation.pdf>.

¹⁴ National Alliance to End Homelessness, "Cost of Homelessness," 2015, http://www.endhomelessness.org/pages/cost_of_homelessness.

¹⁵ Testimony of Karen Dale, RN, MSN, "FY 2016 Budget Hearing," AmeriHealth District of Columbia, Before the Council of the District of Columbia Committee on Health and Human Services, April 24, 2015: 4.

¹⁶ Missoula Reaching Home Workgroup, "Reaching Home: Missoula's 10-Year Plan to End Homelessness 2012-2022," October 2012: 11, <http://www.ci.missoula.mt.us/DocumentCenter/View/21013>

- As of 2009, Billings estimated each homeless person cost the city over \$15,000 per year in public services, with an estimated cost of \$115,000 to serve each chronically homeless individual per year. With nearly 2,400 people experiencing homelessness in Billings each year, costs exceed \$54 million annually.¹⁷
- A rough estimate for the total annual cost of homelessness in Flathead County in 2013 was in the multi-million dollar range.¹⁸
- The Minnesota Supportive Housing and Managed Care Pilot program found that homeless single adults with highly complex needs such as medical problems, mental illness, chemical dependency, and traumatic experiences used an average of \$13,954 per year in services prior to entering permanent supportive housing.¹⁹
- A study in Maine found that rural homelessness costs the state \$18,623 per person, including costly emergency room services and behavioral health costs.²⁰

Housing and Service Providers in Partnership

- Innovative yet common form of Permanent Supportive Housing (PSH)
- Many of these arrangements involve agencies on the service side that are not Medicaid providers, but some examples of partnerships involve a service partner with some capacity to use Medicaid financing.

Examples

Central City Concern (Portland)²¹

- Permanent Supportive Housing provider has clinic, patient centered medical home, primary care and mental health team on-site.
- Coordinated with housing through Supportive Housing Healthcare Coordinator, who:
 - Develops care coordination that connects housing and health services
 - Identifies high needs residents with gaps in health care support
 - Conducts needs assessment at intake to identify health issues
 - Streamlines referral process to connect housing residents to health care
 - Obtains signed releases at outset of process
- Housing information is contained in medical records.
- Housing residents who are clinic patients have electronic medical records updated.

Pathways (Washington, D.C.)²²

- Permanent supportive housing program with adjacent clinic
- Integrated Health team (HealthWorks) with nurse practitioner, medical assistant, peer health specialist, nutritionist
- Nurses on the ACT team get appointments with primary care doctors
- Set-aside appointments at partner FQHC

¹⁷ City of Billings Mayor's Committee on Homelessness Community Development Division, "Welcome Home Billings," October 2009: 5, <http://www.ci.billings.mt.us/DocumentCenter/Home/View/4985>

¹⁸ Flathead Homelessness Interagency Resource and Education, "Finding the Way Home: Five-Year Plan to Address Homelessness (2014-2019)," 2014: 13, <http://flatheadhealth.org/wp-content/uploads/2015/01/5-Year-Plan-to-Address-Homelessness.pdf>

¹⁹ The National Center on Family Homelessness, "The Minnesota Supportive Housing and Managed Care Pilot: Evaluation Summary," March 2009, <http://www.air.org/sites/default/files/downloads/report/Evaluation-Minnesota-Supportive-Housing-and-Managed-Care-Pilot-2009.pdf>

²⁰ State of Maine, "Cost of Rural Homelessness: Rural Permanent Supportive Housing Cost Analysis," May 2009, <http://www.portlandmaine.gov/DocumentCenter/Home/View/2274>

²¹ Central City Concern, "Central City Concern Supportive Housing," PowerPoint, presented at National Alliance to End Homelessness Conference, July 2012. Available at: <http://www.centralcityconcern.org/research/>.

²² Pathways to Housing D.C., "Housing First," 2015, <https://www.pathwaystohousingdc.org/housing-first>.

- SAMHSA grant has been used over last five years to integrate primary care into behavioral health care
- Created Wellness suite with a medical assistant in the agency waiting room to interact with people, directing them to the adjacent clinic

Chicago²³

- Heartland Health Outreach (a Health Center) collaborates with Mercy Housing Lakefront to provide on-site health clinics in PSH
- Links tenants seen in those housing-based clinics to Heartland Health Outreach's main clinic for ongoing care and treatment.
- These services are Medicaid-reimbursable if clients are enrolled in Medicaid.

Los Angeles²⁴

- A Community of Friends (a housing provider) has arrangements with various providers of Medicaid-reimbursable and county-funded mental health services for supports to tenants in its many buildings.
- Skid Row Housing Trust has arrangements with JWCH's Center for Community Health and Los Angeles Christian Health Center (both Health Centers) as well as Exodus Recovery and LAMP (mental health providers), among others, to serve its tenants.

Health Care for the Homeless Programs as Housing Programs

Case Study: Family Health Centers, Inc. (Louisville, KY)²⁵

- Health Care for the Homeless program (Phoenix Health Center) with Permanent Supportive Housing vouchers under Housing First
- HCH Director runs the Coordinated Assessment system for the CoC
- Full-time SOAR worker, mental health therapist, and two social service workers that provide substance abuse counseling, referral, and case management
- Peer Support Program – provides residents with one-on-one mentoring
- PSH residents receive medical, dental, and behavioral health services through Phoenix Health Center

Housing Navigators

Housing navigators work as “brokers,” providing options for individual patients to community health workers or social workers for them to discuss with clients.

Case Study: Hennepin Health (MN)²⁶

Background:

- Housing navigators (employed by the county's Human Services and Public Health Department) play a broker role: They do not work directly with clients. Instead, they work with the social workers and community health workers who are part of clinical teams.

²³ ASPE, “Medicaid and Permanent Supportive Housing for Chronically Homeless Individuals: Emerging Practices from the Field,” August 2014, available at: <http://aspe.hhs.gov/daltcp/reports/2014/EmergPrac.pdf>.

²⁴ ASPE, “Medicaid and Permanent Supportive Housing for Chronically Homeless Individuals: Emerging Practices from the Field,” August 2014, available at: <http://aspe.hhs.gov/daltcp/reports/2014/EmergPrac.pdf>.

²⁵ Connie Campos, “Grantee Spotlight: Family Health Centers, Inc.,” U.S. Substance Abuse and Mental Health Administration, Homeless Resource Center, 2013, <http://homeless.samhsa.gov/resource/grantee-spotlight-family-health-centers-inc-55979.aspx>.

²⁶ State of Minnesota, “Reform 2020: Pathways to Independence- Section 1115 Waiver Proposal,” resubmitted to CMS November 21, 2012: 58-59. <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6535E-ENG>.

- Clinical teams and housing navigators use a “tiering system” to target assistance to the most vulnerable patients who are homeless or unable to return to a safe and stable living situation.
- The goal is to focus on those whose lack of housing contributes to escalating medical costs.

Process:

- Community health workers and social workers who make referrals gather information about patients and then work with the housing navigators to identify options that offer the best fit for each individual in terms of eligibility, needs, and preferences.
- Housing navigators know about all of the housing options in the county, and they know which programs use a housing-first approach and which have rules about sobriety. Options include emergency or short-term options as well as permanent supportive housing.
- Housing navigators track information about housing program characteristics, including application procedures and vacancies, and then offer up to three options for the community health workers or social workers to discuss with their clients.
- Community health workers or social workers are responsible for helping clients follow through to complete applications and get into housing.
- If client is rejected by a suggested housing provider, navigators try to find other options.
- Housing navigators also provide information that community health workers can use to follow up on their own to assist other patients who have lower levels of need.

Housing Transition and Support Services

- Enable participants who are transitioning into a PSH unit, including persons who were homeless or transitioning from institutions, to secure their own housing; or
- Provide assistance continuously thereafter including at any time the participant’s housing is placed at risk (e.g., eviction, loss of roommate or income).

Case Study: Louisiana²⁷

Background:

- Interventions are included in two Home and Community Based Services (HCBS) Waiver programs and in the state's Medicaid 1915(i) program, which includes:
 - Community Psychiatric Treatment and Support (CPST)
 - Combined case management and direct services intervention, and
 - ACT services for persons with serious mental illness, including those with co-occurring substance abuse disorders.
- Identical housing support interventions in state’s CABHI grant, their Access to Recovery (ATR) program, and their CDBG funded housing support services.
- Nearly 3,000 households are now served. Persons who were homeless at the time of referral to supportive housing have been major beneficiaries of this service.
- The Louisiana Department of Health and Hospitals (DHH) manages the program in partnership with the Louisiana Housing Corporation and local CoC designated agencies.
- Providers are certified as PSH providers to deliver these services, and receive ongoing training and coaching to help them meet Medicaid requirements and address challenges.

²⁷ Deborah Canavan Thiele, The Corporation for Supportive Housing, “Creating a Medicaid Supportive Housing Services Benefit: A Framework for Washington and Other States,” August 2014, http://www.csh.org/wp-content/uploads/2014/08/Creating_Medicaid_Supportive_Housing_Servcies_Benefit_WashingtonState.pdf and ASPE, “Medicaid and Permanent Supportive Housing for Chronically Homeless Individuals: Emerging Practices from the Field,” August 2014, available at: <http://aspe.hhs.gov/daltcp/reports/2014/EmergPrac.pdf>.

Medicaid Services Included:

- Housing assessment identifying the participant's preferences related to housing and needs for support to:
 - Maintain housing
 - Budget for housing/living expenses
 - Obtain/access sources of income necessary for rent, home management, and establishing credit
 - Understand and meet obligations of tenancy
- Assistance locating, securing, and maintaining housing
- Development of an individualized housing support plan based upon a housing assessment that includes short-term and long-term measurable goals, an approach to meeting each goal, where other provider(s) or services may be required to meet the goal
- Participation in development of the Plan of Care
- Individual supportive counseling and assistance with daily living skills development
- Looking for alternatives to housing if PSH is unavailable
- Assistance with landlord negotiations
- Intervention and help requesting assistance from Crisis Intervention Services if a participant's housing is placed at risk (e.g., eviction, loss of roommate or income)

Managed Care Strategies²⁸

Managed care organizations (MCOs) may pay for services on a fee-for-service basis. However, in recent years, states have moved away from just using a straight fee-for-service payment for many of the health care services covered by Medicaid, relying instead on Medicaid managed care approaches to organizing payment and delivery of medical and/or behavioral health services for growing numbers of Medicaid beneficiaries.

Strategies for MCOs to Effectively Serve Homeless People

1. Target resources to those with greatest needs. Develop methods for identifying the highest need/highest cost beneficiaries, which will typically include people who are chronically homeless or have ongoing housing stability problems. Target intensive care management and housing stabilization services for this population.
2. Develop innovative funding strategies for funding the care management and housing stabilization services needed by people who are chronically homeless or at-risk. This includes using funds included in their capitated payment to fund specialized care management or coordination and essential services that are difficult to fund under a fee-for-service system. (This may require State and CMS approvals.)
3. Reinvest a portion of profits on an annual basis (cost-savings after covering risk and contingency) into housing and other services needed to stabilize the population, and hopefully, allow more cost-savings to be incurred. This is particularly important as a strategy to fund additional PSH, respite housing, and other housing needed by the target population.
4. Establish partnerships with a range of agencies serving the target population in order to coordinate (not duplicate) resources and support robust and effective interventions that

²⁸ Information from: ASPE's Medicaid and Permanent Supportive Housing for Chronically Homeless Individuals: Emerging Practices from the Field (mostly Chapter 6), available at: <http://aspe.hhs.gov/daltcp/reports/2014/EmergPrac.pdf> and CSH's Integrating Housing in State Medicaid Policy, http://www.csh.org/wp-content/uploads/2014/04/State_Health_Reform_Summary.pdf.

effectively stabilize individuals served. This includes homeless housing and service providers who have expertise with the population.

Practical Examples²⁹

Facilitate Homeless Enrollment and Access to Care

This involves taking steps to ease the transition and facilitate continuity of care (if they had care before) for newly enrolled homeless clients, including ensuring that procedures are in place for quickly making changes in provider assignment and for facilitating access to the most appropriate care providers for people who are homeless, supportive housing tenants, and people with behavioral health disorders. It also involves taking steps to increase MCO organizational capacity and cultural competence to help newly enrolled homeless beneficiaries.

Reach Out to Organizations with Experience Working with Homeless People

Contract with organizations such as homeless service agencies and those providing PSH or services to clients in PSH in order to provide key services (care coordination, targeted case management (TCM), behavioral health care, or other services) that support ongoing health and wellness.

Case Study: Minnesota Special Needs Basic Care Plans

- Minnesota state legislation enacted in 2011 requires that Medicaid recipients with disabilities be assigned to a Special Needs Basic Care health plan
- Plans are responsible for:
 - Covering both health and behavioral health services;
 - Completing comprehensive health assessments and providing care coordination services to help patients get care from primary care providers, specialists, and other health care services; and
 - A benefit package that includes targeted case management services for people with serious mental illness.
- To fulfill their responsibilities, some plans work with mental health service providers, including those who deliver TCM services in PSH, to establish contracts and share training and other resources.
- Medica, one of the Special Needs Care Plans, shares its care management tools (such as assessment instruments, care plans, and information systems) with the plan's vendors.
 - Medica recognizes that some of these partner organizations have a background in social services but less capacity or experience with medical issues.
 - Therefore, Medica nurses and nurse practitioners are available to these partners to provide clinical consultations or do home visits as needed.
- **Outcome:** Data shows a large increase in the number of mental health clients who have seen their primary care providers and had physical exams.

Use a Tiering System

Match people with the most appropriate level of care based on the complexity of their health and social needs. This should be linked to a tiered reimbursement rate that pays more for care provided to people with complex health needs and histories of high service utilization and costs (e.g. those who are homeless and have multiple ER visits, hospital admissions and/or detox stays).

²⁹ Information from: ASPE's Medicaid and Permanent Supportive Housing for Chronically Homeless Individuals: Emerging Practices from the Field (mostly Chapter 6), available at: <http://aspe.hhs.gov/daltcp/reports/2014/EmergPrac.pdf> and CSH's Integrating Housing in State Medicaid Policy, http://www.csh.org/wp-content/uploads/2014/04/State_Health_Reform_Summary.pdf.

Incorporate a “Super-Utilizer” Program

Create a program that identifies high-need/high-cost members and targets evidence-based interventions to meet their needs, including Housing First, PSH, and intensive service supports.

Case Study: Minnesota

- The State’s contract with the Special Needs Basic Care Plans allow the MCOs to provide “in lieu of” services—meaning some services that are not defined in the state Medicaid plan but “make sense” because of the needs of members and the potential to achieve cost offsets.
- Representatives of Medica (one of the MCOs participating in managed care in Minnesota) are initially focusing on providing these services to members who are experiencing homelessness and/or making frequent use of hospital care or other health services.

Reinvest a Share of Cost Savings

Use a share of “annual” cost savings for “re-investment” back into supportive housing and other key programs and services, such as care coordination, housing navigation, and recuperative care/medical respite/bridge housing programs.

Case Study: Community Behavioral Health in Philadelphia

- The City of Philadelphia operates a not-for-profit behavioral health managed care organization called Community Behavioral Health (CBH).
- CBH partners with the city’s housing agencies and the Department of Behavioral Health, utilizing both Medicaid and city designated funding to finance services and housing for supportive housing residents based on their contract with the Pennsylvania Department of Human Services (Medicaid agency).
- If a participant is deemed eligible for Medicaid, CBH offers a set of services that community-based homeless service providers deliver.
- CBH cost savings become city revenue after risk and contingency obligations are made. CBH may request those funds be allocated to supporting one-time expenditures based on their state approved housing plan.
- Investments can be made for capital, rental assistance, contingency funds and one-time services and administrative costs.

APPENDIX L: INNOVATIVE FUNDING STRATEGIES

The following is an overview of innovative funding mechanisms and potential funding streams for creating and expanding housing and supportive service programs.

INNOVATIVE FUNDING STRATEGIES

The information in this document is intended to present examples of innovative funding mechanisms for creating and expanding housing programs, including permanent supportive housing. A variety of examples are presented to facilitate strategic discussions around whether and how the ideas presented can be incorporated in your H² plan. The following topics are covered:

- The Case for Funding Permanent Supportive Housing
- Summary of CMS's Recent Guidance on Medicaid Funding Housing-Related Services
- Case Studies of Innovative Permanent Supportive Housing Funding Strategies
- Potential Revenue Sources for Housing Trust Funds
- Public-Private Partnerships
- Public Hospitals and Health Systems
- Social Impact Bonds ("Pay for Success")
- Medicaid Funding Opportunities Under the Affordable Care Act
- Appendix 1: List of Additional Resources

The Case for Funding Supportive Housing

Permanent Supportive Housing (PSH) is a program model that combines affordable housing with tenancy supports and housing-based case management for people with chronic health conditions and disabilities.

A growing body of research shows PSH improves health outcomes and lowers system costs:

- Illinois saw a 39% reduction in total cost of services for 177 residents in its PSH programs two years after moving in, including services from Medicaid, mental health hospitals, substance use treatment centers, prisons and county jails, and hospitals. Mainstream services costs decreased by almost \$5,000 per person.¹
- In Denver, a longitudinal analysis of system costs of 19 PSH residents revealed 34% fewer emergency room visits, 40% fewer inpatient visits, 82% fewer detox visits, and 76% fewer incarceration days.²

Supportive housing is also considered to be very important for individuals living with HIV/AIDS (PLWHA). Existing research shows that housing supports increase stability and connection to care for PLWHA and are consistently linked to improved HIV treatment access, continuous care, better health outcomes, and reduced risk of ongoing HIV transmission.³

One option to explore to fund services that support housing stability is Medicaid. CMS cannot approve a state Medicaid service that covers "housing" room and board costs as part of a mandatory or optional benefit. However, it can cover services in supportive housing. States have expanded their services approaches to cover most "supports" included in "best practice" supportive housing definitions. *[See below for guidance from CMS on Medicaid funding for housing-related services.]*

¹ The Heartland Alliance Mid-America Institute on Poverty, "Supportive Housing in Illinois: A Wise Investment," April 2009: 11. <http://www.illinois.gov/nursinghomesafety/Documents/Supportive%20Housing%20in%20Illinois%20-%20A%20Wise%20Investment.pdf>.

² Jennifer Perlman and John Parvensky, "Denver Housing First Collaborative: Cost Benefit Analysis and Program Outcomes Report," Colorado Coalition for the Homeless, December 11, 2006, http://www.denversroadhome.org/files/FinalDHFCostStudy_1.pdf.

³ Housing Opportunities for Persons with AIDS, "HIV Care Continuum: The Connection Between Housing and Improved Outcomes Along the HIV Care Continuum," November 2014: 8. <https://www.hudexchange.info/resources/documents/The-Connection-Between-Housing-and-Improved-Outcomes-Along-the-HIV-Care-Continuum.pdf>.

One approach to identifying services and supports that can be covered by Medicaid is to compare needed services with coverable interventions, provider requirements, Medicaid care coordination, and other reimbursable administrative tasks to determine what can be covered.

Innovative Funding for Permanent Supportive Housing

CMS Guidance on Medicaid Coverage of Housing-Related Services for Individuals with Disabilities⁴

On June 26, 2015, the CMS released an informational bulletin intended to clarify the circumstances under which Medicaid reimburses for certain housing-related activities for individuals with disabilities, older adults needing long term services and supports (LTSS), and those experiencing chronic homelessness.

Housing related services are defined as a range of flexible services and supports available to individuals with disabilities and older adults needing LTSS:

- 1) Individual Housing Transition Services – services that support an individual’s ability to prepare for and transition to housing
 - Conducting a tenant screening and housing assessment
 - Developing an individualized housing support plan
 - Assisting with the housing application and housing search processes.
 - Identifying resources to cover housing transition expenses
 - Ensuring that the living environment is safe and ready for move-in
 - Assisting in arranging for and supporting the details of the move
 - Developing a housing support crisis plan
- 2) Individual Housing & Tenancy Sustaining Services - services that support the individual in being a successful tenant in his/her housing arrangement and thus able to sustain tenancy
 - Providing early identification and intervention for housing jeopardizing behaviors
 - Education and training on the role, rights and responsibilities of the tenant and landlord
 - Coaching on developing and maintaining relationships with landlords/property managers
 - Resolving disputes with landlords/neighbors and advocacy/linkage with community resources to prevent eviction or other adverse action
 - Assistance with the housing recertification process
 - Coordinating with the tenant to update and modify housing support plan
- 3) State-level Housing Related Collaborative Activities - services that support collaborative efforts across public agencies and the private sector that assist a state in identifying and securing housing options.
 - Developing agreements and working relationships with housing and community development agencies
 - Participating and contributing to state and local planning processes
 - Working with housing partners to create and identify opportunities for more housing, including coordinating housing locator systems and developing data tracking systems to include housing

⁴ U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, “Coverage of Housing Related Activities and Services for Individuals with Disabilities,” Informational Bulletin, June 26, 2015. <http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf>.

The Medicaid authorities and demonstrations through which states can be reimbursed for these services include:

- 1) 1915(c) HCBS waiver
- 2) 1915(i)
- 3) 1915(k), also known as Community First Choice (CFC)
- 4) 1915(b) waivers
- 5) Targeted case management (TCM)
- 6) Section 1115 waivers
- 7) Money Follows the Person (MFP) Rebalancing Demonstration Grants

[See Appendix 2 of this Worksheet for an explanation of these waivers and how they may be used.]

Washington state currently has a pending Section 1115 waiver application, which includes a benefit that is consistent with the language in CMS' guidance. The proposed eligibility criteria for beneficiaries in Washington's application include people meeting HUD's definition of chronic homelessness.

Case Studies

New York State: Leveraging State Medicaid Funding⁵

Background: New York's governor established the Medicaid Redesign Team (MRT) to identify methods to reduce costs and increase quality and efficiency in the Medicaid program. The implementation of the initial recommendations resulted in substantial cost savings.

- Beginning in Fiscal Year 2012-2013, the MRT launched a variety of initiatives redirecting a portion of the cost savings, including developing supportive housing targeted to high-cost Medicaid users.
- The MRT supportive housing initiative funds innovative pilot projects, capital, rental subsidies and supportive services.
- State Agency partners include: Homes and Community Renewal (HCR), Office of Temporary and Disability Assistance (OTDA), Office of Mental Health (OMH), Office for People with Developmental Disabilities (OPWDD), Office of Alcoholism and Substance Abuse Services, (OASAS), and the Department of Health's AIDS Institute.
- The state Medicaid Program allocates funds to those state agencies, which in turn award Medicaid dollars directly to permanent supportive housing (PSH) providers that are housing high users of Medicaid.

PSH Funding:

The MRT Supportive Housing initiative has leveraged significant Medicaid savings under the MRT initiative to create new affordable housing units. Pilots within the initiative are aimed at high-need beneficiaries, including persons living with HIV/AIDS and people with mental and substance abuse disorders.

The MRT Supportive Housing Allocation for FY 2015-2016 and FY 2016-2017 is \$127,000,000 per year, including \$47M each year for capital; \$5M each year for rental subsidies and supportive

⁵ ASPE, "Medicaid and Permanent Supportive Housing for Chronically Homeless Individuals: Emerging Practices from the Field," August 2014, available at: <http://aspe.hhs.gov/daltcp/reports/2014/EmergPrac.pdf> and Corporation for Supportive Housing, "Integrating Housing in State Medicaid Policy," April 2014, http://www.csh.org/wp-content/uploads/2014/04/State_Health_Reform_Summary.pdf.

services; **nearly \$40M each year for new supportive housing pilot programs**; and \$2.5M each year for tracking and evaluation.

MRT Supportive Housing Pilot: Housing and Health Homes

- Will provide rental subsidies and/or on-site or community based services to provide housing for homeless or unstably housed Medicaid members that are enrolled in New York State's Health Home Program.
- Supportive housing providers were required to identify/receive commitment from one or more designated Health Homes to be a provider partner.
- Intent of Program: Identify best practices, procedures, and methods for supportive housing providers to collaborate with Health Homes to:
 - Identify/locate homeless/unstably housed enrolled health home members/individuals eligible for Health Homes;
 - Provide housing as a means to facilitate access to health services and improve the health status of health home members;
 - Coordinate efforts of the Health Home Case Manager and the Housing Specialist to implement the Health Homes Member's Plan of Care; and
 - Provide opportunity for housing providers/Health Homes to develop innovative services/methods to ensure Health Home members remain stably housed.
- Total amount available for procurement: up to \$8M (up to \$4M per year for 2 years). Maximum award made to successful applicant does not exceed \$400,000 per fiscal year.

Massachusetts: Leveraging Medicaid to Fund Supportive Services⁶

Background: The Massachusetts Behavioral Health Partnership (MBHP), Massachusetts' Medicaid behavioral health carve-out, partnered with the Massachusetts Housing and Shelter Alliance (MHSA) to develop a behavioral health managed care model that supports members who have experienced chronic homelessness and are now residing in a Housing First program.

- Includes eight strategic partnerships between behavioral health providers in the MBHP network and non-network housing programs that have federal or state funded housing vouchers that could be used for MBHP enrollees.
- The program provides nonclinical community-based support services to adults who are experiencing chronic homelessness so they can be permanently housed in the community. Community-based, mobile, multi-disciplinary teams of paraprofessionals deliver a range of services, including:
 - Assisting consumers in enhancing daily living skills;
 - Providing service coordination and linkage;
 - Assisting with obtaining benefits, housing, and health care;
 - Developing a crisis plan;
 - Providing prevention and intervention; and
 - Fostering empowerment and recovery, including linkages to peer support and self-help groups.

PSH Funding:

- MBHP worked with the state to create a new Medicaid benefit: the Community Support Program for People Experiencing Chronic Homelessness (CSPECH). MBHP designed the CSPECH benefit to allow Medicaid to reimburse for the care coordination and case

⁶ Corporation for Supportive Housing, "Integrating Housing in State Medicaid Policy," April 2014, http://www.csh.org/wp-content/uploads/2014/04/State_Health_Reform_Summary.pdf.

management not included in a basic Medicaid plan, and to pay for these services using a bundled rate.

- The state included the CSPECH as part of an 1115 waiver that allowed MBHP to pay for medically necessary “diversionary services” to reduce avoidable hospitalizations.
- MBHP pays the service providers \$17 per day per person to receive a mix of the services. Bundling the services into a single payment structure streamlines provider administration and reimbursement.
- *Note: The MBHP’s use of a Medicaid benefit to fund supportive services is consistent with CMS’s recent Guidance on Medicaid-reimbursable Housing-Related Services.*

Los Angeles: Leveraging Non-Medicaid Resources to Increase Housing Inventory⁷

Background: The Housing for Health (HFH) Program is an ambitious program by the Los Angeles County Department of Health Services (DHS) to link housing, health, and behavioral health services for the same population through linkages with housing providers and DHS’s own network of County hospitals, clinics, and contracted service providers that are part of its health services safety net.

- HFH’s primary target population is people experiencing homelessness who are extremely vulnerable because of their health conditions or who are frequent users of County hospital emergency rooms or inpatient care.
- HFH draws from a variety of housing options, including PSH units, licensed residential care and recuperative care facilities, temporary housing for people experiencing short-term crises, and interim housing where people can stay while completing the application process for permanent housing.

PSH Funding:

- HFH leverages the services funding it receives from DHS to secure housing opportunities and additional funding resources.
 - Initially, the County did not pay for the cost of housing itself, securing HFH’s housing inventory by funding the associated property management and supportive services instead.
 - For example, HFH’s first PSH units were created by attaching DHS-funded service teams to tenant-based Housing Choice Vouchers provided by City and County public housing authorities. DHS also partnered with the City Housing Department to acquire and renovate houses and apartment buildings that were in foreclosure.
- In response to the 2013 federal sequestration, which froze the issuance of new housing vouchers, the County began funding housing directly. In addition, DHS worked with the County Board of Supervisors and the Conrad N. Hilton Foundation to launch an \$18 million Flexible Housing Subsidy Pool (FHSP) to provide housing subsidies lined with wraparound intensive case management services for at least 2,400 persons.
 - DHS contracted with Brilliant Corners (BC), a nonprofit organization, to administer the FHSP. BC has been able to maximize the impact of the FHSP dollars by searching for available rental units all over the County, assisting project participants in being matched to the right unit, contracting directly with landlords for units in scattered-site or project-based buildings, and offering special 2-month leases to landlords to take units off the market and hold them for future referrals.
- DHS has managed to finance HFH’s property management and supportive services from its existing budget

⁷ ASPE, “Medicaid and Permanent Supportive Housing for Chronically Homeless Individuals: Emerging Practices from the Field,” August 2014, available at: <http://aspe.hhs.gov/daltcp/reports/2014/EmergPrac.pdf>.

- Most of DHS's contributions to HFH were already in its departmental budget, where they were covering the costs of care delivered in DHS's health service facilities that were not reimbursed through insurance.
- In addition, the advent of Healthy Way LA, the County's Low Income Health Program, and its federal Medicaid match for the costs of care, freed up those local resources, making them available for DHS to cover the cost of supportive services.
- DHS has also determined that its contributions to HFH are offset by major reductions in spending for emergency department use, hospitalizations, and re-hospitalizations by the target population, as well as stays in other high-cost settings such as jails and nursing homes.
- DHS uses a Request for Qualifications process for its property management and supportive services contracts, which has contributed to HFH's ability to take advantage of housing opportunities in a timely manner.
 - DHS established master contracts with 8 property management companies and about 20 supportive service providers. Once housing becomes available and HFH places its priority people into it, DHS adds specifics to those master contracts, entering into agreements for the number of people to receive supportive services or the number of units to receive property management services.

Minnesota: Coordinating with MCOs to Increase PSH capacity⁸

Background: Minnesota state legislation enacted in 2011 requires that Medicaid recipients with disabilities be assigned to a Special Needs Basic Care health plan unless individuals opt out of enrollment. Special Needs Basic Care Plans are responsible for:

- Covering both health and behavioral health services;
- Completing comprehensive health assessments and providing care coordination services to help patients get care from primary care providers, specialists, and other health care services;
- A benefit package that includes targeted case management services for people with serious mental illness.

PSH Funding:

Medica, one of Minnesota's Special Needs Care Plans for Medicaid recipients with disabilities, subcontracted with Hearth Connection, Inc., a non-profit, intermediary housing organization, to conduct a permanent supportive housing demonstration project targeting Medica's 88 highest cost users of Medicaid.

- Hearth Connection provides administrative support, fiscal oversight and research to a network of supportive housing providers.
- Medica decided to address the needs of its Medicaid enrollees experiencing long-term homelessness and chronic conditions and are frequent users of health systems.
- All 88 enrollees were identified through an algorithm created by Medica.
- Medica staff identifies potential enrollees and Hearth Connection locates the enrollee and determines eligibility for their program, including whether the person is homeless.
- If eligible, Hearth Connection facilitates payment of services and housing (using existing HUD resources and the existing state voucher program) and conducts staff training for both Medica and supportive housing providers.

⁸ ASPE, "Medicaid and Permanent Supportive Housing for Chronically Homeless Individuals: Emerging Practices from the Field," August 2014, available at: <http://aspe.hhs.gov/daltcp/reports/2014/EmergPrac.pdf>; State of Minnesota, "Reform 2020: Pathways to Independence- Section 1115 Waiver Proposal," resubmitted to CMS November 21, 2012: 58-59. <https://edocs.dhs.state.mn.us/lfsrver/Public/DHS-6535E-ENG>.

- Medica pays for services within supportive housing, delivers care coordination, and conducts the evaluation of the project.
- The funds provided by Medica to the Hearth Connection, which in turn funds the PSH providers, are often called “alternative service dollars.”

Additional Funding Resources

Housing Trust Fund⁹

- Established sources of funding for affordable housing construction and related purposes.
- Generally established through ordinance or legislation, which dedicates a revenue source or establishes other obligations that create revenue.
- Revenue sources can be **private** funds or **public** funds, such as revenue from real estate taxes or fees, revenue from other taxes, interest earned on Government-Held and Market Rate Accounts, or revenue generated from Government Programs.

The following examples may be considered as potential revenue sources for a newly established state or local housing trust fund:

- ARCH (A Regional Coalition for Housing) in King County, Washington
 - Grants and low-interest contingent loans from member cities.
 - Surplus land and/or reduced building permit fees from some cities.
- Bainbridge Island Housing Trust Fund
 - Donations from realtors and brokers with each home sale.
 - Matching of private contributions by City of Bainbridge Island general fund.
 - Until 2008, contributions from Washington Mutual for each mortgage it wrote.
- Miami-Dade County Homeless Trust
 - Federal and state funds, including 1% food and beverage tax at all restaurants that have a liquor license and gross more than \$400,000 per year.
- Santa Barbara Housing Trust Fund
 - Accesses lines of credit from local banks that loan money at lower interest rate.
 - Rates then brokered out to developers as construction funds.
- Nebraska Homeless Shelter Assistance Trust Fund
 - \$0.25 per \$1,000 of real estate sales as part of state’s Documentary Stamp Tax.
- Georgia’s Homeless Opportunity Fund
 - One-time \$22 million revenue bond financed through a rental car tax.
- Greensboro Nussbaum Housing Partnership Fund
 - Greensboro, North Carolina dedicates 0.7 percent of property tax levied to the Fund, which finances affordable housing and homeless programs.

Public-Private Partnerships

Public-private partnerships are government services or private business ventures funded and operated through a partnership of government and one or more private sector companies.

Case Study: Washington Youth and Families Fund¹⁰

- Created by the Washington State Legislature in 2004 to reduce and end family homelessness.

⁹ Center for Community Change, “Housing Trust Fund Revenue Sources,” <http://housingtrustfundproject.org/htf-elements/revenue-sources/>

¹⁰ Washington Department of Commerce, “Washington Families Fund,” 2013, <http://www.commerce.wa.gov/Documents/Washington-Families-Fund-2013-Fact-Sheet.pdf>

- Funds model programs and innovative strategies that address problems of homelessness at a systems and family level. 80 organizations have been funded.
- **\$55M** combined investment over 10 years: \$17M by the State; \$38.5M by 25 private partners.
- Developed a comprehensive systems change intervention to change how communities in Washington State address family homelessness using best practices and emerging concepts:
 - Prevention: Keep individuals and families linked to services.
 - Coordinated Entry and Assessment: Streamline access to housing and services.
 - Rapid Re-Housing: Get people into housing quickly. Support increases in housing supply.
 - Tailored Programs & Services: Deliver the right level of service at the right time.
 - Economic Opportunities: Support educational and employment opportunities.
 - Evaluation: Collect data to evaluate impact and improve the work being done.

Public Hospitals and Health Systems¹¹

Under the ACA, nonprofit hospitals are now required to complete a community health needs assessment (CHNA) every three years. The objective of the CHNA is to assess the most prevalent health needs and barriers to accessing health care and maintaining good health in the community. These needs assessments can demonstrate to hospitals the health benefits of stable housing and encourage financial investments aimed at increasing housing stability.

Case Study: St. Joseph Health System¹²

In Orange County CA, the **St. Joseph Hospital System has been investing in the construction of affordable housing based on its CHNAs, which revealed the major impact that lack of affordable housing has had on the health of its community.** There are currently 82 low-income housing units for seniors slated for development in Anaheim and there are plans to build a development for large families in the near future. Funding for the senior housing was secured from the City of Anaheim and loan funding for the land from SJHS.

St. Joseph is also a founding member of the Kennedy Commission, an organization devoted to advocating for affordable housing in Orange County, lending an important voice to efforts to expand affordable housing in the community. The chair of the County Board of Supervisors recently informed the partnership that its support resulted in the allocation of \$35 million from the county's general fund to support low-income housing over the next five years.

Case Study: Florida Hospital¹³

In November, 2014, the **Florida Hospital in Orlando, FL announced a \$6 million pledge to address homelessness in Central Florida, with the goal of housing 300 of Orlando's chronically homeless individuals in three years.** \$4 million will be earmarked to support PSH units using a Housing First model. The Florida Hospital's contribution will serve as the kick-off investment in the Central Florida Foundation's new "Impact Homeless Fund," a collaborative, public and private investment-solutions vehicle to help those facing homelessness in Orange, Osceola, and Seminole Counties.

¹¹ Patient Protection and Affordable Care Act (PPACA), Pub. L., No. 111-148, 124 Stat. 119: March 23, 2010

¹² Kevin Barnett, DrPH, MCP, "Best Practices for Community Health Needs Assessment and Implementation Strategy Development: A Review of Scientific Methods, Current Practices, and Future Potential," Public forum convened by the Centers for Disease Control and Prevention, Atlanta, Georgia, July 11-13, 2011: 2. <http://www.phi.org/uploads/application/files/dz9vh55o3bb2x56lcrzyel83fwfu3mvu24oqqvn5z6qaeiw2u4.pdf>.

¹³ Corporation for Supportive Housing, "Florida Hospital Pledges Millions to End Homelessness," November 12, 2014, <http://www.csh.org/2014/11/florida-hospital-pledges-millions-to-end-homelessness/>.

Social Impact Bonds (SIBs)¹⁴

- Contractual agreements to deliver verifiable social outcomes in exchange for payment. If the promised outcomes are not achieved, no payment is made.
- Upfront funding is secured from the private sector and philanthropic foundations.
- Government pays for services only if and when a service provider achieves clearly defined, measurable results.
- Also known as “Pay for Success (PFS)” or “Pay for Performance (PFP)”.

SIB Efforts Targeting Homeless Populations

Massachusetts¹⁵

In June 2015, the Massachusetts Housing and Shelter Alliance (MHSA) announced the launch of the Massachusetts Alliance for Supportive Housing (MASH) as a Pay for Success (PFS) initiative with the goal of placing nearly half of the state’s chronically homeless population in supportive housing. MASH will be run as a partnership between the MHSA, the Corporation for Supportive Housing (CSH), and the United Way of Massachusetts Bay and Merrimack Valley. The PFS initiative will operate roughly 500 units across Massachusetts over two years. As of mid-July 2015, the initiative had already placed 43 individuals into permanent supportive housing.

California¹⁶

In August 2015, Santa Clara County launched California’s first Pay for Success Project: Project Welcome Home. The project aims to improve housing stability and supportive services for the chronically homeless by providing community-based clinical services and permanent supportive housing to 150-200 chronically homeless individuals who are frequent users of the County’s emergency rooms, acute mental health facilities, and jails. Project Welcome Home received nearly \$7 million in upfront funding from private and philanthropic funders, who will only be repaid by the government if the Project successfully assists participants to achieve continuous stable housing.

¹⁴ Kristina Costa, “Fact Sheet: Social Impact Bonds in the United States,” Center for American Progress, February 12, 2014, <https://www.americanprogress.org/issues/economy/report/2014/02/12/84003/fact-sheet-social-impact-bonds-in-the-united-states/>.

¹⁵ Massachusetts Housing and Shelter Alliance, “Pay for Success Initiative Begins Moving Tenants Into Housing,” *The North Star* Summer 2015, 11(2): 1.

¹⁶ Gary Graves, “Paying for Success: The Santa Clara County Experience,” National Council on Crime & Delinquency, June 16, 2014, <http://www.nccdglobal.org/blog/paying-for-success-the-santa-clara-county-experience> and Third Sector Capital Partners, “Pay for Success in Santa Clara County- Acute Mental Health: Frequent Users Care Coordination Project,” PowerPoint Presentation, February 6, 2015, <https://www.sccgov.org/sites/mhd/MentalHealthBoard/SystemPlanning/Documents/2015/SPFC-Feb-handouts/Pay-for-Success-MH-Presentation-to-BHB-SCC-MH-PFS-Overview-02-06-15.pdf>.

Innovative Financing: Practice Example

Hennepin Health (Minnesota)¹⁷

Background:

- Administered by the County, including health care and human service systems.
- Designed to enroll and deliver care to adults newly eligible for Medicaid under ACA.
- Tiering system: matches people to appropriate types of care at different levels based on health/social needs; more intensive services for high needs.

Finances:

- Hennepin Health (HH) receives Medicaid funding on capitated basis (i.e., fixed payment per-member per-month for total cost of care, including all Medicaid-covered services other than long-term care).
- Shared savings pool funded from savings from having a more efficient care model: By the end of year 1, HH reported savings “all over the place,” including 29% reduction in inpatient hospitalizations and 24% reduction in emergency department visits

MEDICAID FUNDING OPPORTUNITIES UNDER THE AFFORDABLE CARE ACT¹⁸

The Affordable Care Act (ACA) created significant potential to improve and expand access to treatment and services for homeless people. The ACA supports integrated services, provider coordination, comprehensive preventive care, behavioral health care, health education (including substance abuse education), and evaluation activities.

To expand services covered through Medicaid, a state can adopt waivers or propose state plan amendments (SPAs) to the Centers for Medicare and Medicaid Services (CMS).

- A **waiver** is an exception to restrictions on what services can be reimbursed through Medicaid.
- A **SPA** is a proposed set of changes that when accepted become part of the amended state plan.

Medicaid Waivers, Amendments, and Funding Opportunities

Option	Did it exist pre-ACA?	Who qualifies?	What services are covered?
(1) HCBS- 1915(i) SPA	Yes	Individuals who can live in the community but need a range of services to do so.	Case management, personal care, adult day health, home health aide, and psychosocial rehabilitation.
(2) HCBS-1915(c) Waiver	Yes	Individuals whose disability level meets eligibility for institutional care.	Case management, home health aide, personal care, adult day health, and respite care.
(3) 1915(k) Waiver - Community 1 st Choice	No	Individuals who would otherwise need institutional care.	Home attendance assistance with daily living and health related tasks.
(4) 1115 Waiver	Yes	Proposed by State.	Proposed by State.

¹⁷ ASPE, “Medicaid and Permanent Supportive Housing for Chronically Homeless Individuals: Emerging Practices from the Field,” August 2014, available at: <http://aspe.hhs.gov/daltcp/reports/2014/EmergPrac.pdf>; State of Minnesota, “Reform 2020: Pathways to Independence- Section 1115 Waiver Proposal,” resubmitted to CMS November 21, 2012: 58-59. <https://edocs.dhs.state.mn.us/lfsrserver/Public/DHS-6535E-ENG>.

¹⁸ Families USA, “State Plan Amendments and Waivers: How States Can Change Their Medicaid Programs,” Issue Brief, June 2012, http://familiesusa.org/sites/default/files/product_documents/State-Plan-Amendments-and-Waivers.pdf.

Option	Did it exist pre-ACA?	Who qualifies?	What services are covered?
(5) Health Homes	No	Individuals with chronic health conditions or serious mental illness.	Care management and coordination, transitional and follow-up care, referrals.
(6) Center for Innovation Demonstration Project	No	Proposed by State.	Proposed by State.
(7) Rehabilitation Option	Yes	Individuals who need to attain/retain independence or self-care abilities.	Medical and remedial rehabilitation services, including diagnosis and screening.

(1) Home and Community-Based Services (HCBS)-1915(i) State Plan Amendment

- Allows Medicaid beneficiaries with disabilities to receive services in their home or community as an alternative to institutional care such as nursing homes.
- CMS will allow states to provide HCBS benefits for specific populations through a state plan amendment, provided the state can meet all federal requirements:
 - Beneficiaries must be elderly or people with disabilities.
 - Beneficiaries must have incomes not more than 150% of FPL or up to 300% of SSI.
 - Beneficiaries must meet access to care criteria (less than that of institutional care).
 - Beneficiaries must have a choice in providers.
 - The benefit must be implemented state-wide.
 - The state must serve all beneficiaries who meet the benefit's eligibility criteria. It cannot limit the number of people who will be served, nor limit based on diagnosis, type of illness, or condition.
 - The state must demonstrate it can provide its share of the cost of the program.
- Provides a 50/50 federal-state reimbursement rate (or higher, depending on the state) to fund case management, personal care, adult day health, and home health aide services.
- For individuals with mental illness, it also covers psychosocial rehabilitation services.
- Existed before the ACA, but the ACA expanded its scope by:
 - Making individuals earning up to 150% of the Federal Poverty Line eligible under it
 - Giving states additional flexibility in the range of covered services proposed
 - Giving states flexibility in defining the targeted population group
 - Eliminating eligibility wait lists by removing the cap on the number of enrollees

Relevance: This amendment could be used to provide care to some of the most vulnerable tenants in supportive housing.

- Significant overlap between chronically homeless people and those who would qualify for services under this SPA.
- Many services covered under 1915(i) overlap with those commonly provided by supportive housing programs (e.g. case management, treatment planning, counseling, transportation, and life skill development).

(2) HCBS-1915(c) Waiver

- Similar to the 1915(i) amendment: provides case management, psychosocial rehabilitation, and other services for individuals with serious mental illness or other disabling conditions.
- Applies exclusively to individuals who meet a state's eligibility requirements for institutional care (due to mental disabilities, physical disabilities, developmental disabilities, old age, etc.).

Relevance: Same as 1915(i) SPA, but would apply to narrower group.

(3) HCBS-1915(k) Waiver – Community First Choice Option

- Provides for daily living assistance services to persons who would otherwise need to be housed in a skilled nursing facility.
- Under this waiver, when an individual is moved from an institution into a community, states may contribute to such expenses as security and utility deposits, first month's rent, and basic household supplies.

Relevance: Could apply to supportive housing residents with severe mental illness and substance abuse issues or other severely disabling conditions.

(4) 1115 Waiver

- Allows a state to apply to expand eligibility, restructure funding or payment processes, or use Medicaid to fund nearly any type of conceivable service if the state can illustrate a medical necessity and demonstrate that the proposed changes will have a budget-neutral effect (i.e., over a five-year period, the demonstration project must result in no additional federal spending than if the program did not exist).
- May target specific populations for receipt of 1115 Waiver services.
- Once approved, 1115 demonstration projects remain in effect for five years, with the possibility of renewal.

Relevance: Post-ACA, states are beginning to make the case to CMS that providing funding for housing assistance, for example, can reduce expenditures in other areas, such as ER usage.

(5) Health Homes

- Established by the ACA.
- A coordinated team of health care providers or agencies that provides a comprehensive system of care coordination for individuals with chronic health conditions
- States have a lot of flexibility in how they set up their health homes: a state Medicaid plan may contain multiple health home provisions that target different populations.
- To create a health home, a state applies to CMS for permission to include in its Medicaid plan.
 - The state defines the desired target population, what services the health home will provide, and how it will operate.
 - Once approved, for the first two years of a health home's existence, the federal Medicaid match rate for services provided by the health home is 90 percent, after which the rate equals that for standard Medicaid services in that state.

(6) Center for Innovation Demonstration Projects

- ACA established the Center for Medicare and Medicaid Innovation (CMMI).

(7) Rehabilitation Option

- Covers services that are specifically rehabilitative: they must help a person to regain functions that have been lost in some way.
- In some states, therapy, counseling, and other mental health services may be reimbursable under this authority.

APPENDIX 1: LIST OF ADDITIONAL RESOURCES

*Homeless-Targeted Federal Sources*¹⁹

Department of Health and Human Services (HHS)

Health Care for the Homeless (HCH)

HCH programs provide for primary health care and substance abuse services, emergency care with referrals to hospitals for in-patient care services and/or other needed services, and outreach services to assist difficult-to-reach homeless persons in accessing care and establishing eligibility for entitlement programs and housing.

Projects for Assistance in Transition from Homelessness (PATH)

PATH funds community-based outreach, mental health, substance abuse, case management and other support services, as well as a limited set of housing services.

Services in Supportive Housing (SSH)

SSH grants reduce chronic homelessness through providing permanent housing for individuals and families living with severe mental illness and/or substance abuse disorders.

Grants for the Benefit of Homeless Individuals (GBHI)

GBHI grants enable communities to expand and strengthen treatment services for people experiencing homelessness.

Basic Center Program; Transitional Living Program for Older Homeless Youth; Street Outreach Program

These programs provide support for projects aimed at homeless and runaway youth.

Cooperative Agreements to Benefit Homeless Individuals (CABHI and CABHI-States)

CABHI and CABHI-States grants support the integration of treatment and services for people experiencing chronic homelessness who also have mental, substance use, or co-occurring disorders on the local and state level, respectively.

Department of Housing and Urban Development (HUD)

Continuum of Care Program (CoC)

The CoC Program provides HUD funding for permanent housing, transitional housing, supportive services, Homeless Management Information System (HMIS), and homelessness prevention to applicants designated by the Continuum of Care.

Emergency Solutions Grants (ESG)

Provides funding for emergency shelter, transitional housing, and permanent housing for the homeless. Funds can be used for street outreach, emergency shelter, homelessness prevention, rapid re-housing assistance, and HMIS, as well as administrative activities.

HUD Veterans Affairs Supportive Housing Program (HUD-VASH)

HUD-VASH targets homeless veterans with housing vouchers from HUD and case management from the Department of Veterans Affairs.

Department of Veterans Affairs (VA)

Supportive Services for Veteran Families Program (SSVF)

SSVF provides grants to provide permanent housing to Veteran families who would otherwise be homeless.

The Grant and Per Diem (GPD) Program

The GPD Program funds local agencies providing transitional housing and service centers for homeless Veterans.

¹⁹ Libby Pearl, et al, for the Congressional Research Service, "Homelessness: Targeted Federal Programs and Recent Legislation," CRS Report, May 6, 2015. <https://www.fas.org/sfp/crs/misc/RL30442.pdf>

Acquired Property Sales for Homeless Providers Program

This program offers discount mortgages on VA-foreclosed properties to homeless provider organizations to shelter homeless Veterans.

Private Sources

Foundation Directory, fonline.foundationcenter.org

A directory of sources for funding; subscription required for extended information and to search by topic

GrantWatch, grantwatch.com

GrantWatch lists available grants by subject, including homelessness; subscription required

GrantStation, grantstation.com

GrantStation provides a database of private grantmakers and publishes a weekly newsletter highlighting upcoming funding opportunities; subscription required

NOZA, nozasearch.com

NOZA is a database of previous charitable donations, which can be used to determine appropriate organizations and amounts to approach for funding; subscription required

Relevant Non-Homeless-Targeted Federal Sources

Department of Health and Human Services (HHS)²⁰

Community Interoperability & Health Information Exchange Cooperative Agreement Program

Provides funding to organizations that propose actionable approaches to increase adoption and use of standards-based interoperable health IT tools and Health Information Exchange (HIE) services among non-eligible care providers through effective training and workflow redesign.

Community Mental Health Services Block Grant (MHBG)

Provides comprehensive mental health services to adults with a serious mental illness and children with a serious mental disturbance.

Community Services Block Grant

Community Services Block Grants provide services to address education, unemployment, housing assistance, nutrition, emergency services, health, and substance abuse needs.

Community Health Center Program

The centers provide primary care services on a sliding-scale rate system.

Health Resources and Services Administration (HRSA) Grants

HRSA makes grants to organizations to improve and expand health care services for underserved people, focusing on the following program areas: Health Professions, HIV/AIDS, Maternal & Child Health, Primary Health Care/Health Centers, Rural Health, Healthcare Systems, Organ Donation, and Clinician Recruitment.

Ryan White HIV/AIDS Program

The Ryan White Program works with cities, states, and local community-based organizations to provide services to people who do not have sufficient health care coverage or financial resources to cope with HIV disease. The majority of Ryan White HIV/AIDS Program funds support primary medical care and essential support services. A smaller portion funds technical assistance, clinical training, and the development of innovative models of care.

and Services Administration (HRSA), HIV/AIDS Bureau (HAB).

Social Services Block Grant

Social Services Block Grants are flexible grants that enable states to provide social services and programs to reduce dependency on social services.

²⁰ U.S. Department of Health and Human Services, "Supportive Services: Non-Targeted or Mainstream Programs," <http://www.hhs.gov/programs/social-services/homelessness/grants/index.html#mainstream>

Substance Abuse Prevention and Treatment (SAPT) Block Grant

The Center for Substance Abuse Treatment (CSAT) works with States and local groups to plan, carry out, and evaluate activities to prevent and treat substance abuse.

Title V, Federal Real Property Assistance Program (FRPAP)

FRPAP transfers available Federal surplus properties to States, municipalities, and nonprofit organizations for homeless assistance purposes such as supportive services, emergency shelter, transitional housing, and permanent supportive housing.

Social Security Administration Supplemental Security Income (SSI)

Federal income supplement program which provides cash to meet basic needs for food, clothing, and shelter designed to aged, blind, and disabled people, who have little or no income.

Department of Housing and Urban Development (HUD)²¹

Section 811 Supportive Housing for Persons with Disabilities

Section 811 funding develops and subsidizes rental housing with supportive services for very-low income adults with disabilities.

Section 202 Supportive Housing for the Elderly Program

Through Section 202, HUD finances and provides rent subsidies for supportive housing for very-low income elderly persons.

Section 8 Housing Choice Vouchers

Section 8 vouchers assist very-low income families, the elderly, and disabled persons pay for housing in the private market.

Community Development Block Grants

These grants provide funds to address a wide range of community development needs.

HOME Investment Partnerships Program (HOME)

HOME provides formula grants to states and localities that communities use – often in partnership with local nonprofit groups – to fund a wide range of activities including building, buying, and/or rehabilitating affordable housing for rent or homeownership or providing direct rental assistance to low-income people.

Housing Opportunities for Persons with AIDS (HOPWA)

Under the HOPWA Program, HUD makes grants to local communities, States, and nonprofit organizations for projects that benefit low-income persons living with HIV/AIDS and their families.

National Housing Trust Fund (HTF)

*The HTF provides formula grants to states and state-designated entities to fund the production or preservation of affordable housing through the acquisition, new construction, reconstruction, and/or rehabilitation of non-luxury housing with suitable amenities
affordable housing for extremely low- and very low-income households, including homeless families.*

Department of Homeland Security²²

Emergency Food & Shelter Program

Provides program funds, allocated by a local board, to provide food, lodging, and related transportation and equipment

²¹ U.S. Department of Housing and Urban Development, "Programs of HUD: Major Mortgage, Grant, Assistance, and Regulatory Programs," 2016, <http://portal.hud.gov/hudportal/documents/huddoc?id=HUDPrograms2016.pdf>

²² U.S. Department of Homeland Security, Federal Emergency Management Agency (FEMA), "Emergency Food & Shelter Program (EFSP) Fact Sheet," May 2016, <https://www.fema.gov/media-library-data/1465337041511-1722bbc6932f929a512f53ea666a6280/FACTSHEETEmergencyFoodandShelterProgram-2016.pdf>

APPENDIX M: PROGRESS TRACKING TOOL

The following is a tool for communities to identify and track their progress in integrating their homeless assistance and healthcare systems and services.

Healthcare-Housing Integration Progress Tracking Tool

Overall Objective: Integrated and coordinated housing and health care that fosters:

- housing stability, health and wellness for people who are homeless or at-risk; and
- efficient, effective use of health care and housing resources.

Performance Category: Systems Change, Planning and Leadership

Target Outputs/Outcomes	N/A	Not Yet Started	Increased Understanding/Skills	Applied Knowledge/Concrete Progress	Accomplished
Action Planning session completed					
Action Plan (including implementation guidelines) finalized					
Ongoing and regular Leadership/Implementation Team meetings, with active participation by representatives from housing, health care, and other mainstream systems					
H ² Plan components embedded in other system plans, structures					

Performance Category: Enrollment

Target Outputs/Outcomes	N/A	Not Yet Started	Increased Understanding/Skills	Applied Knowledge/Concrete Progress	Accomplished
Expertise regarding Medicaid eligibility requirements and enrollment resources in homeless assistance agencies					
Identification of homeless/housing system clients in need of Medicaid and benefit program enrollment or renewal assistance					
Medicaid and other benefit program enrollment assistance available and offered to all eligible uninsured homeless/housing system clients					
100% enrollment in Medicaid and SSI/SSDI of eligible members of the H ² Target Populations: (1) people experiencing homelessness and (2) low-income people living with HIV/AIDS					

Performance Category: Engagement					
Target Outputs/Outcomes	N/A	Not Yet Started	Increased Understanding/Skills	Applied Knowledge/Concrete Progress	Accomplished
Connection to ongoing primary care for all homeless/housing system clients					
Increased rates of medication and health appointment adherence among homeless/housing system clients					
Improved measurable health outcomes for homeless/housing system clients with one or more chronic conditions					
Reduction of avoidable use of emergency and inpatient hospital services					
Reduction in costs incurred and/or number of visits to emergency rooms for non-emergencies					
Performance Category: Integration					
Target Outputs/Outcomes	N/A	Not Yet Started	Increased Understanding/Skills	Applied Knowledge/Concrete Progress	Accomplished
Written policies or agreements that require housing system-health care system connection (e.g. Memoranda of Understanding between housing agency and Federally Qualified Health Center; hospital policies that require participation in CoC)					
Direct links from health care providers to CoC Coordinated Entry System(s)					
Awareness and understanding of CoC Coordinated Entry System(s) by health care providers					
Regular participation by health care providers in CoC Coordinated Entry System(s)					
Discharge planning processes (in hospitals, jails, alcohol and					

drug treatment programs) that include consideration of housing needs and, if necessary, link to housing assistance system					
Integration of primary care and other health services into CoC and/or Coordinated Entry System(s)					
Integration Models (e.g., FQHC that has agreed to provide primary health care to each member of Target Populations that seeks housing assistance) operating in each CoC/county/community					
Performance Category: Data-Driven Interventions					
Target Outputs/Outcomes	N/A	Not Yet Started	Increased Understanding/Skills	Applied Knowledge/Concrete Progress	Accomplished
Health care data systems that collect housing-related information (e.g., consistent use of ICD10 codes relating to homelessness by all hospitals)					
Sharing of data between homeless/housing assistance providers and health care providers					
Integration of data across homeless/housing assistance and health care system					
Identification of shared priority sub-populations and development of targeted interventions					
Performance Category: Resource Maximization					
Target Outputs/Outcomes	N/A	Not Yet Started	Increased Understanding/Skills	Applied Knowledge/Concrete Progress	Accomplished
Expansion, waivers, state plan options, demonstration programs and other action to maximize use of Medicaid to support housing stability					
Medicaid billing for services provided by homeless housing and services providers (through direct billing by providers or partnerships with managed care organizations or other health					

providers)					
Maximization of health and human services funding (i.e., increased successful applications for relevant funding opportunities)					
Increased percentage of CoC funds going toward direct housing costs / Decreased percentage of CoC funds going toward services/treatment					

Note: This document was generated by TA providers to support direct TA for H² Initiative communities. It is created as a working tool for implementation planning in selected H² sites.

APPENDIX N: LESSONS LEARNED FROM H² ACTION PLANNING

The following contains a selection of lessons learned regarding implementation planning and structure and facilitating coordination between housing and healthcare providers, as well as an Emerging Framework for Systems-Level Alignment to End Homelessness.

Housing – Healthcare Integration (H²) Initiative

Lessons Learned

Implementation Planning and Structure

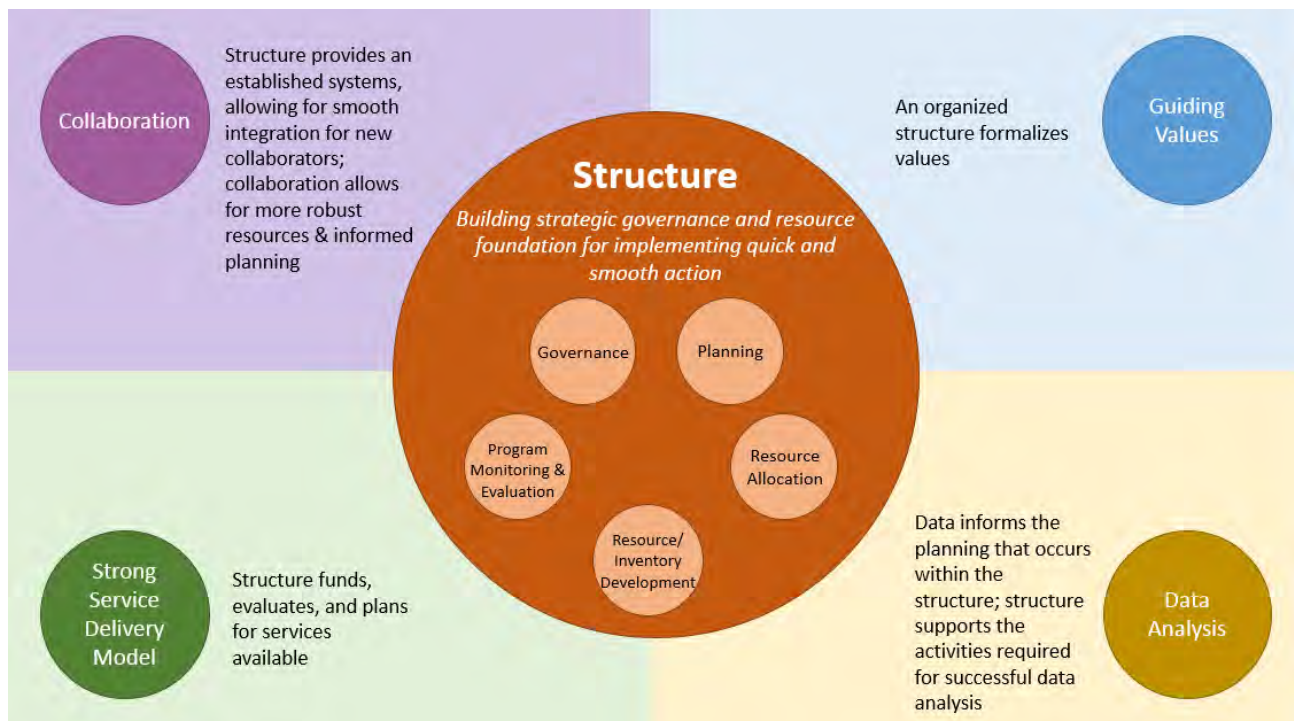
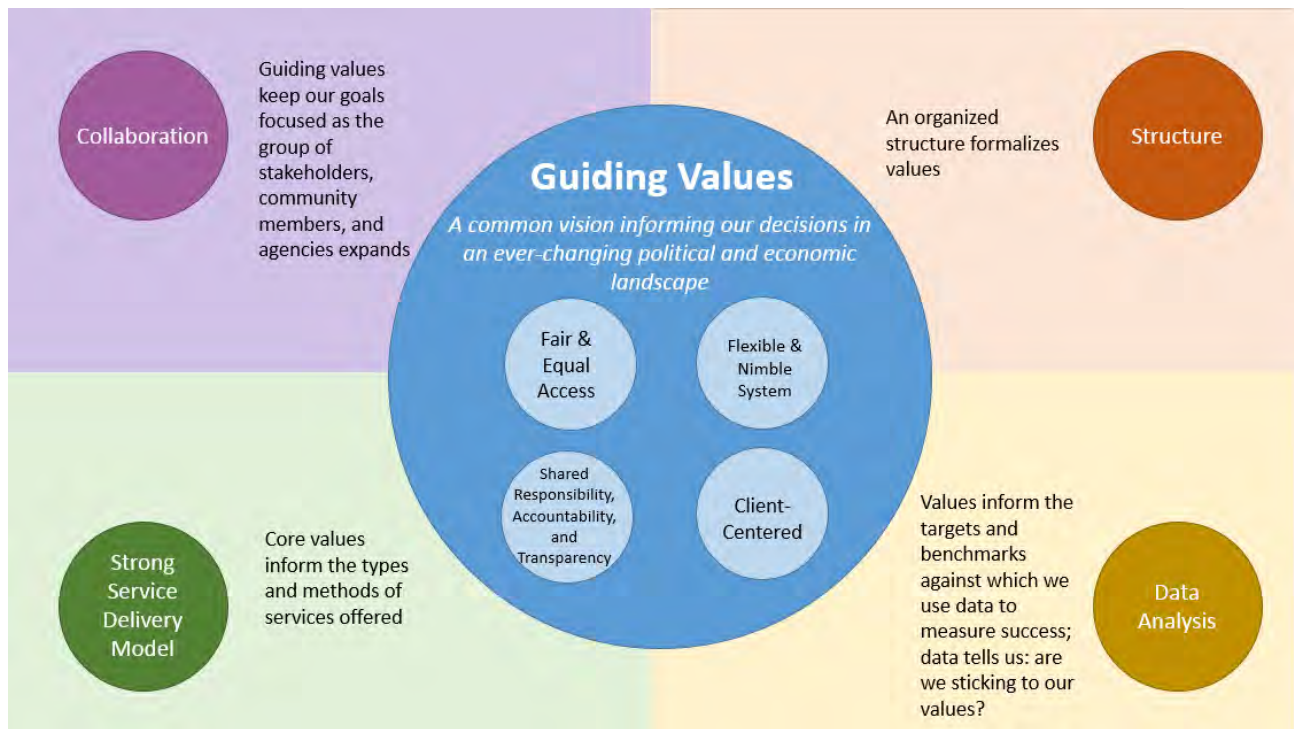
- Incorporate H² Leadership Team or plan element into existing state level structures, such as interagency councils or state plans
- Create work groups to focus on discrete plan sections or strategies
- Leverage large ongoing efforts, such as emerging Coordinated Assessment/Entry systems, by prioritizing H² implementation efforts linked to strategies that complement those efforts
- Conduct frequent user data matches across systems (e.g. homeless assistance, criminal justice, health care) to demonstrate need for collaboration and identify most vulnerable
- Compare existing State Medicaid plan covered services with those most needed by people experiencing homelessness and target Medicaid enrollment to people who need/use those services. Conduct HMIS-Medicaid data match to identify gap.
- Leverage support of Federal Partners
 - HRSA: Build or improve relationships between Federally Qualified Health Centers, including encouraging Health Centers to apply to open new sites in strategic locations and/or for funding to serve people experiencing homelessness
 - SAMHSA: Apply for and utilize CABHI grants to facilitate H2 implementation
 - CMS: Apply for and participate in CMS Innovation Accelerator Program Technical Assistance.

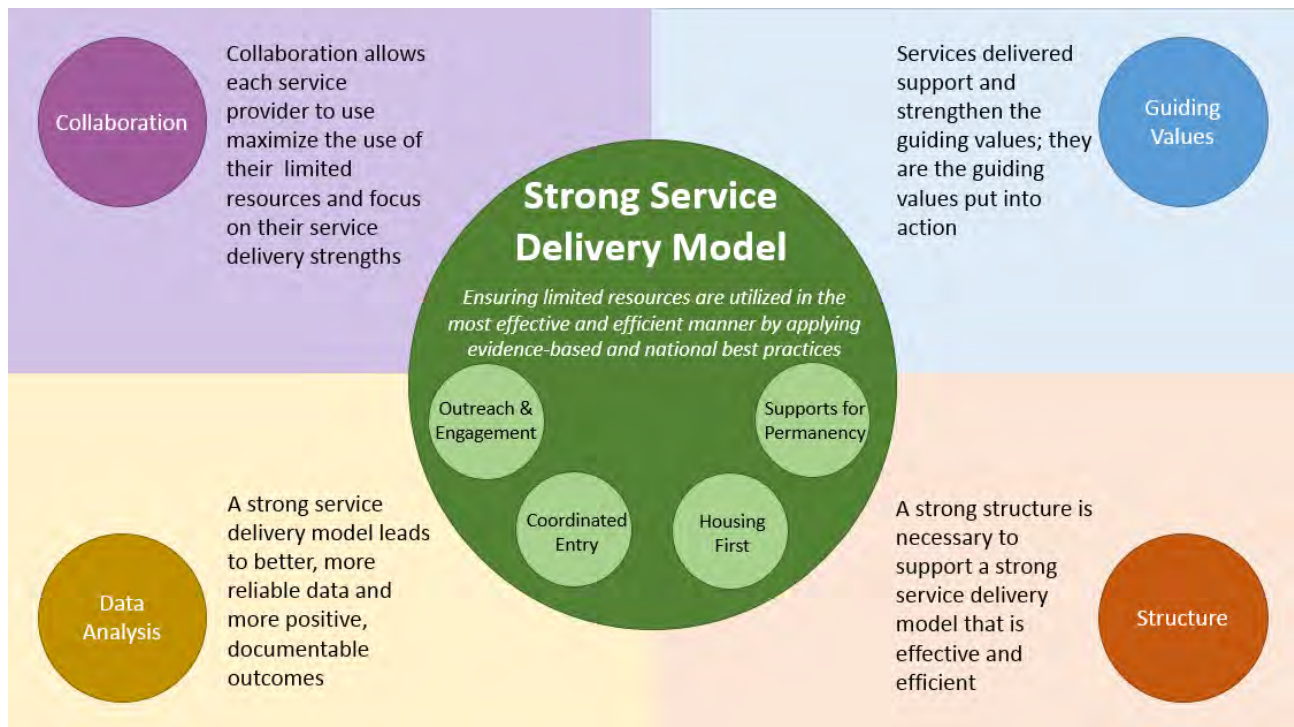
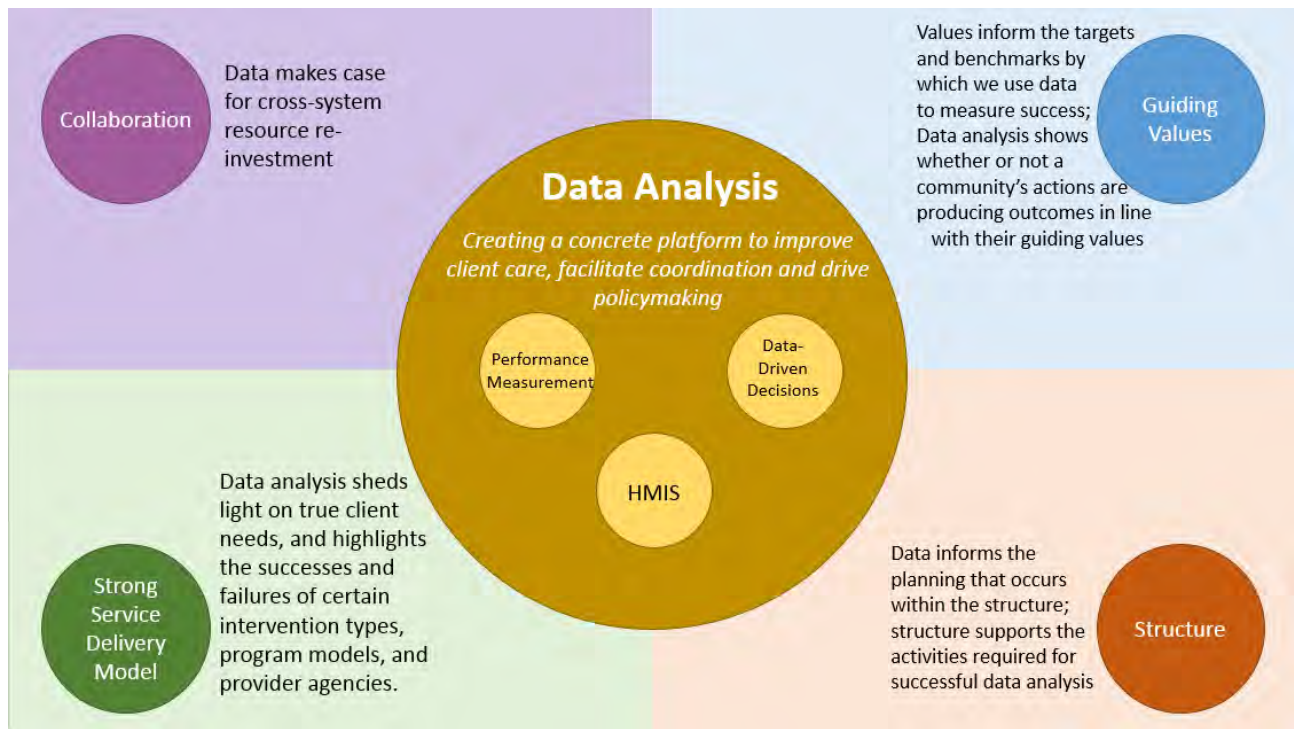
Facilitating Coordination Between Housing and Health Care Providers

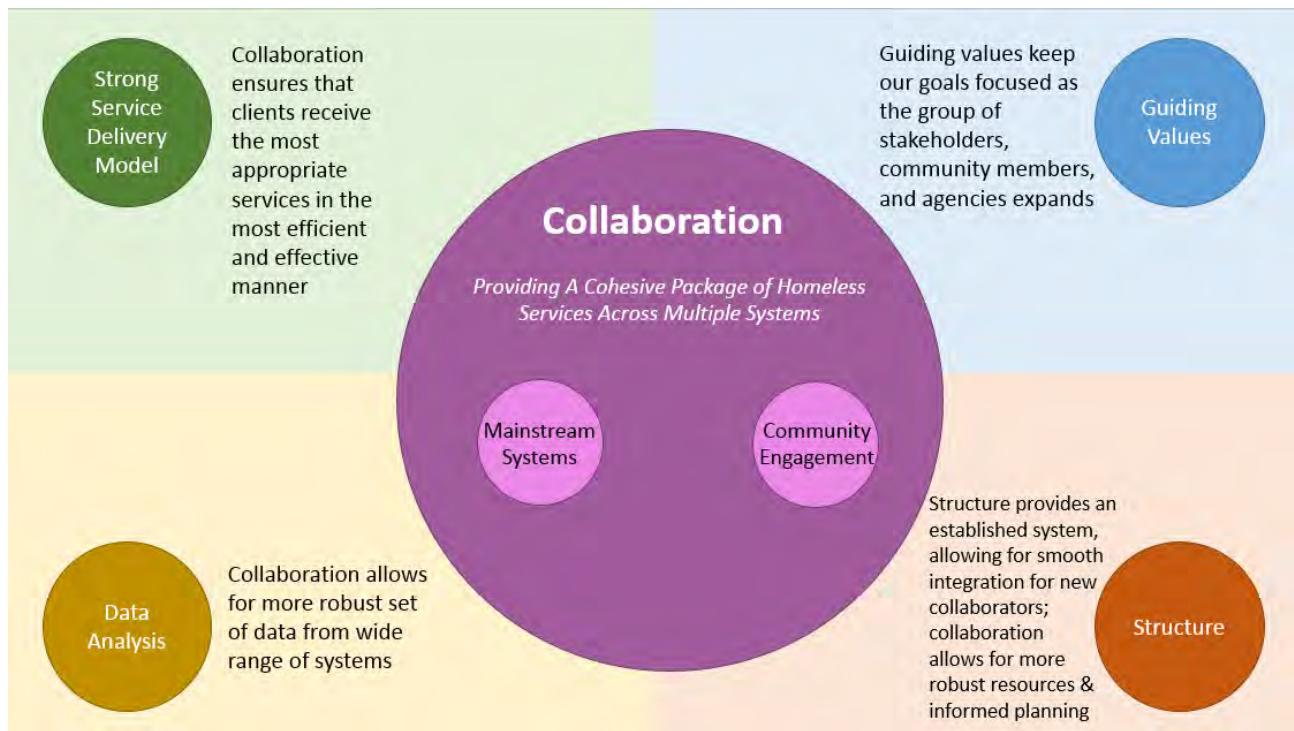
- Regular meetings with housing and health care (and other supportive services) providers, preferably building upon existing forums or coalition meetings. A portion of each meeting can be devoted to an in-depth conversation about a specific topic (e.g. Coordinated Entry; obligations of Managed Care organizations to serve members) and stakeholders can be strategically invited based on the topic. Purpose is to engage in cross-system education, both of how systems operate and what various providers' needs and incentives are.
- Case conferencing for highly vulnerable and/or higher cost clients that have housing, health, and other needs. Case conferences to include representatives from the CoC/housing system, as well as health care.
- Pilot "Frequent user" programs to identify and target resources to people with housing needs that also have health care (primary and/or behavioral) and other supportive service needs.

- Improved discharge planning protocols at hospitals, jails/prisons, psychiatric institutions. Discharge planning process should begin at point of admission and include housing element/connection to CoC.
- Partnerships between CoC and FQHCs, including locating FQHC clinics on-site at shelters and/or permanent housing buildings, or having mobile vans visit shelters and outreach to unsheltered people.
- Relationships between CoC and managed care organizations.
 - Data matching that allow MCOs to compare their membership lists with HMIS.
 - CoC agencies can provide assistance with identifying, locating, and connecting “missing” members with MCOs. Possibility of MCO providing “finders” fee to CoC for this assistance.
 - Managed care organizations (or hospitals) may also be willing to fund respite beds to save costs of patients staying in hospital longer than medically necessary as a result of not having sufficient place to live while finishing course of treatment.
 - Inserting housing/housing stability as an outcome in managed care contracts.
- Connecting health care and supportive service providers that are not part of HUD-funded CoC system to Coordinated Entry System.
 - Formally: e.g., non-CoC providers entering some data into HMIS, CoC agency staff located on-site at hospitals, especially emergency departments
 - Informally: non-CoC providers simply being aware of “entry points” into Coordinated Entry System and how to connect patients that need housing assistance to those points.
- Collection of housing-related data by hospitals and other health care providers (e.g. by using homelessness and housing-related ICD-10 codes). Likely requires education on identifying patients with housing needs.
- Educating housing/homeless assistance providers about how Medicaid can fund supportive services:
 - What supportive services are or could be covered by a state’s Medicaid plan
 - What existing Medicaid billers in the area provide or could provide those services, or would be willing to contract with non-Medicaid billers - such as









APPENDIX O: DEVELOPING A MEDICAID SUPPORTIVE HOUSING SERVICES BENEFIT – CONSIDERATIONS AND DECISION POINTS

The following is a tool designed to assist States in the development of a Medicaid benefit to pay for services in supportive housing. It describes components of the decision-making process that should be given consideration at each major decision points and provides sample language, including from existing waivers or waiver applications in other states.

DEVELOPING A MEDICAID SUPPORTIVE HOUSING SERVICES BENEFIT

CONSIDERATIONS AND DECISION POINTS

EXECUTIVE SUMMARY

This tool is designed to assist States in the development of a Medicaid benefit to pay for services in supportive housing. Initial development of a Medicaid waiver benefit requires stakeholders and policymakers to make three preliminary determinations:

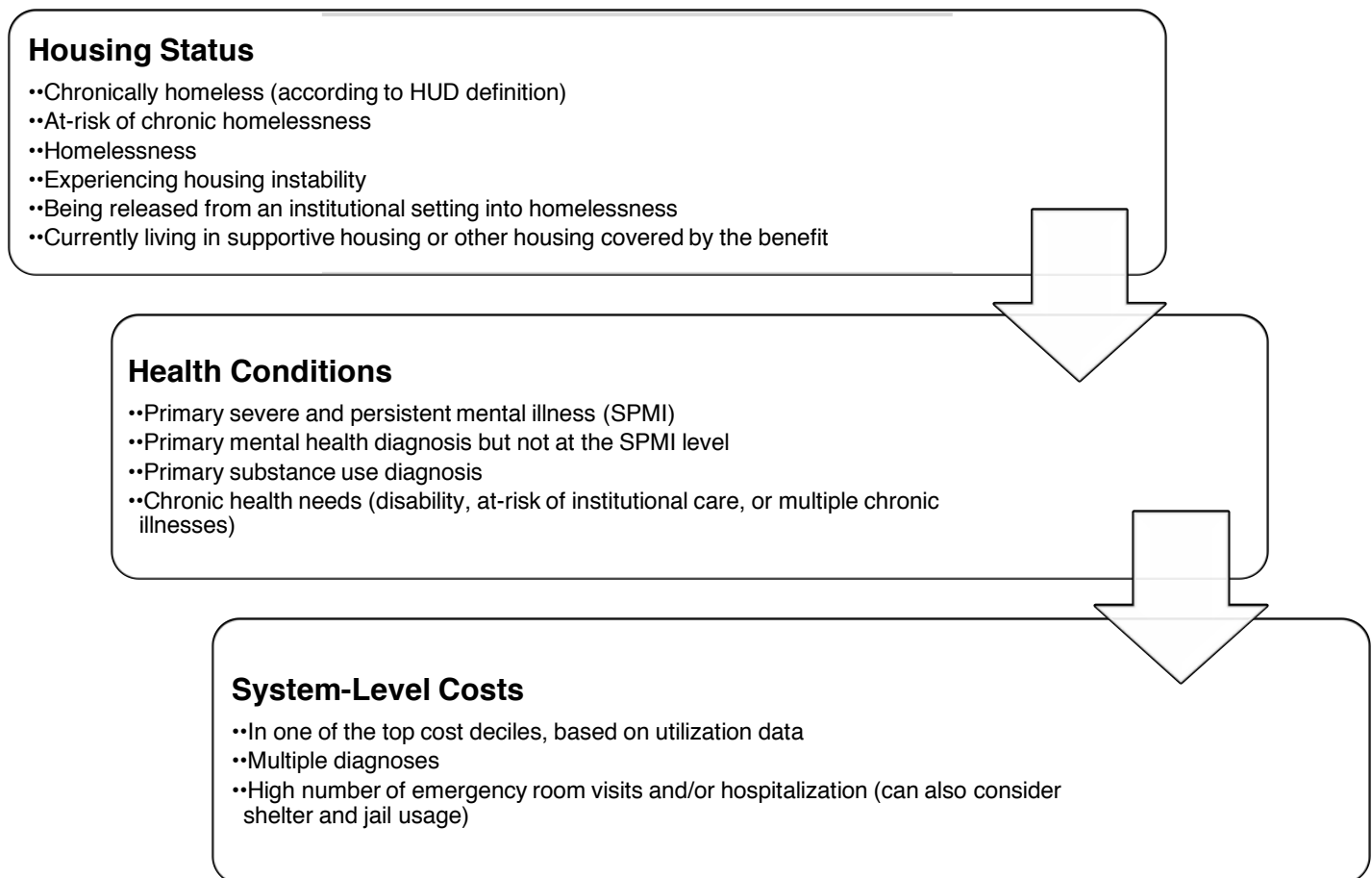
1. **Benefit Eligibility:** Determine which population will be eligible to receive assistance under the Medicaid supportive housing services benefit. (Page 1)
2. **Service Package:** Determine the scope of the services that the Medicaid supportive housing services benefit will financially support. (Page 7)
3. **State Medicaid Plan Changes:** Determine which state plan option(s) the State will need to apply for in order to obtain the Medicaid supportive housing services benefit. (Page 13)

This tool describes components of the decision-making process that should be given consideration at each of the above-listed decision points and provides sample language from existing waivers or waiver applications in other states.

Following the discussion of considerations and decision points is a decision tool in the form of a chart, to assist with determining how a State should proceed in applying for a Medicaid supportive housing services benefit.

BENEFIT ELIGIBILITY

In order to develop a Medicaid permanent supportive housing services benefit, a State must first establish the medical necessity criteria defining which beneficiaries would be eligible for the new benefit. States typically find it necessary to define eligibility on the basis of three factors: 1) housing status; 2) health conditions; and, 3) system-level costs. The following chart graphically illustrates some of the options a State may wish to consider when defining the scope of benefit eligibility.



To determine which eligibility criteria are desirable, a State should consider a number of other factors:

- **Scope of the Beneficiary Group:** A State can target its benefit narrowly or broadly. For example, benefits can be limited to persons who are chronically homeless or who were chronically homeless prior to entering a supportive housing program, or services can be made available to a broader group of beneficiaries, such as those with complex needs and/or patterns of high-cost service utilization who have experienced a prolonged period of housing instability or homelessness (such as those returning from institutional settings with housing needs).
- **Cross-Category Considerations:** Related to scope, A State can determine whether the benefit should be targeted at persons meeting certain levels of need under just one of the above categories, under a combination of two categories, or under each of the three categories. For instance, the benefit could be applicable to all chronically homeless persons, or only to those chronically homeless persons whose system-level costs fall within the top decile.

- **Tiered Structure:** A State can also define tiered levels of eligibility that are linked to service packages of varying intensity. By way of example, chronically homeless persons with co-occurring disorders that accrue system-level costs in the top decile could receive more intensive services, involving small case loads and frequent face-to-face contact. The larger group of people who are experiencing housing instability and have significant behavioral health and/or health needs, but who are neither chronically homeless nor fall within the top decile of high costs users, would then receive a more restrictive benefit, such as one that includes housing stabilization supports and facilitation of access to appropriate care.
- **Pilot benefit:** A State may choose to pilot an effort with a narrow eligibility definition (affecting only a relatively small group of beneficiaries) and then expand that definition at a later time.

Sample Language: Eligibility

California 1915(c) Waiver: CA Multipurpose Senior Services Program (0141.R05.00)

- Medi-Cal individual who, but for the provision of such services, would require the Nursing Facility (NF) level of care;
- Aged 65 years and older;
- Individuals shall only be enrolled in one HCBS waiver at any one time;
- Individuals must reside in a county with an MSSP site

Source: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/CA0141.zip>

California 1915(c) Waiver: San Francisco Community Living Support Benefit (0855.R00.00)

A person eligible for the CLSB Waiver must:

- Be a resident of the city and county of San Francisco.
- Be at least age 21 years or over.
- Be determined to meet nursing facility level of care as defined in relevant sections of the California Code of Regulations.
- Be either homeless and at imminent risk of entering a nursing facility, or, reside in a nursing facility and want to be discharged to a community setting.
- Have one or more medical co-morbidities.
- Be capable of residing in a housing setting with the availability of waiver services that are based on a Community Care Plan.

Source: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/CA0855.zip>

Louisiana 1915(c) Waiver: LA Community Choices (0866.R01.00)

- Individuals age 65 and older who are Medicaid eligible and meet nursing facility level of care; and,
- Adults with physical disabilities age 21-64 who are disabled according to Medicaid standards or SSI disability criteria, Medicaid eligible, and meet nursing facility level of care.

Source: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/LA0866.zip>

Louisiana 1915(c) Waiver: LA Supports Waiver (0453.R02.00)

Individuals age 18 and over with autism, developmental disabilities, or intellectual disabilities

Source: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/LA0453.zip>

Connecticut 1915(i) Waiver

In order to qualify for Home and community based services under the 1915i, the applicant must a minimum of 65 years of age and require assistance with 1 or 2 critical needs.

Critical needs are as follows: bathing, dressing, toileting, eating/feeding, transferring, meal preparation, medication administration.

Persons with needs beyond 2 critical needs will be served under a 1915c waiver.

Source: <http://www.ct.gov/dss/lib/dss/pdfs/SPA12001.pdf>

California 1915(i) Waiver

Needs-based HCBS Eligibility Criteria:

The individual has a need for assistance demonstrated by:

- A need for habilitation services, as defined in Section 1915(c)(5) of the Social Security Act (42 U.S.C. Section 1396 et seq.), to teach or train in new skills that have not previously been acquired, such as skills enabling the individual to respond to life changes and environmental demands; and
- A likelihood of retaining new skills acquired through habilitation over time; and
- A condition which results in major impairment of cognitive and/or social functioning, representing sufficient impairment to require interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential, that continues, or can be expected to continue, indefinitely; and the existence of

significant functional limitations in at least three of the following areas of major life activity, as appropriate to the person's age:

- Receptive and expressive language;
- Learning;
- Self-care;
- Mobility;
- Self-direction;
- Capacity for independent living.

In addition to the needs identified above, the individual must also have a diagnosis of a developmental disability, as defined in Section 4512 of the Welfare and Institutions Code and Title 17, California Code of Regulations, Section 54000 and Section 54001...

Source: <http://www.dds.ca.gov/waiver/docs/SPA.pdf>

Washington State 1115 Waiver

Foundational Community Supports

Supportive Housing Benefit: Housing-related activities (Individual Housing Transition Services, Individual Housing and Tenancy Sustaining Services) that include a "to be defined" range of flexible services and supports available to Medicaid enrollees age 18 and older, who require tenancy supports to access and maintain housing. To be eligible, individuals must meet one or more of the following criteria:

1. Meet HUD definition of chronically homeless (see below)

OR

2. Have frequent or length institutional contacts (emergency room visits, nursing facility stays, hospital, psychiatric hospital stays, jail states) – frequency, length and acuity to be determined

OR

3. Have frequent or length adult residential care stays: Adult Residential Treatment Facilities (RTF), Adult Residential Care (ARC), Enhanced Adult Residential Care (EARC), Assisted Living (AL), Adult Family Home (AFH), Expanded Community Services (ECS) or Enhanced Service Facilities (ESF) – frequency, length and acuity to be determined

OR

4. Have frequent turnover of in-home caregivers or providers – frequency, length and acuity to be determined by ALISA CARE assessment

OR

5. Meet specific risk criteria (PRISM risk score of 1.5 or above)

HUD Chronically Homeless Definition: The definition of “chronically homeless” currently in effect for the CoC Program is that which is defined in the CoC Program interim rule at 24 CFR 578.3, which states that a chronically homeless person is:

- (a) An individual who:
 - (i) Is homeless and lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and,
 - (ii) Has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year or on at least four separate occasions in the last 3 years; and
 - (iii) Can be diagnosed with more or more of the following conditions: substance use disorder, serious mental illness, developmental disability (as defined in section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000 (42 U.S.C. 15002)), post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability;
- (b) An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition [as described in Section I.D.2.(a) of this Notice], before entering that facility; or,
- (c) A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) of this definition [as described in Section I.D.2.(a) of this Notice], including a family whose composition has fluctuated while the head of household has been homeless.

Source: <http://www.hca.wa.gov/hw/Documents/waiverappl.pdf>

New York State 1115 Waiver

Target Populations

Individuals would be eligible for supportive housing services insofar as they are at high risk of not being able to live independently if they are not provided with the supportive services available through this program. Funding would target “high users” of Medicaid services, with a primary focus on the Health Home eligible population. As such, the program would work in conjunction with New York’s Health Homes and Managed Long Term Care Plans to provide needed housing services to New York’s most complex Medicaid populations.

The target populations intended to be recipients of the housing and services developed as a result of this program, include, but are not limited to:

- Chronically homeless adults who suffer from mental illness and/or substance abuse;
- Chronically homeless and physically disabled;
- Chronically homeless adults living with HIV/AIDS;
- Single adults who are presently living in New York State-operated psychiatric centers;
- Young adults with a serious mental illness and/or substance abuse disorder;

- Individuals with serious behavioral health or health conditions coming out of prison or jail;
- Individuals residing in long term care settings who prefer to return to the community (i.e. adult homes and nursing homes);
- Individuals residing in acute hospitals (i.e. hospital homeless) who cannot be discharged because they lack housing options;
- Low-income disabled individuals enrolled in or eligible for Managed Long Term Care plans or Consumer Directed Programs;
- Frail elderly individuals living in arrangements, which create a potential for harm or neglect.

Source: https://www.health.ny.gov/health_care/medicaid/redesign/docs/2012-08-06_waiver_amendment_request.pdf

California 1115 Waiver (Under Development)

- Potential target populations: high-utilizers, nursing facility discharges; those experiencing or at risk for homelessness.

SERVICE PACKAGE

In conjunction with developing the eligibility criteria on which the Medicaid supportive housing services benefit will be based, a State must work to define the scope of services that the benefit will pay for. As before, the service package can be narrow or broad, or can be tiered to provide a more intensive package of services to persons with greater needs. Services fall into one of three categories:

1. **Individual Housing Transition Services:** Housing transition services provide direct support to individuals with disabilities, older adults needing long-term services and supports, and those experiencing chronic homelessness.
2. **Individual Housing & Tenancy Sustaining Services:** Housing & tenancy sustaining services support individuals to maintain tenancy once housing is secured. The availability of ongoing housing-related services in addition to other long-term services and supports promotes housing access, fosters community integration and inclusion, and develops natural support networks.
3. **State-Level Housing-Related Collaborative Activities:** Strategic, collaborative activities design to assist in identifying and securing housing resources.

The chart below reflects some of the services a State could choose to include in an application for a Medicaid supportive housing services benefit:

Housing Transition Services	Housing & Tenancy Sustaining Services	Housing-Related Collaborative Activities
Tenant Screening/Housing Assessment: Identify the participant's preferences and barriers related to successful tenancy, including collecting information on potential housing transition barriers and identification of housing retention barriers	Identification of Barriers to Housing Stability: Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations	Working Agreements: Development of formal and informal agreements and working relationships with state and local housing and community development agencies to facilitate access to existing and new housing resources
Housing Support Plan: Development of an individualized housing support plan based upon the housing assessment that identified barriers, including short- and long-term measurable goals for each issue, establishment of the participant's approach to meeting the goal, and identification of when other providers or services, both reimbursed and not reimbursed by	Tenant/Landlord Rights Training: Education and training on the role, rights, and responsibilities of the tenant and landlord	Planning Processes: Participating and contributing to the planning processes of state and local housing and community development agencies, for example, by providing demographic, housing need, and other relevant data for the populations served by the LTSS agencies, among other planning activities

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Medicaid, may be required to meet the goal		
Housing Search Assistance	Relationship Building: Coaching on development and maintenance of key relationships with landlords/property managers with a goal of fostering successful tenancy	Identification of Housing Opportunities: Working with housing partners to create and identify opportunities for additional housing options for people wishing to transition to community-based housing
Housing Application Assistance	Dispute Resolution: Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction of other adverse action	Housing Locator Systems: Coordinating available housing locator systems
One-Time Expenses: Identification of resources to cover expenses such as security deposits, moving costs, furnishings, adaptive aids, environmental modifications, moving costs, and other one-time expenses	Eviction Defense: Advocacy and linkage with community resources to prevent eviction when housing is, or may potentially become, jeopardized	Data Tracking Systems: Coordinating data tracking systems to include housing
Environmental Review: Ensuring that the living environment is safe and ready for move-in	Housing Recertification: Assistance with the housing recertification process	
Moving Expenses: Assistance with arranging for and supporting the details of the move	Housing Support Crisis Plan: Coordination with the tenant to review, update, and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers	
Housing Support Crisis Plan: Development of a housing support crisis plan including prevention and early intervention services when housing is jeopardized	Tenancy Training: Continuing training in being a good tenant and lease compliance, including ongoing support with activities related to household management	

Sample Language: Services

California 1915(c) Waiver: CA Multipurpose Senior Services Program (0141.R05.00)

- Case Management
- Personal Care Services
- Respite Care (in-home and out-of-home)
- Environmental Accessibility Adaptations
- Housing Assistance/Minor Home Repair, etc.
- Transportation
- Chore Services
- Personal Emergency Response System (PERS)/Communication Device
- Adult Day Care/Support Center/Health Care
- Protective Supervision
- Meal Services – Congregate/Home Delivered
- Social Reassurance/Therapeutic Counseling
- Money Management
- Communication Service: Translation/Interpretation

Source: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/CA0141.zip>

California 1915(c) Waiver: San Francisco Community Living Support Benefit (0855.R00.00)

- Care Coordination
- Enhanced Care Coordination
- Community Living Support Benefit in licensed settings and Direct Access to Housing (DAH) sites
- Behavioral Assessment and Planning
- Environmental Accessibility Adaptations in DAH sites
- Home delivered meals in DAH sites

Source: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/CA0855.zip>

Louisiana 1915(c) Waiver: LA Community Choices (0866.R01.00)

Provides adult day care, caregiver temporary support, support coordination, assistive devices and medical supplies (assistive technology), environmental accessibility adaptation, home delivered meals, housing stabilization, housing transition or crisis intervention, monitored in-home caregiving, non-medical transportation, nursing, personal

assistive services, skilled maintenance therapy, transition intensive support coordination, and transition services

Source: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/LA0866.zip>

Louisiana 1915(c) Waiver: LA Supports Waiver (0453.R02.00)

Provides:

- Day habitation
- Habitation
- Prevocation Services
- Respite
- Support Coordination
- Supported Employment
- Housing Stabilization Service
- Housing Stabilization Transportation Service
- Personal Emergency Response System

Source: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/LA0453.zip>

Connecticut 1915(i) Waiver

Provides:

- Adult Day health
- Case (Care) Management
- Homemaker
- Personal Care Assistant
- Respite
- Assisted Living
- Assistive Technology
- Chore Services
- Companion
- Environmental Accessibility Modifications
- Mental Health Counseling
- Home Delivered Meals
- Personal Emergency Response System
- Transportation

Source: <http://www.ct.gov/dss/lib/dss/pdfs/SPA12001.pdf>

California 1915(i) Waiver

Provides:

- Habilitation – Community Living Arrangement Services
- Habilitation – Day Services
- Habilitation – Behavioral Intervention Services
- Respite Care
- Supported Employment
- Prevocational Services
- Homemaker
- Home Health Aide Services
- Community Based Adult Services (formerly “Adult Day Health Care”)
- Other – Personal Emergency Response System
- Other – Vehicle Modification and Adaptation

Source: <http://www.dds.ca.gov/waiver/docs/SPA.pdf>

New York State 1115 Waiver

Supportive Housing Services Program

New York seeks to dedicate \$75 million annually for supportive housing services to increase supportive housing. Funds would be distributed through a competitive request for proposal process. Sustainable projects, with the greatest Medicaid ROI, would be prioritized over other projects. Funds must target high cost, high need Medicaid members who require supportive services to live independently. This Program would work in conjunction with the Supportive Housing Capital Expansion Program as multiple projects would receive funds for both capital and supportive services. Funds may be used for various supportive housing services, including but not limited to:

- Crisis management;
- Case management;
- Patient navigation and care coordination services (including linkages with Health Homes);
- Counseling;
- Relapse management;
- Linkages to community resources;
- Education and employment assistance;
- Landlord-tenant mediation;
- Entitlement advocacy;
- Budgeting and help with legal issues.

Source: https://www.health.ny.gov/health_care/medicaid/redesign/docs/2012-08-06_waiver_amendment_request.pdf

California 1115 Waiver (Under Development)

- Provide funding for housing-based case management/tenancy supports (outreach and engagement, housing search assistance, crisis intervention, application assistance for housing and benefits, etc.)
- Allow health plans flexibility to provide non-traditional Medicaid services (discharge planning, creating care plan, coordination with primary, behavioral health and social services, etc.)
- Allow plan contribution of funding to savings pool with county partners that could be used to fund respite care, housing subsidies, additional housing-based case management
- Allow for health plans and counties to form regional integrated care partnership pilot programs leveraging the range of existing local, state, and federal resources in a targeted approach

STATE MEDICAID PLAN CHANGES

1915(c) HCBS WAIVERS

1915(c) HCBS Waivers: General Description

Who May Be Eligible? Services funded through the 1915(c) waiver program can only be used for persons who are either living in an institution (such as a hospital or nursing facility) currently, or who would require that level of care without access to the Medicaid services provided through this waiver.

What Services Can Be Offered? The 1915(c) waiver program can be used to cover some housing-related services, including:

- Assessment of the participant's housing needs and presenting options;
- Assistance with securing housing, including the completion of housing applications and securing of required documentation (e.g., Social Security card, birth certificate, prior rental history);
- Housing search assistance;
- Communication with landlord;
- Coordination of moving;
- Tenancy training;
- Establishment of procedures and contacts to retain housing;
- Environmental modifications to install necessary accommodations for accessibility;
- One-time financial assistance (including security deposits, set-up fees for utilities or service access, essential household furnishings and moving expenses such as furniture, window coverings, food preparation items, and bed/bath linens); or,
- Services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy.

What Services Cannot Be Covered? The 1915(c) waiver program cannot be used to cover the following:

- Monthly rental or mortgage expenses;
- Food;
- Regular utility charges; or,
- Household appliances or items intended purely for diversional/recreational purposes.

What's Unique About 1915(c) Waivers? The supportive housing services benefit created through the 1915(c) waiver program can be limited to a certain geographic area or to a set number of beneficiaries

1915(i) HCBS STATE PLAN OPTIONAL BENEFIT

1915(i) HCBS State Plan Optional Benefit: General Description

Who May Be Eligible? Services funded through the 1915(i) waiver program must be used to support beneficiaries who meet needs-based (and not descriptive or diagnosis-based) eligibility criteria relating to behavior, cognitive abilities, medical risk factors, or function level. CMS allows states to provide benefits for specific populations through a state plan amendment, provided the state can meet all federal requirements:

- Beneficiaries must be elderly or persons with disabilities;
- Beneficiaries must have incomes not more than 150% of FPL or up to 300% of SSI;
- Beneficiaries must have a choice in providers;

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- Benefits must be implemented state-wide;
- State must serve all beneficiaries who meet the benefit's eligibility criteria (cannot limit the number of people who will be served, nor limit based on diagnosis, type of illness, or condition); and,
- The state must demonstrate that it can provide its share of the cost of the program.

What Services Can Be Offered? The 1915(i) waiver program can be used to cover housing-related services similar to those available in the 1915(c) waiver program such as:

- Assessing the participant's housing needs and presenting options;
- Assistance with securing housing, including the completion of housing applications and securing of required documentation (e.g., Social Security card, birth certificate, prior rental history);
- Housing search assistance;
- Communication with landlord;
- Coordination of moving;
- Tenancy training;
- Establishment of procedures and contacts to retain housing;
- Environmental modifications to install necessary accommodations for accessibility;
- One-time financial assistance (including security deposits, set-up fees for utilities or service access, essential household furnishings and moving expenses such as furniture, window coverings, food preparation items, and bed/bath linens); or,
- Services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy.

What Services Cannot Be Covered? The 1915(i) waiver program cannot be used to cover the following:

- Monthly rental or mortgage expenses;
- Food;
- Regular utility charges; or,
- Household appliances or items intended purely for diversional/recreational purposes.

What's Unique About 1915(i) Waivers? Individuals do not have to meet an individual level of care to be served through the 1915(i) waiver program, so States can choose to serve adults with behavioral health issues or others who could not be served under a 1915(c) waiver.

SECTION 1115 RESEARCH AND DEMONSTRATION PROGRAMS

Section 1115 Research and Demonstration Programs: General Description

Who May Be Eligible? The state has a high level of flexibility to target specific populations for services not typically reimbursed by Medicaid.

What services can be offered? The 1115 Research and Demonstration program may be used to provide housing-related services to individuals already in the community, such as:

- Assistance to the beneficiary with problem-solving;
- Advocacy with landlords;
- Access to community resources to assist with back-owed rent; or,
- Assistance to individuals to complete required forms for subsidized housing.

In addition, for persons leaving institutions, the program can be used to cover housing-related services such as:

- Housing location assistance;
- Completion of forms for subsidies;
- Moving expenses; or,
- Household set-up.

What's Unique About Section 1115 Research and Demonstration Programs? Since the Secretary of Health and Human Services may approve any Section 1115 Demonstration programs that further the objectives of Medicaid and the Children's Health Insurance Program, these programs give states additional flexibility to design and improve their programs, to demonstrate and evaluate policy approaches, such as using innovative services delivery systems that improve care, increase efficiency, and reduce costs. However, demonstration programs must be "budget neutral" to the federal government, which means that during the course of the project federal Medicaid expenditures will not be more than federal spending without the demonstration.

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DECISION TOOL TO ASSIST WITH DETERMINING HOW YOUR STATE SHOULD PROCEED IN APPLYING FOR A MEDICAID SUPPORTIVE HOUSING SERVICES BENEFIT

Decision Point	Next Step(s)	Partner(s)	Timeline
Benefit Eligibility			
How broad should the scope of the beneficiary group? (Pg. 1 above)			
What housing status(es) should the beneficiary group have? (Pg. 1)			
What health conditions should the beneficiary group have? (Pg. 1)			
Should systems costs be considered in defining the beneficiary group? (Pg. 1)			
How should these beneficiary categories be linked? (Pg. 1-2)			
Should benefits have a tiered structure? (Pg. 2)			
What partners do we need to engage to determine the scope			

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and definition of the beneficiary group?			
What data do we need to support the application based on the definition of the beneficiary group?			
Service Types			
What type of services should the benefit to cover? (Pg. 7)			
Should the benefit cover housing transition services (i.e., tenant screening/assessment, support plan, search assistance, application assistance, one-time expenses, environmental review, moving expenses, support crisis plan)? (Pg. 7-8)			
Should the benefit cover housing and tenancy sustaining services (i.e., identifications of barriers, tenant/landlord rights training, relationship building, dispute resolution, eviction defense, housing recertification, support crisis plan, tenancy training)? (Pg. 7-8)			
Should the benefit cover housing-related collaborative activities (i.e., working agreements, planning processes, identification of housing opportunities, housing			

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locator systems, data tracking systems)? (Pg. 7-8)			
Should the services cut across these definitions?			
Should services have a tiered structure?			
What partners do we need to engage to determine the scope and definition of eligible services?			
What data do we need to support the application based on the definition of eligible?			
Waiver Types			
What waiver type should the state apply for? (Pgs. 13-17)			
What are the benefits/drawbacks of a 1915(c) waiver? (Pgs. 13-14)			
What are the benefits/drawbacks of a 1915(i) waiver? (Pgs. 14-15)			
What are the benefits/drawbacks of a Section 1115 Research and Demonstration Program?			

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(Pgs. 15-17)			
What partners do we need to engage to determine which waiver to apply for?			
Other Items			
Who else needs to be brought to the table?			
What is currently happening?			

APPENDIX P: RECOMMENDED ADDITIONAL QUESTIONS TO HUD'S ANNUAL PERFORMANCE REPORT

The following is a summary of recommended health coverage and treatment-related questions to add to HUD's CoC Annual Performance Report (APR), utilizing existing HMIS Data Standards. The proposed additions were created and submitted to HUD in 2015 as part of HUD's H² Initiative Data Enhancement Recommendations.

APR Recommendations: **Using Existing HMIS Standards**



Recommendation #1: Create APR question(s) that track program performance in enrolling their clients in health insurance

This recommendation supports the goal of measuring and incentivizing increased rates of enrollment at program and CoC system levels (2).

Proposed Information to Utilize	Rationale	Barriers
Numbers enrolled in each insurance type <ul style="list-style-type: none"> Data Standards 4.4 	Can be measured for increase in enrollment at provider and CoC system levels by comparing numbers enrolled at entry vs. stayers and leavers; can be analyzed against	Confusion about different insurance types, what constitutes insurance, and eligibility requirements
Number enrolled in VA or other insurance (Veterans only) <ul style="list-style-type: none"> Data Standards 3.7, 4.4 	Data Standard 4.1 (Housing Status) to evaluate relationship between insured status and housing outcomes and identify gaps	
Potential Utilizers: <ul style="list-style-type: none"> CoCs & programs utilize program-level data to monitor/evaluate program performance in increasing health insurance coverage of program clients HUD utilizes system-level data to evaluate CoC performance in increasing program participant enrollment in Medicaid Advocates on any level utilize system-level data to evaluate relationship between insured status and housing outcomes 		

Recommendation #2: Create APR question that lists the reason for a client's lack of insurance coverage (HOPWA only*)

This recommendation supports the goal of enhancing our understanding of barriers to accessing insurance and healthcare (4).

Proposed Information to Utilize	Rationale	Barriers
Reason if no insurance coverage (HOPWA only) <ul style="list-style-type: none"> Data Standards 4.4 	Facilitates identification of gaps and barriers to coverage	Requires further analysis to respond to gaps identified and address barriers to coverage

Potential Utilizers:

- CoCs utilize program-level data to identify system-wide gaps and barriers to coverage
- HUD utilizes system-level data to identify nationwide gaps and barriers to coverage

*Potentially expand this question to all HMIS participants; see recommendation #8

Recommendation #3: Create APR question(s) that compares the number of people with documented health conditions vs. the number of people who have received treatment

This recommendation supports the goal of facilitating more efficient connections with healthcare providers by tracking referrals and treatment, supporting a culture of crossover (3).

Proposed Information to Utilize	Rationale	Barriers
Number of documented conditions (by condition: chronic health condition, HIV/AIDS, mental health, substance abuse) • Data Standards 4.7, 4.8, 4.9, 4.10	Can be used to compare documented conditions vs. treatment received; promotes more efficient connections with health care system	Would need to be compared against other information to be meaningful

Potential Utilizers:

- CoCs and programs utilize program-level data to monitor/evaluate program performance in ensuring clients who need treatment are provided appropriate linkages
- Managed care organizations and other health insurance entities utilize program- and system-level data to evaluate success in linking treatment to conditions

Recommendation #4: Create APR question that counts the number of times clients were provided services (HOPWA only*)

This recommendation supports the goal of facilitating more efficient connections with healthcare providers by tracking referrals and treatment, supporting a culture of crossover (3).

Proposed Information to Utilize	Rationale	Barriers
For each category of service (e.g., case management, health/medical care, mental health care/counseling, substance abuse services/treatment; SSVF: case management, health care services): date of service <ul style="list-style-type: none">• Data Standard 4.14C	Identify most and least provided service types and better understand treatment needs and demand	Only a subset of programs; limited data to understand services provided

Potential Utilizers:

- CoCs, HUD, and service providers utilize system-level data to evaluate gaps and opportunities in the provision of services.

*Potentially expand this question to all HMIS participants; see recommendation #8

APPENDIX Q: PROPOSED CHANGES TO HMIS DATA STANDARDS

The following are recommendations for potential changes to HMIS Data Element 4.4 (Health Insurance), as well as additional optional changes. The proposed changes were created and submitted to HUD in 2016 as a result of the H² planning process as part of HUD's H² Initiative Data Enhancement Recommendations.

The proposed changes are designed to maximize HMIS capacity to empower CoCs to effectively advocate for their clients and meet their healthcare needs. Homeless and healthcare providers need the ability to ensure full and complete benefit enrollment, facilitate access to care, and aid clients in navigating services and treatment. To this end, the proposals below are oriented around five concepts voiced through the H² process:

1. **Increase homeless service provider capacity to serve as points of contact to facilitate enrollment.** Many eligible individuals remain uninformed of their appropriate healthcare coverage options, and thus remain uninsured. HMIS adjustments can allow communities to monitor and incentivize the enrollment of eligible homeless program participants. This supports homeless providers in increasing awareness and developing capacity to maximize healthcare coverage and harness critical mainstream resources.
2. **Create the data structure required to support HMIS functionality and workflows that promote frequent, easy updates of client records.** Currently, outside of program entry and exit, most CoC programs are only required to update client information once a year, and the workflow of most HMIS systems is built around these minimum requirements. This timeline provides limited opportunity to use HMIS data elements to meaningfully track the enrollment process and healthcare service(s) utilization.
3. **Incorporate renewal reminders into HMIS to improve coverage maintenance.** Insured homeless clients have difficulty sustaining coverage and complying with renewal requirements. Many are missing renewal windows due to issues related to clients' residential instability (e.g., misdirected correspondence). HMIS modifications can increase provider capacity to support enrolled clients by making it easy to build in healthcare maintenance checks (e.g., renewal deadline reminders) into regular client interactions.
4. **Support efforts to use HMIS to identify coverage breakdowns, propose solutions, and increase accountability for cross-enrollment.** Homeless housing and healthcare providers need to be better informed to support clients' connections to care and housing. Expanding HMIS functionalities around enrollment and renewal tracking can help support deeper performance analysis and provider accountability. Consider creating an ROI standard form with each managed care entity in the state that enables the MCO to report health insurance status changes directly to the HMIS administrator for the purpose of updating client records in HMIS. Strengthen ties with criminal justice system to report on coverage impacts of incarceration.

RECOMMENDED HMIS DATA STANDARDS CHANGES: ADDITIONS TO HMIS DATA ELEMENT 4.4 (HEALTH INSURANCE)

The proposal adds to the HMIS data element (4.4) focused on health insurance to achieve the aims above while minimizing additional burdens on HMIS users and vendors:

- (1) Where client is not enrolled in any insurance program, add:
 - Detail on submission of common application if pending (date, method, application/confirmation number)
- (2) For each health insurance type enrolled, add:
 - Coverage detail (account number, enrollment/renewal date, expiration date, contact)
 - Application detail if pending (date, method, application/confirmation number)
- (3) Include additional insurance types:
 - Indian Health Service (IHS) Health Care Benefits
 - Covered by Other Insurance
 - Add coverage detail (including membership, coverage, ACA standards)
 - Add application detail if pending
- (4) For each type of health insurance not enrolled, require:
 - Reason for lack of enrollment (currently required for HOPWA clients only)
 - Add "Previously enrolled but lapsed" among reasons for lack of enrollment

The changes to this element are driven by four primary desirable outcomes: increased awareness and

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accountability among CoC programs to address barriers to coverage and care; increased knowledge of eligibility, enrollment, renewal, and coverage requirements; increased rates of health insurance coverage; and, deepened understanding of barriers to coverage and the tools to respond.

OUTCOMES	RATIONALE	PROPOSED DATA STANDARD REVISIONS
<i>Increased Awareness and Accountability Among CoC Programs to Address Barriers to Coverage and Care</i>	<p>Requires program staff to pay attention to clients' enrollment status, eligibility issues, and renewal barriers</p> <p>Allows CoCs to monitor programs' performance data and to hold programs accountable for their clients' health insurance coverage</p>	<p>Detail on submission of common application if pending</p> <p>Coverage detail</p> <p>Application detail</p> <p>Reason for lack of enrollment, including addition of "previously enrolled but lapsed" as a reason</p>
<i>Increased Knowledge of Eligibility, Enrollment, Renewal, and Coverage Requirements</i>	Encourages program staff to learn eligibility, enrollment, and renewal requirements, as well as the ACA's Minimum Essential Coverage requirements	<p>Detail on submission of common application if pending</p> <p>Coverage detail</p> <p>Application detail</p> <p>ACA health insurance standards</p>
<i>Increased Rates of Health Insurance Coverage</i>	<p>Increases timely renewal by soliciting information needed to prevent termination</p> <p>Facilitates enrollment of uninsured participants by asking whether eligibility has been assessed</p>	<p>Detail on submission of common application if pending</p> <p>Coverage detail</p> <p>Application detail</p>
<i>Deepening Understanding of Barriers to Coverage and Tools to Respond</i>	<p>Supports more robust, evidence-based understanding of barriers to insurance enrollment and retention</p> <p>Supports HMIS vendors to develop caseworker tools to streamline eligibility assessment and renewal processes, using data HMIS already gathered (e.g., 3.3, 3.7, 3.8, 4.2, 4.3, 4.5, 4.6, 4.7, 4.8, 4.9, 4.10, 4.30)¹</p>	<p>Reason for lack of enrollment, including addition of "previously enrolled but lapsed" as a reason</p> <p>Coverage detail</p>

Challenges

- Staff follow-up may be needed if a client does not have the information required
- Any extra data collection adds to the overall staff burden. However, line staff familiarity with eligibility and renewal criteria helps ensure more accurate data collection and likely reduces the additional time spent addressing these questions. Integrating this additional data may help reduce staff follow-up time spent later on connecting clients to appropriate care.

¹ Includes universal data elements (3.3, 3.7, 3.8) for date of birth, veteran status, and disabling condition. Program-specific data elements (4.2, 4.3, 4.5, 4.6, 4.7, 4.8, 4.9, 4.10, 4.30) include income and sources, non-cash benefits, physical disability, developmental disability, chronic health conditions, HIV/AIDS, mental health problems, substance abuse, and pregnancy status.

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These proposed revisions to the Data Standards are intended to collect the data points necessary to make HMIS a useful and effective tool for streamlining, increasing, and maintaining client enrollment in all appropriate healthcare options for which they are eligible. Note that, while the changes to the Data Element below will generate the data needed to enable and monitor this process, some revisions to HMIS functionality are required to fully streamline this process. For instance, the full set of recommended changes include some to the programming specs, such as incorporating auto-population features and/or validation and verification features.

SAMPLE HMIS DATA STANDARDS MANUAL TEXT: REDLINED DATA ELEMENT 4.4

4.4 Health Insurance

Rationale: Health insurance information is important to determine whether clients currently have health insurance coverage and are accessing all mainstream medical assistance benefits for which they may be eligible, and to ascertain a more complete picture of their economic circumstances.

Collection Point(s): At project entry, annual assessment, and project exit. Update as changes to healthcare coverage occur.

Subjects: All clients.

Federal Partner Requiring Collection: HUD, HHS, VA [refer to Federal Partner Program Specific pages throughout this document.]

Data Collection Instructions: Data on Health Insurance collected at project entry and project exit are to reflect the information as of the date of entry and exit. Data collections for project entry and exit information are to be dated the same date as the date of project entry and the date of project exit.

An annual assessment is required for all persons residing in the project one year or more. Health Insurance must be recorded in the HMIS as an Annual Assessment even if there is no change. Updates are required for persons aging into adulthood.

Data Element Fields: 4.4 Health Insurance

Field Names	Data Types/Response Categories
INFORMATION DATE	(Date)
COVERED BY HEALTH INSURANCE	No
	Yes
	Client doesn't know
	Client refused
(If no for "Covered by Health Insurance") Has the client submitted the state's common application for which results are pending? (Functionality: Auto-populate detail below)	No
	Yes
	(Application date)
	(Application method)
	(Application/confirmation number)
	(Name of staff member assisting in application)
	(Contact information of staff member assisting in application)
(If yes for "Covered by Health Insurance") Indicate all applicable sources of health insurance below	
MEDICAID	No
	Yes
	Applied; decision pending
(Required for HOPWA only)	Applied; decision pending

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(If no for Medicaid) Indicate the reason	Applied; client deemed not eligible by insurance provider
	Client did not apply; no official eligibility/enrollment determination
	Insurance type N/A for this client
	Previously enrolled but lapsed
	Client doesn't know
	Client refused
(If yes for Medicaid) Coverage detail	(Record/account/member number)
	(Enrollment date/most recent renewal)
	(Expiration date)
	(Insurance provider contact information)
(If applied; decision pending for Medicaid) Application detail	(Application date)
	(Application method)
	(Application/confirmation number)
MEDICARE	No
	Yes
	Applied; decision pending
(Required for HOPWA only) (If no for Medicare) Indicate the reason	Applied; decision pending
	Applied; client deemed not eligible by insurance provider
	Client did not apply; no official eligibility/enrollment determination
	Insurance type N/A for this client
	Previously enrolled but lapsed
	Client doesn't know
(If yes for Medicare) Coverage detail	Client refused
	(Record/account/member number)
	(Enrollment date/most recent renewal)
	(Expiration date)
(If applied; decision pending for Medicaid) Application detail	(Insurance provider contact information)
	(Application date)
	(Application method)
	(Application/confirmation number)
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (or use local name)	No
	Yes
	Applied; decision pending
(Required for HOPWA only) (If no for State Children's Health Insurance Program) Indicate the reason	Applied; client deemed not eligible by insurance provider
	Client did not apply; no official eligibility/enrollment determination
	Insurance type N/A for this client
	Previously enrolled but lapsed
	Client doesn't know
	Client refused
(If yes for State Children's Health Insurance Program) Coverage detail	(Record/account/member number)
	(Enrollment date/most recent renewal)
	(Expiration date)
	(Insurance provider contact information)
(If applied; decision pending for State Children's Health Insurance Program)	(Application date)
	(Application method)

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<i>Application detail</i>	(Application/confirmation number)
VETERAN'S ADMINISTRATION (VA) MEDICAL SERVICES (Optional Functionality: Yes response verifies veteran status)	No
	Yes
	Applied; decision pending
<i>(Required for HOPWA only)</i> (If no for Veteran's Administration Medical Services) Indicate the reason	Applied; client deemed not eligible by insurance provider
	Client did not apply; no official eligibility/enrollment determination
	Insurance type N/A for this client
	Previously enrolled but lapsed
	Client doesn't know
	Client refused
<i>(If yes for Veteran's Administration Medical Services)</i> Coverage detail	(Record/account/member number)
	(Enrollment date/most recent renewal)
	(Expiration date)
	(Insurance provider contact information)
<i>(If applied; decision pending for Veteran's Administration Medical Services)</i> Application detail	(Application date)
	(Application method)
	(Application/confirmation number)
AIDS Drug Assistance Program (ADAP)	No
	Yes
	Applied; decision pending
<i>(If no for ADAP)</i> Indicate the reason	Applied; client deemed not eligible by insurance provider
	Client did not apply; no official eligibility/enrollment determination
	Insurance type N/A for this client
	Previously enrolled but lapsed
	Client doesn't know
	Client refused
<i>(If yes for ADAP)</i> Coverage detail	(Record/account/member number)
	(Enrollment date/most recent renewal)
	(Expiration date)
	(Insurance provider contact information)
<i>(If applied; decision pending for ADAP)</i> Application detail	(Application date)
	(Application method)
	(Application/confirmation number)
EMPLOYER-PROVIDED HEALTH INSURANCE	No
	Yes
	Applied; decision pending
<i>(Required for HOPWA only)</i> (If no for Employer-Provided Health Insurance) Indicate the reason	Applied; decision pending
	Applied; client deemed not eligible by insurance provider
	Client did not apply; no official eligibility/enrollment determination
	Insurance type N/A for this client
	Previously enrolled but lapsed
	Client doesn't know
<i>(If yes for Employer-Provided Health Insurance)</i> Coverage detail	Client refused
	(Provider Name)
	(Plan/group number)

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	(Insurance type: HMO, PPO, etc.)
	(Record/account/member number)
	(Enrollment date/most recent renewal)
	(Expiration date)
	(Insurance provider contact information)
(If applied; decision pending for Employer-Provided Health Insurance)	(Application date)
Application detail	(Application method)
	(Application/confirmation number)
HEALTH INSURANCE OBTAINED THROUGH COBRA	No
	Yes
	Applied; decision pending
(Required for HOPWA only)	Applied; decision pending
(If no for Health Insurance Obtained Through COBRA)	Applied; client deemed not eligible by insurance provider
Indicate the reason	Client did not apply; no official eligibility/enrollment determination
	Insurance type N/A for this client
	Previously enrolled but lapsed
	Client doesn't know
	Client refused
(If yes for Health Insurance Obtained Through COBRA)	(Provider Name)
Coverage detail	(Plan/group number)
	(Insurance type: HMO, PPO, etc.)
	(Record/account/member number)
	(Enrollment date/most recent renewal)
	(Expiration date)
	(Insurance provider contact information)
(If applied; decision pending for Health Insurance Obtained Through COBRA)	(Application date)
Application detail	(Application method)
	(Application/confirmation number)
PRIVATE PAY HEALTH INSURANCE	No
	Yes; client covered under own insurance
	Yes; client covered under other's insurance
	Applied; decision pending
(Required for HOPWA only)	Applied; decision pending
(If no for Private Pay Health Insurance)	Applied; client deemed not eligible by insurance provider
Indicate the reason	Client did not apply; no official eligibility/enrollment determination
	Insurance type N/A for this client
	Previously enrolled but lapsed
	Client doesn't know
	Client refused
(If yes for Private Pay Health Insurance)	(Provider Name)
Coverage detail	(Plan/group number)
	(Insurance type: HMO, PPO, etc.)
	(Record/account/member number)
	(Enrollment date/most recent renewal)
	(Expiration date)
	(Insurance provider contact information)
(If applied; decision pending for Private Pay Health Insurance)	(Application date)

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<i>Insurance)</i>	(Application method)
<i>Application detail</i>	(Application/confirmation number)
STATE HEALTH INSURANCE FOR ADULTS (or use local name)	No
	Yes
	Applied; decision pending
<i>(Required for HOPWA only)</i>	Applied; decision pending
<i>(If no for State Health Insurance for Adults)</i>	Applied; client deemed not eligible by insurance provider
<i>Indicate the reason</i>	Client did not apply; no official eligibility/enrollment determination
	Insurance type N/A for this client
	Previously enrolled but lapsed
	Client doesn't know
	Client refused
<i>(If yes for State Health Insurance for Adults)</i>	(Provider Name)
<i>Coverage detail</i>	(Plan/group number)
	(Insurance type: HMO, PPO, etc.)
	(Record/account/member number)
	(Enrollment date/most recent renewal)
	(Expiration date)
	(Insurance provider contact information)
<i>(If applied; decision pending for State Health Insurance for Adults)</i>	(Application date)
<i>Application detail</i>	(Application method)
	(Application/confirmation number)
INDIAN HEALTH SERVICE (IHS) HEALTH CARE BENEFITS	No
	Yes
	Applied; decision pending
<i>(If no for Indian Health Service Health Care Benefits)</i>	Applied; client deemed not eligible by insurance provider
<i>Indicate the reason</i>	Client did not apply; no official eligibility/enrollment determination
	Insurance type N/A for this client
	Previously enrolled but lapsed
	Client doesn't know
	Client refused
<i>(If yes for Indian Health Service Health Care Benefits)</i>	(Name of local HIS, Tribal, or Urban Indian Health Program Facility Where Registered)
<i>Coverage detail</i>	(Record/account/member number)
	(Enrollment date/most recent renewal)
	(Expiration date)
	(Insurance provider contact information)
<i>(If applied; decision pending for Indian Health Service Health Care Benefits)</i>	(Name of local HIS, Tribal, or Urban Indian Health Program Facility Where Registered)
<i>Application detail</i>	(Application date)
	(Application method)
	(Application/confirmation number)
OTHER INSURANCE	No
	Yes
	Applied; decision pending
<i>(If no for Other Insurance)</i>	Applied; client deemed not eligible by insurance provider
<i>Indicate the reason</i>	

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	Client did not apply; no official eligibility/enrollment determination
	Insurance type N/A for this client
	Previously enrolled but lapsed
	Client doesn't know
	Client refused
<i>(If yes for Other Insurance) Coverage detail</i>	(Name of insurance provider)
	(Type of plan: supplemental, dental or vision only, short-term, fixed, limited benefit)
	(Record/account/member number)
	(Enrollment date/most recent renewal)
	(Expiration date)
	(Insurance provider contact information)
	(Whether the insurance offers all essential health benefits)
	(Whether the insurance meets minimal actuarial value)
	(Whether the insurance meets accreditation standards)
<i>(If applied; decision pending for Other Insurance) Application detail</i>	(Name of insurance provider)
	(Application date)
	(Application method)
	(Application/confirmation number)

Response Category Descriptions:

- **Information Date:** The date of project entry or exit, the date the annual assessment was completed or the date updated information was collected.
- **Covered by Health Insurance and specific Sources:** If the response to *Covered by Health Insurance* is “No” then ~~no further data collection is required~~ record whether or not the client was assessed for eligibility and the reason why insurance is not being received for each health insurance source. If the response is “Yes” then record whether or not the client is covered by each of the listed insurance types, ~~the date of enrollment or most recent renewal, and the name of the health insurance provider for each (if applicable);~~ if the client is “Covered by Other Insurance” then also record the type of health plan offered by the client’s other insurance and whether it meets the Affordable Care Act (ACA)’s standards for health insurance. ~~If required by a funder, enter the reason why such insurance is not being received for each health insurance source. To reduce data collection and reporting burden, if a client reports having no health insurance coverage, no additional data collection is required unless required by a specific funder.~~
- ~~Indian Health Insurance was omitted in error — please record as Indian Health Insurance under Medicaid until the Data Standards are fully updated in the future.~~
- Insurance accessed through the federal or a state Health Exchange (e.g. healthcare.gov), except for Medicaid should be recorded as Private Pay Health Insurance, even if a subsidy covering most of the cost of insurance was provided.
- If the Health Exchange provided access to Medicaid and Medicaid was received then enter the health care as Medicaid.
- Record TRICARE – available to veterans based on military service – as “Employer-Provided Health Care.”

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- Medicaid is a partnership between federal and state funds. It should always be listed as Medicaid not State Health Insurance.
- Indigent care received by a medical provider or hospital to cover a health care cost is not insurance and should not be recorded in HMIS.

Special Considerations: None.

OPTIONAL CHANGES: ADD HEALTHCARE MANAGEMENT FUNCTIONALITY

Adding healthcare management functionality could further leverage the use of HMIS to enhance client access to healthcare. The examples below illustrate sample text for collecting information on clients' primary healthcare providers, recent emergency room/urgent care visits and hospitalizations, as well as ongoing conditions and active prescriptions.

Note: The optional changes below extend the current thinking of how HMIS is used in collecting and using client data. They may not be the direction that HUD is willing to move at the moment, but are proposed in response to conversations about integrating housing and healthcare. The level of personal health info suggested requires some consideration of a range of implications we look forward to discussing with you.

Sample HMIS Data Standards Manual Text

4.[] Healthcare Providers

Rationale: To increase participants' access to health care.

Collection Point(s): At project entry, annual assessment, and project exit. Update as healthcare provider information changes.

Subjects: All clients.

Federal Partner Requiring Collection: n/a

Data Collection Instructions: Data on Healthcare Providers collected at project entry and project exit are to reflect the information as of the date of entry and exit. Data collections for project entry and exit information are to be dated the same date as the date of project entry and the date of project exit.

An annual assessment is required for all persons residing in the project one year or more. Physician information must be recorded in the HMIS as an Annual Assessment even if there is no change.

Data Element Fields: [] Healthcare Providers

Field Names	Data Types/Response Categories
Information Date	(Date)
Has a Primary Healthcare Physician?	No
	Yes; ongoing care
	Yes; inactive
	Client doesn't know
	Client refused
(if yes) Date of Last Visit	(Date)
	Client doesn't know

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Field Names	Data Types/Response Categories
	Client refused
(if yes) Date of Next Visit	(Date)
	Client doesn't know
	Client refused
Physician Name and Clinic/Practice Group	(Text)
	Client doesn't know
	Client refused
Physician/Clinic/Practice Group Street Address	(Text)
Physician/Clinic/Practice Group City	(Text)
Physician/Clinic/Practice Group State	(Text)
Physician/Clinic/Practice Group ZIP Code	(Text)
Physician/Clinic/Practice Group Telephone Number	(Text)
Physician/Clinic/Practice Group	(Text)
Primary Healthcare Physician Contact Information Quality	Full contact information reported
	Incomplete or estimated contact information reported
	Client doesn't know
	Client refused
Medical Record Release (Functionality)	Yes
	No
	(Attach)
(if no) Why doesn't the client have a primary healthcare physician?	No health insurance
	Insurance doesn't adequately cover desired services
	Client needs help finding an appropriate doctor
	Client needs help making/keeping appointments
	Client receives primary healthcare from nurse practitioner or other medical professional
	Client doesn't want health care
	Client doesn't know
	Client refused
Other Medical Specialist(s)	(Type)
(Functionality: Recreate form as completed)	(Name/Practice Group)
	(Street Address)
	(City)
	(State)
	(Zip Code)
	(Telephone Number)

Response Category Descriptions:

- **Information Date:** The date of project entry or exit, the date the annual assessment was completed or the date updated information was collected.
- **Has a Primary Care Physician:** If the response to *Has a Primary Care Physician* is "No" then record the reason why client does not have a primary care physician. If the response is "yes," then record the date of the client's last visit to the physician, the physician's name and clinic/practice group, and the physician's contact information.
- **Date of Last/Next Visit:** Record the month and year of the last/next visit to primary care physician (MM-YYYY).

Special Considerations: None

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Field Names	Data Types/Response Categories
Information date	(Date)
Has the client visited an emergency room or urgent care facility in the past year?	No
	Yes
	Client doesn't know
	Client refused
(if yes) Date of last visit	(Date)
	Client doesn't know
	Client refused
(if yes) How many times has the client visited an emergency room or urgent care facility in the past year?	(Number)
	Client doesn't know
	Client refused
(if yes) Facility name	(Text)
	Client doesn't know
	Client refused
(if yes) Street address	(Text)
(if yes) City	(Text)
(if yes) State	(Text)
(if yes) ZIP code	(Text)
(if yes) Telephone number	(Text)
(if yes) Contact information quality	Full contact information reported
	Incomplete or estimated contact information reported
	Client doesn't know
	Client refused
(if yes) Purpose of visit	(Text)
	Client doesn't know
	Client refused
(if yes) Outcome/follow-up	(Text)
	Client doesn't know
	Client refused
Has the client been hospitalized in the past year? (Including mental health)	No
	Yes
	Client doesn't know
	Client refused
(if yes) Date of entry	(Date)
	Client doesn't know
	Client refused
(if yes) Date of release	(Date)
	Client doesn't know
	Client refused
(if yes) How many times has the client been hospitalized in the past year?	(Text)
	Client doesn't know
	Client refused
(if yes) Facility name	(Text)
	Client doesn't know
	Client refused

(if yes) Street address	(Text)
(if yes) City	(Text)
(if yes) State	(Text)
(if yes) ZIP code	(Text)
(if yes) Telephone number	(Text)
(if yes) Contact information quality	Full contact information reported
	Incomplete or estimated contact information reported
	Client doesn't know
	Client refused
(if yes) Purpose of visit	(Text)
	Client doesn't know
	Client refused
(if yes) Outcome/follow-up	(Text)
	Client doesn't know
	Client refused

4. ☐ Medical Emergencies

Rationale: To improve participants' access to health care.

Collection Point(s): At project entry, annual assessment, and project exit.

Subjects: All clients.

Federal Partner Requiring Collection: n/a

Data Collection Instructions: Data on recent emergency room/urgent care visits and hospitalizations collected at project entry and project exit are to reflect the information as of the date of entry and exit. Data collections for project entry and exit information are to be dated the same date as the date of project entry and the date of project exit.

An annual assessment is required for all persons residing in the project one year or more.

Data Element Fields: ☐ Medical Emergencies

Response Category Descriptions:

- *Information Date:* The date of project entry or exit, the date the annual assessment was completed or the date updated information was collected.
- *Purpose of visit:* Provide description or select from drop-down menu (e.g., "annual check-up," "sick call," "diagnostic," "lab work," "follow-up").
- *Recent emergency room or urgent care visit:* If the response to *Has the client visited an emergency room or urgent care facility in the past year* is "No" then no further information is needed. If the response is "yes," then record the date of the client's last visit to the emergency room/urgent care facility, the facility name and clinic/practice group, and the facility's contact information.

Healthcare & Housing (H²) Initiative | Data Enhancement Recommendations

- *Recent hospitalization:* If the response to *Has the client been hospitalized in the past year* is “No” then no further information is needed. If the response is “yes,” then record the dates of the client’s last hospitalization, the facility name and clinic/practice group, and the facility’s contact information.

Special Considerations: None

4. ☐ Ongoing Care

Rationale: To improve participants’ access to health care.

Collection Point(s): At project entry, annual assessment, and project exit. Update as necessary.

Subjects: All clients.

Federal Partner Requiring Collection: n/a

Data Collection Instructions: Data on recent ongoing conditions, active prescriptions, and follow-up care instructions collected at project entry and project exit are to reflect the information as of the date of entry and exit. Data collections for project entry and exit information are to be dated the same date as the date of project entry and the date of project exit.

An annual assessment is required for all persons residing in the project one year or more.

Data Element Fields: ☐ Ongoing Care

Field Names	Data Types/Response Categories
Information date	(Date)
Does the client have any of the following ongoing chronic conditions?	No
	Alzheimer’s disease and related dementia
	Arthritis (osteoarthritis and rheumatoid)
	Asthma
	Atrial fibrillation
	Autism spectrum disorders
	Cancer
	Chronic kidney disease
	Chronic obstructive pulmonary disease
	Depression
	Diabetes
	Heart failure
	Hepatitis (Chronic Viral B & C)
	HIV/AIDS
	Hyperlipidemia (high cholesterol)
	Hypertension (high blood pressure)
	Ischemic heart disease
	Osteoporosis
	Schizophrenia and other psychotic disorders
	Stroke
Does the client have any active prescriptions? (Functionality: Recreate form as completed)	Client doesn’t know
	Client refused
	No
	Yes
	Client doesn’t know

	Client refused
(if yes) Prescription type	(Text)
	Client doesn't know prescription name
	Client doesn't know whether prescribed
	Client refused
(if yes) Does the client take the drug as prescribed?	No
	Yes
	Client doesn't know
	Client refused
(if yes) Prescription number	(Text)
(if yes) Prescription date	(Text)
(if yes) Prescription expiration	(Text)
(if yes) Number of refills	(Text)
(if yes) Prescribing physician name	(Text)
(if yes) Prescribing physician telephone number	(Text)
(if yes) Pharmacy name	(Text)
(if yes) Pharmacy telephone number	(Text)

Response Category Descriptions:

- **Information Date:** The date of project entry or exit, the date the annual assessment was completed or the date updated information was collected.
- **Active prescriptions:** If the response to *Does the client have any active prescriptions* is "No" then no further information is needed. If the response is "yes," then record the prescription type, number, dates, refills, prescribing physician's name/contact information, and pharmacy name/contact information.
- **Prescription type:** Enter the name of the prescription medicine.

Special Considerations: None

APPENDIX R: BENEFITS DECODER

The following is a reference guide to help line workers assist clients in identifying their health coverage and benefits and ensuring accurate corresponding data entry into HMIS. It contains two separate documents: a sample decoder (created for San Francisco) and a manual to assist communities to create their own Benefits Decoder tool.

Benefits Decoder Pilot Project

San Francisco



What is the Benefits Decoder?

- ♦ A pocket reference to help line workers easily identify, understand, and take advantage of their clients' healthcare coverage and benefits.
- ♦ A tool for improving both data quality and service delivery.
- ♦ Part of the H² Healthcare & Housing Data Enhancement Initiative.
- ♦ The first of several handbooks that will be prepared for all H² communities who show interest in the material.

Questions? E-mail decoder@homebaseccc.org

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HOW TO USE THIS GUIDE

(1) Header at top of page identifies name and general category of plan

(2) Photos illustrate format of typical member ID card (some patients may have cards that look different)

(3) Icons show which categories of services are included: black means the service is covered, and grey means the service is uncovered, available only for minors, or requires a significant extra monthly premium.

(4) Program Eligibility and Cost explains who is allowed to enroll in the plan and what they can expect to pay out of pocket for major services.

(5) Program Benefits explains in more detail what kind of services are provided under the plan and how often those services can be used.

(6) HMIS Data Entry block shows you how to answer the questions in HMIS Data Standard 4.4.

Questions marked with “Ask” mean that you need to check with the client

(7) For More Info gives you contact information so you can follow up with the insurer and ask questions.

AARP UnitedHealth Rx Plan

A Part D prescription drug plan to add on to Medicare



Program Eligibility & Cost

This plan is only available for senior citizens, i.e., people over the age of 65.

Program Benefits

This is a Medicare Part D prescription-drug plan only. It covers most types of generic pills, creams, and injectables when purchased from in-network

HMIS Data Entry	
Covered by Health Insurance:	Ask
Medicaid/MediCal:	No
Medicare:	Yes
State Children's Health Insurance Program (CHIP):	No

For More Info

Program information – including card design, benefits, and eligibility criteria – are subject to change. use the contacts below to find the most up-to-date information.

Members: (866) 460-8854
Non-Members: (888) 867-5564
Phone service available 8 am - 8 pm, 7 days/week

AARP UnitedHealth Rx Plan

A Part D prescription drug plan to add on to Medicare

FRONT OF CARD



BACK OF CARD



Program Eligibility & Cost

This plan is only available for senior citizens, i.e., people over the age of 65.

AARP UnitedHealthCare Rx Plan is a relatively affordable prescription drug plan (with premiums of about \$31 / month). Co-pays can drop as low as \$1 for generic drugs, or even \$0 on mail-order generics, but patients gave the plan low ratings for “high risk medication” and “medication therapy management services.”

Program Benefits

This is a Medicare Part D prescription-drug plan only. It covers most types of generic pills, creams, and injectables when purchased from in-network pharmacies, but does not cover doctors, nurses, or physical therapy. Medicare Part D is meant to go alongside a general-purpose health insurance policy like Medicare Parts A+B.



Primary Care



Family Planning



Dental



Rx Drug



Mental Health



Vision

HMIS Data Entry

Data Element 4.4: Health Insurance

Covered by Health Insurance:	Ask
Medicaid/MediCal:	No
Medicare:	Yes
State Children’s Health Insurance Program (CHIP):	No
Veteran’s Administration (VA) Medical Services:	No
Health Insurance obtained through COBRA:	No
Private Pay Health Insurance:	No
Employer-Provided Health Insurance:	No
State Health Insurance for Adults:	No

For More Info

Program information – including card design, benefits, and eligibility criteria – are subject to change. Use the contacts below to find the most up-to-date information.

Members: (866) 460-8854
Non-Members: (888) 867-5564
Phone service available 8 am - 8 pm,
7 days/week

<http://www.AARPMedicareRx.com>

Anthem Blue Cross HMO

A ‘CaliforniaCare’ program available through Medi-Cal Access Plan (“MCAP”)

CALIFORNIA ID CARD *AND* MCAP ELIGIBILITY *AND* ANTHEM ID CARD



Program Eligibility & Cost

Medi-Cal Access Plan covers **medium-income pregnant** residents of California: you must be wealthy enough that you are not eligible for zero-cost Medi-Cal, but poor enough that it is difficult for you to afford your own health insurance. See http://mcap.dhcs.ca.gov/Costs/Income_Guidelines.aspx for exact income range.

Participants must present both a State of California BIC and an Anthem Blue Cross ID card to receive services. Participants can enroll their infant children in the Medi-Cal Access Infant Program.

Program Benefits

The plan includes nutritional services, smoking cessation, substance abuse treatment, prenatal care, maternity care, postnatal care, mental health care, pharmacy, primary care, and a full range of family planning services, including sterilization, abortion, and abortion counseling.



Primary Care



Family Planning



Dental



Rx Drug



Mental Health



Vision

HMIS Data Entry

Data Element 4.4: Health Insurance

Covered by Health Insurance:	Yes
Medicaid/MediCal:	Yes
Medicare:	No
State Children’s Health Insurance Program (CHIP):	Yes
Veteran’s Administration (VA) Medical Services:	No
Health Insurance obtained through COBRA:	No
Private Pay Health Insurance:	No
Employer-Provided Health Insurance:	No
State Health Insurance for Adults:	No

For More Info

Program information – including card design, benefits, and eligibility criteria – are subject to change. use the contacts below to find the most up-to-date information.

Customer Service: (877)-687-0549
TDD / Spanish: (888) 757-6034
Available Monday - Friday,
8:30 a.m. to 7:00 p.m. PT

http://mcap.dhcs.ca.gov/Plans_Providers/Plans/Anthem_Blue_Cross_HMO.aspx

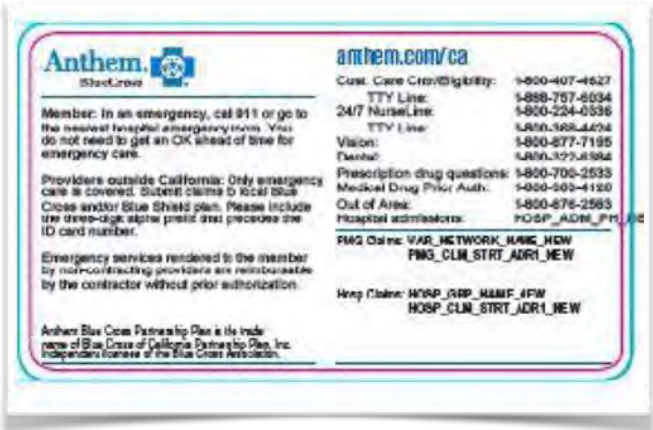
Anthem Blue Cross HSA/PPO

A private health savings account with provider choice via Covered California

FRONT OF CARD



BACK OF CARD



Program Eligibility & Cost

Anyone living in California who doesn't have health insurance through an employer can sign up for this plan through Covered California.

The plan has a \$4,500 deductible for medical and drugs, and a 40% co-pay pretty much across the board, except for preventative care, which is free.

Members of this plan can make tax-free deposits to a special "health savings account," so they are useful for people who earn enough money to pay federal income tax, i.e., over \$9,750 per year.

Program Benefits

The plan includes a full range of physical, pharmacy, behavioral, and mental health services.

Notably, the plan includes coverage for 30 days per year of inpatient care and 20 outpatient visits per year for mental or nervous disorders and substance abuse. The plan also covers chemotherapy, acupuncture, advanced medical imaging, skilled nursing, and urgent care.



Primary Care



Family Planning



Dental



Rx Drug



Mental Health



Vision

HMIS Data Entry

Data Element 4.4: Health Insurance

Covered by Health Insurance:	Yes
Medicaid/MediCal:	Yes
Medicare:	No
State Children's Health Insurance Program (CHIP):	Yes
Veteran's Administration (VA) Medical Services:	No
Health Insurance obtained through COBRA:	No
Private Pay Health Insurance:	No
Employer-Provided Health Insurance:	No
State Health Insurance for Adults:	No

For More Info

Program information – including card design, benefits, and eligibility criteria – are subject to change. Use the contacts below to find the most up-to-date information.

Customer Service: (877)-687-0549
TDD / Spanish: (888) 757-6034
Available Monday - Friday,
8:30 a.m. to 7:00 p.m. PT

http://mcap.dhcs.ca.gov/Plans_Providers/Plans/Anthem_Blue_Cross_HMO.aspx

Anthem Blue Cross Medi-Cal

A private plan offering full coverage under California’s Medicaid program.

FRONT OF CARD



BACK OF CARD



Program Eligibility & Cost

Medi-Cal is California's Medicaid program. To be eligible, you must be either low-income (less than 133% of the federal poverty line) or fit into a particular category of medical need.

The medical need categories include families with children, seniors, people with disabilities, children in foster care, pregnant women, and people with specific diseases such as breast cancer, tuberculosis, or HIV/AIDS.

Program Benefits

Anthem Blue Cross' affiliate has contracted with the Department of Health Care Services to provide Medi-Cal health benefits to its Medi-Cal recipients.

Anthem provides all regular Medi-Cal benefits, plus free checkups, a 24/7 nurse helpline, free medical interpreters, and free rides to approved health services.



Primary Care



Family Planning



Dental



Rx Drug



Mental Health



Vision

HMIS Data Entry

Data Element 4.4: Health Insurance

Covered by Health Insurance:	Yes
Medicaid/MediCal:	Yes
Medicare:	No
State Children’s Health Insurance Program (CHIP):	No
Veteran’s Administration (VA) Medical Services:	No
Health Insurance obtained through COBRA:	No
Private Pay Health Insurance:	No
Employer-Provided Health Insurance:	No
State Health Insurance for Adults:	No

For More Info

Program information – including card design, benefits, and eligibility criteria – are subject to change. Use the contacts below to find the most up-to-date information.

Phone: (800) 407-4627
TDD/TYY: (888) 757-6034
Available Monday - Friday
from 7 am to 7 pm PST

<https://mss.anthem.com/ca/Pages/medi-cal.aspx>

Anthem Blue Cross PPO

A private plan offering a wide choice of providers through Covered California

FRONT OF CARD



BACK OF CARD



Program Eligibility & Cost

Anyone living in California who doesn't have health insurance through an employer can sign up for this plan through Covered California.

The program has high deductibles and is unlikely to be useful for most low-income clients, but the pharmacy deductible is only \$500/year. After that, drugs at in-network pharmacies are free to the patient, making this a good choice for heavy users of prescription drugs. Lab testing is also somewhat affordable at a \$40 co-pay per visit.

Program Benefits

The plan includes a full range of physical, pharmacy, behavioral, and mental health services.

Patients can choose their own doctors.



Primary Care



Family Planning



Dental



Rx Drug



Mental Health



Vision

HMIS Data Entry

Data Element 4.4: Health Insurance

Covered by Health Insurance:	Yes
Medicaid/MediCal:	Yes
Medicare:	No
State Children's Health Insurance Program (CHIP):	Yes
Veteran's Administration (VA) Medical Services:	No
Health Insurance obtained through COBRA:	No
Private Pay Health Insurance:	No
Employer-Provided Health Insurance:	No
State Health Insurance for Adults:	No

For More Info

Program information – including card design, benefits, and eligibility criteria – are subject to change. Use the contacts below to find the most up-to-date information.

Customer Service: (877)-687-0549
TDD / Spanish: (888) 757-6034
Available Monday - Friday,
8:30 a.m. to 7:00 p.m. PT

http://mcap.dhcs.ca.gov/Plans_Providers/Plans/Anthem_Blue_Cross_HMO.aspx

Blue Shield of CA HSA/PPO

A private health savings account with provider choice via Covered California

FRONT OF CARD



BACK OF CARD



Program Eligibility & Cost

Anyone living in California who doesn't have health insurance through an employer can sign up for this plan through Covered California.

The plan has a \$4,500 deductible for medical and drugs, and a 40% co-pay pretty much across the board, except for preventative care, contraception, breast pumps, and prenatal/postnatal care, and pediatric vision/dental, which are free.

Members of this plan can make tax-free deposits to a special "health savings account."

Program Benefits

This plan provides some coverage for most services, including mental health care, abortions, prenatal care, hospital stays, routine pediatric vision and dental, and prescription drugs.

Hearing aids, weight loss treatment, and adult dental/vision are not covered.

Patients can choose their own doctors.



Primary Care



Family Planning



Dental



Rx Drug



Mental Health



Vision

HMIS Data Entry

Data Element 4.4: Health Insurance

Covered by Health Insurance:	Yes
Medicaid/MediCal:	No
Medicare:	No
State Children's Health Insurance Program (CHIP):	No
Veteran's Administration (VA) Medical Services:	No
Health Insurance obtained through COBRA:	Ask
Private Pay Health Insurance:	Yes
Employer-Provided Health Insurance:	Ask
State Health Insurance for Adults:	No

For More Info

Program information – including card design, benefits, and eligibility criteria – are subject to change. Use the contacts below to find the most up-to-date information.

Quotes: (888) 626-6780
TTY: (800) 241-1823
Customer Service: (800) 393-6130

<https://www.blueshieldca.com/bsca/find-a-plan/home.sp>

Blue Shield of CA Bronze PPO

A private non-profit medical plan available through Covered California

FRONT OF CARD



BACK OF CARD



Program Eligibility & Cost

Anyone living in California who doesn't have health insurance through an employer can sign up for this plan through Covered California.

The website shows inconsistent cost information. Some versions of the summary of benefits say that the first 3 visits per year of primary care or urgent care are exempt from the deductible, although there are still copays ranging from \$70 - \$120 / visit. Other versions say that X-Rays, ER visits, and Hospital visits are free. Most services are subject to a \$6,000/year deductible.

Program Benefits

This plan provides some coverage for most services, including mental health care, abortions, prenatal care, hospital stays, routine pediatric vision and dental, and prescription drugs.

Hearing aids, weight loss treatment, and adult dental/vision are not covered.

Patients can choose their own doctors.



Primary Care



Family Planning



Dental



Rx Drug



Mental Health



Vision

HMIS Data Entry

Data Element 4.4: Health Insurance

Covered by Health Insurance:	Yes
Medicaid/MediCal:	No
Medicare:	No
State Children's Health Insurance Program (CHIP):	No
Veteran's Administration (VA) Medical Services:	No
Health Insurance obtained through COBRA:	Ask
Private Pay Health Insurance:	Yes
Employer-Provided Health Insurance:	Ask
State Health Insurance for Adults:	No

For More Info

Program information – including card design, benefits, and eligibility criteria – are subject to change. Use the contacts below to find the most up-to-date information.

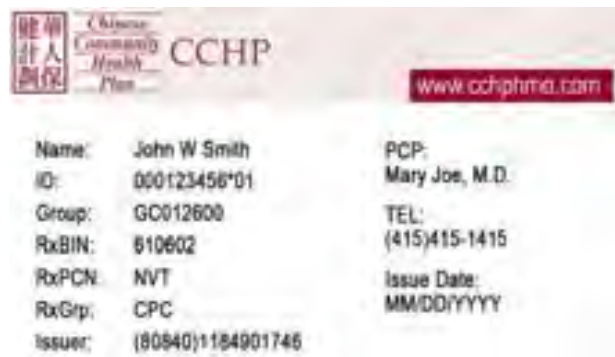
Quotes: (888) 626-6780
TTY: (800) 241-1823
Customer Service: (800) 393-6130

<https://www.blueshieldca.com/bsca/find-a-plan/home.sp>

CCHP Bronze 60 / Minimum HMO

Chinese Community Health Plan’s commercial offerings for Covered California

FRONT OF CARD



WITH COVERED CALIFORNIA LOGO



Program Eligibility & Cost

The Chinese Community Health Plan (CCHP) is local to San Francisco, and is primarily known for its programs for senior citizens. However, it also offers Bronze 60 and Minimum Coverage HMO plans to the general public through Covered California.

Anyone living in California who doesn’t have health insurance through an employer can sign up for this plan through Covered California, even if they have no Chinese heritage.

Program Benefits

These plans offer limited value for low-income patients, because they have a \$6,000 annual deductible and require the patient to handle either high co-pays (\$70 for primary care under the Bronze plan) or the entire cost of the service (Minimum Coverage HMO) until the deductible has been met. However, they do provide free preventative care, and free dental and vision care for minors. There is also a \$500 out-of-pocket maximum on prescription drugs.



Primary Care



Family Planning



Dental



Rx Drug



Mental Health



Vision

HMIS Data Entry

Data Element 4.4: Health Insurance

Covered by Health Insurance:	Yes
Medicaid/MediCal:	No
Medicare:	No
State Children’s Health Insurance Program (CHIP):	No
Veteran’s Administration (VA) Medical Services:	No
Health Insurance obtained through COBRA:	No
Private Pay Health Insurance:	Yes
Employer-Provided Health Insurance:	Ask
State Health Insurance for Adults:	No

For More Info

Program information – including card design, benefits, and eligibility criteria – are subject to change. use the contacts below to find the most up-to-date information.

Member Services: (888)-755-7888
English TTY: (877) 681-8898
Chinese TTY: (877) 681-8898
English Sales: (888) 681-3888
Chinese Sales: (415) 834-2118
Available Mon - Sat, 8:30 a.m. to 5:00 p.m.
<http://www.cchphealthplan.com>

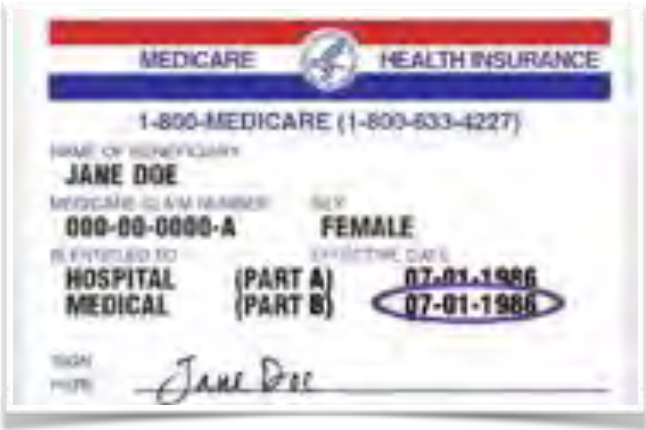
CCHP Senior Program HMO

Chinese Community Health Plan’s offering through Medicare Advantage

MEDICARE ID CARD

AND

CCHP ID CARD



Program Eligibility & Cost

This plan is only available to senior citizens, i.e., to people over 65 years of age. The CCHP Senior Program is an alternative to traditional Medicare.

The premium is \$46 per month, and dental insurance is available for an additional \$16 per month. The out-of-pocket maximum is \$3,400/year. This is a fairly typical Medicare Advantage plan that will be attractive to Chinese-speaking seniors.

Program Benefits

The plan includes coverage for primary care, eyeglasses, skilled nursing, lab work, and prescription drugs, with moderate co-pays (\$15 for doctor office visits, \$3 for preferred generic drugs, \$195 for outpatient surgery).



Primary Care



Family Planning



Dental



Rx Drug



Mental Health



Vision

HMIS Data Entry

Data Element 4.4: Health Insurance

Covered by Health Insurance:	Yes
Medicaid/MediCal:	No
Medicare:	Yes
State Children’s Health Insurance Program (CHIP):	No
Veteran’s Administration (VA) Medical Services:	No
Health Insurance obtained through COBRA:	No
Private Pay Health Insurance:	No
Employer-Provided Health Insurance:	No
State Health Insurance for Adults:	No

For More Info

Program information – including card design, benefits, and eligibility criteria – are subject to change. use the contacts below to find the most up-to-date information.

Member Services: (888)-755-7888
English TTY: (877) 681-8898
Chinese TTY: (877) 681-8898
English Sales: (888) 681-3888
Chinese Sales: (415) 834-2118
Available Mon - Sat, 8:30 a.m. to 5:00 p.m.
<http://www.cchphealthplan.com>

CCHP Senior Select HMO SNP

Chinese Community Health Plan’s Medicare + Medicaid combination package

CALIFORNIA ID CARD

AND

CCHP ID CARD



Program Eligibility & Cost

This plan is only available to people who qualify for **both** Medicare **and** Medi-Cal, i.e., to people over age 65 who have little or no income.

The plan offers an attractive package of services for between \$0 and \$14 per month.

Participants must present both a State of California BIC and a CHHP ID card to receive services.

Program Benefits

Benefits include primary care, diagnostics, ambulance, transportation to and from the doctor’s office, skilled nursing, durable medical equipment, dialysis, acupuncture, mental health care, eye exams, and eyeglasses.

Prescription drugs are available for a modest co-pay (typically \$3-\$7 per bottle).



Primary Care



Family Planning



Dental



Rx Drug



Mental Health



Vision

HMIS Data Entry

Data Element 4.4: Health Insurance

Covered by Health Insurance:	Yes
Medicaid/MediCal:	Yes
Medicare:	Yes
State Children’s Health Insurance Program (CHIP):	No
Veteran’s Administration (VA) Medical Services:	No
Health Insurance obtained through COBRA:	No
Private Pay Health Insurance:	No
Employer-Provided Health Insurance:	No
State Health Insurance for Adults:	No

For More Info

Program information – including card design, benefits, and eligibility criteria – are subject to change. Use the contacts below to find the most up-to-date information.

Member Services: (888)-755-7888
English TTY: (877) 681-8898
Chinese TTY: (877) 681-8898
English Sales: (888) 681-3888
Chinese Sales: (415) 834-2118
Available Mon - Sat, 8:30 a.m. to 5:00 p.m.
<http://www.cchphealthplan.com>

Family Mosaic Project

A specialty health plan for Medi-Cal managed care

DEPARTMENT LOGO



Program Eligibility & Cost

This plan is only available to emotionally disturbed children age 17 and younger who qualify for Medi-Cal based on low-income and/or medical need.

To qualify, the child must be involved with at least two public systems (School District, Juvenile Probation, Human Services, Community Behavioral Health) and be at risk of out-of-home placement or be returning from outside placement.

The program is offered only in the Bayview, Mission, and Chinatown neighborhoods.

Program Benefits

Benefits include intensive care management and wraparound behavioral care services for emotionally disturbed children and their families.

The program is sponsored by the San Francisco Department of Public Health, and does not maintain its own website.



Primary Care



Family Planning



Dental



Rx Drug



Mental Health



Vision

HMIS Data Entry

Data Element 4.4: Health Insurance

Covered by Health Insurance:	Ask
Medicaid/MediCal:	Yes
Medicare:	No
State Children’s Health Insurance Program (CHIP):	Ask
Veteran’s Administration (VA) Medical Services:	No
Health Insurance obtained through COBRA:	No
Private Pay Health Insurance:	No
Employer-Provided Health Insurance:	No
State Health Insurance for Adults:	No

For More Info

Program information – including card design, benefits, and eligibility criteria – are subject to change. use the contacts below to find the most up-to-date information.

Call (415) 206-7600
E-mail janet.Avila@sfdph.org or ali.Gilak@sfdph.org
Located at 1309 Evans Street, San Francisco, CA 94124.

Available Mon - Fri, 8:30 a.m. to 5:00 p.m.

HealthNet Bronze 60 EPO

A private medical plan available through Covered California

FRONT OF CARD



BACK OF CARD



Program Eligibility & Cost

Anyone living in California who doesn't have health insurance through an employer can sign up for this plan through Covered California.

The plan has a somewhat lower deductible (\$5,000) and higher co-pays (\$60 for office visits, 30% for inpatient mental health care) as compared to other Bronze plans on the market.

Low-income patients may qualify for subsidies for this plan under Covered California.

Program Benefits

HealthNet Bronze 60 EPO is an "exclusive provider organization." Unlike an HMO, the plan does not require patients to get a referral before seeing a specialist, but patients must still stay within a network of designated providers.

Like other Bronze plans, it provides some coverage for primary care, hospitalization, and prescription drugs, with free preventative care and free basic vision and dental services for minors.



Primary Care



Family Planning



Dental



Rx Drug



Mental Health



Vision

HMIS Data Entry

Data Element 4.4: Health Insurance

Covered by Health Insurance:	Yes
Medicaid/MediCal:	No
Medicare:	No
State Children's Health Insurance Program (CHIP):	No
Veteran's Administration (VA) Medical Services:	No
Health Insurance obtained through COBRA:	Ask
Private Pay Health Insurance:	Yes
Employer-Provided Health Insurance:	Ask
State Health Insurance for Adults:	No

For More Info

Program information – including card design, benefits, and eligibility criteria – are subject to change. use the contacts below to find the most up-to-date information.

Customer Service: (888) 926-4988
Sales: (877) 527-8409
TTY: (888) 926-5180
Phone service available:
8 am - 8 pm, Mon - Fri

<https://www.healthnet.com>

HealthNet Ruby Select HMO

A Medicare Advantage plan with coverage for Parts A, B, and D

FRONT OF CARD



BACK OF CARD



Program Eligibility & Cost

This plan is only available for senior citizens, i.e., people over the age of 65.

The plan has **no** monthly premium. Instead, co-pays are somewhat higher as compared to Medicare Original. In particular, mental health care has co-pays starting at \$25 for a single outpatient visit, with costs increasing for inpatient mental health care.

The plan provides 20 days of free skilled nursing care, and then charges \$75/day.

Program Benefits

The plan includes coverage for prescription drugs as well as primary care, hospital care, skilled nursing care, and some preventative services.

Optional add-on packages of vision and dental are available for a total of about \$50/month.



Primary Care



Family Planning



Dental



Rx Drug



Mental Health



Vision

HMIS Data Entry

Data Element 4.4: Health Insurance

Covered by Health Insurance:	Yes
Medicaid/MediCal:	No
Medicare:	Yes
State Children's Health Insurance Program (CHIP):	No
Veteran's Administration (VA) Medical Services:	No
Health Insurance obtained through COBRA:	No
Private Pay Health Insurance:	No
Employer-Provided Health Insurance:	No
State Health Insurance for Adults:	No

For More Info

Program information – including card design, benefits, and eligibility criteria – are subject to change. Use the contacts below to find the most up-to-date information.

Members: (800) 275-4737 [TTY: 711]
Non-Members: (800) 977-6738 [TTY: 711]
Phone service available:
8 am - 8 pm, 7 days/week

<http://www.AARPMedicareRx.com>

Humana Wal-Mart Rx Plan

A Part D prescription drug plan to add on to Medicare

FRONT OF CARD



BACK OF CARD



Program Eligibility & Cost

This plan is only available for senior citizens, i.e., people over the age of 65.

The premiums are relatively affordable at \$18 / month, and co-pays can drop as low as \$1 for generic drugs, or even \$0 on mail-order generics.

However, patients must use a Wal-Mart or Sam's Club pharmacy when buying drugs, or else they will pay higher prices.

Program Benefits

Humana Wal-Mart Rx Plan complements Medicare by paying most of the cost of certain prescription drugs (mostly generics) when purchased from in-network pharmacies.



Primary Care



Family Planning



Dental



Rx Drug



Mental Health



Vision

HMIS Data Entry

Data Element 4.4: Health Insurance

Covered by Health Insurance:	Ask
Medicaid/MediCal:	No
Medicare:	Yes
State Children's Health Insurance Program (CHIP):	No
Veteran's Administration (VA) Medical Services:	No
Health Insurance obtained through COBRA:	No
Private Pay Health Insurance:	No
Employer-Provided Health Insurance:	No
State Health Insurance for Adults:	No

For More Info

Program information – including card design, benefits, and eligibility criteria – are subject to change. use the contacts below to find the most up-to-date information.

Plan Questions: (866) 945-4481
Phone service available:
8 am - 8 pm, 7 days/week

<https://www.humana.com/medicare/products-and-services/drug-plan/2016-walmart-rx>

Kaiser Permanente HMO/CC

A private HMO plan available through Covered California.

FRONT OF CARD



BACK OF CARD



Program Eligibility & Cost

Anyone living in California who doesn't have health insurance through an employer can sign up for this plan through Covered California.

The Bronze 5000/60 plan offered through Covered California includes three free visits for primary care, urgent care, and/or substance abuse counseling, one free post-natal visit, and unlimited free preventative care, prenatal care, and immunization. Visits outside the annual limits have a co-pay of \$60 each.

Program Benefits

Kaiser Permanente is a major HMO (health care management organization) that provides a variety of primary care services to members at centralized locations (see Eligibility & Cost, on the left, for details).

Care is coordinated through a designated primary care physician, who must authorize most other types of visits, as well as through an electronic medical records system.



Primary Care



Family Planning



Dental



Rx Drug



Mental Health



Vision

HMIS Data Entry

Data Element 4.4: Health Insurance

Covered by Health Insurance:	Yes
Medicaid/MediCal:	No
Medicare:	No
State Children's Health Insurance Program (CHIP):	No
Veteran's Administration (VA) Medical Services:	No
Health Insurance obtained through COBRA:	No
Private Pay Health Insurance:	Yes
Employer-Provided Health Insurance:	Ask
State Health Insurance for Adults:	No

For More Info

Program information – including card design, benefits, and eligibility criteria – are subject to change. Use the contacts below to find the most up-to-date information.

New Member Orientation: (415) 833-2562

Plan Selection: (800) 488-3590 TTY: 711

<https://thrive.kaiserpermanente.org/care-near-you/northern-california/sanfrancisco/>

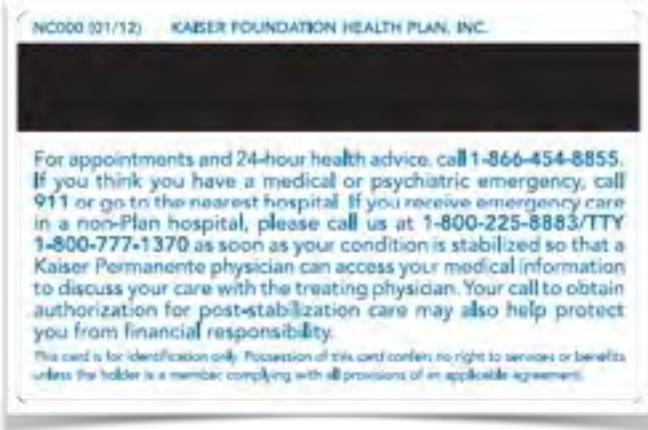
Kaiser Permanente HSA/CC

A private health savings account plan available through Covered California

FRONT OF CARD



BACK OF CARD



Program Eligibility & Cost

Anyone living in California who doesn't have health insurance through an employer can sign up for this plan through Covered California.

The plan has a \$4,500 deductible and 40% co-insurance charges for all services except preventative care, which is free. Members of this plan can make tax-free deposits to a special "health savings account."

Most low-income clients would be better served by Kaiser's traditional HMO plan.

Program Benefits

Kaiser Permanente is an HMO that provides a variety of primary care services, but only at centralized Kaiser locations with Kaiser doctors.

Care is coordinated through a designated primary care physician, who must authorize most other types of visits, as well as through an electronic medical records system.

Hearing aids, private-duty nursing, and weight loss programs are not covered.



Primary Care



Family Planning



Dental



Rx Drug



Mental Health



Vision

HMIS Data Entry

Data Element 4.4: Health Insurance

Covered by Health Insurance:	Yes
Medicaid/MediCal:	No
Medicare:	No
State Children's Health Insurance Program (CHIP):	No
Veteran's Administration (VA) Medical Services:	No
Health Insurance obtained through COBRA:	No
Private Pay Health Insurance:	Yes
Employer-Provided Health Insurance:	Ask
State Health Insurance for Adults:	No

For More Info

Program information – including card design, benefits, and eligibility criteria – are subject to change. Use the contacts below to find the most up-to-date information.

New Member Orientation: (415) 833-2562

Plan Selection: (800) 488-3590 TTY: 711

<https://thrive.kaiserpermanente.org/care-near-you/northern-california/sanfrancisco/>

On Lok Lifeways (PACE)

An all-inclusive plan for ill or disabled seniors funded by Medicaid or Medicare.

LOGO



Program Eligibility & Cost

This program is for senior citizens who are ill or disabled, but who have some ability to move around and who do not need around-the-clock skilled nursing care.

The program is entirely funded by a senior’s Medicare and/or Medicaid benefits. The catch is that participants must use the program exclusively, giving up their other doctors.

Program Benefits

On Lok Lifeways Program of All-inclusive Care for the Elderly allows seniors who are ill or disabled to live in their own home or hotel room while making several visits to a Lifeways Center each week. At the Center, participants have access to medical care, physical therapy, social activities, exercise, and meals customized for their dietary needs.

Lifeways provides a van for transporting program participants to the Center, as well as home care assistants to offer occasional help with shaving, dressing, organizing medicine, and basic shopping and errands.



Primary Care



Family Planning



Dental



Rx Drug



Mental Health



Vision

HMIS Data Entry

Data Element 4.4: Health Insurance

Covered by Health Insurance:	Yes
Medicaid/MediCal:	Ask
Medicare:	Ask
State Children’s Health Insurance Program (CHIP):	No
Veteran’s Administration (VA) Medical Services:	No
Health Insurance obtained through COBRA:	No
Private Pay Health Insurance:	No
Employer-Provided Health Insurance:	No
State Health Insurance for Adults:	No

For More Info

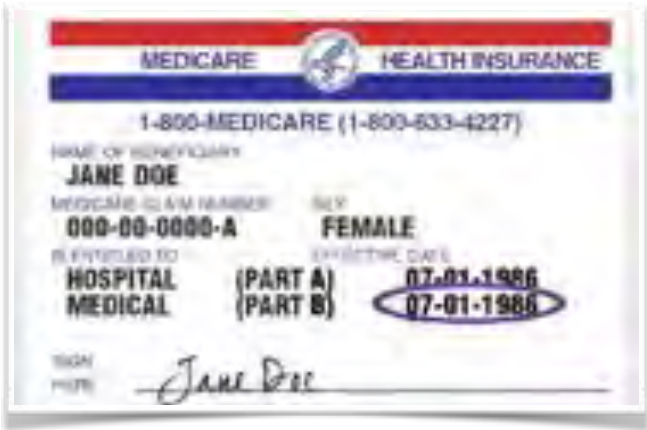
Program information – including card design, benefits, and eligibility criteria – are subject to change. use the contacts below to find the most up-to-date information.

Enrollment: (888) 886-6565
TDD/TYY: (415) 292-8898
Customer Service: (415) 292-8796
Available Monday - Friday
from 8:00 am to 4:30 pm
<http://www.onlok.org/Who-We-Serve/FAQs>

Original Medicare (Parts A+B)

A government health care plan for elderly people.

FRONT OF CARD



BACK OF CARD



Program Eligibility & Cost

This plan is only available for senior citizens, i.e., people over the age of 65.

Patients typically pay 20% of the cost of the treatment, which is set at a relatively low rate by the government and provided by any doctor who is willing to accept the lower rates. Prescription drugs are available only 'on-site', i.e., at an inpatient or outpatient clinic. Drugs that a patient would take home herself from a pharmacy require a Medicare Part D Supplemental plan.

Program Benefits

Medicare Original (Parts A and B) covers primary care, hospital visits, mental health care, prosthetics, dialysis, preventative care and a very limited array of peripheral services, such as eyeglasses for people who have had cataract surgery, dental care that doesn't relate to teeth, and chiropractic care for subluxation only.



Primary Care



Family Planning



Dental



Rx Drug



Mental Health



Vision

HMIS Data Entry

Data Element 4.4: Health Insurance

Covered by Health Insurance:	Yes
Medicaid/MediCal:	No
Medicare:	Yes
State Children's Health Insurance Program (CHIP):	No
Veteran's Administration (VA) Medical Services:	No
Health Insurance obtained through COBRA:	No
Private Pay Health Insurance:	No
Employer-Provided Health Insurance:	No
State Health Insurance for Adults:	No

For More Info

Program information – including card design, benefits, and eligibility criteria – are subject to change. Use the contacts below to find the most up-to-date information.

Insurance Counseling: (800) 434-0222
Order a Booklet: (800) 633-4227
ID Card Replacement: (800) 772-1213
(7 am - 7 pm)

<http://www.medicare.gov/index.html>

San Francisco Health Plan

A community plan offering full coverage under California’s Medicaid program.

FRONT OF CARD



Program Eligibility & Cost

This program is only available for **families** who **live in San Francisco** with low or moderate income. Eligibility depends on annual income, age, family size, and residence in San Francisco.

More information about how to apply is available at <http://healthysanfrancisco.org/visitors/how-do-i-apply/>.

SFHP provides services via Medi-Cal, Healthy Kids, and Healthy Workers.

Program Benefits

Services through Medi-Cal include doctor visits, glasses, eye exams, hospital & ER care, prescription drugs, regular checkups and immunizations, ob/gyn services, family planning, substance abuse programs, dental care, health classes, specialty care, mental health programs, and a 24/7 nurse phone line.



Primary Care



Family Planning



Dental



Rx Drug



Mental Health



Vision

HMIS Data Entry

Data Element 4.4: Health Insurance

Covered by Health Insurance:	Yes
Medicaid/MediCal:	Yes
Medicare:	No
State Children’s Health Insurance Program (CHIP):	No
Veteran’s Administration (VA) Medical Services:	No
Health Insurance obtained through COBRA:	No
Private Pay Health Insurance:	No
Employer-Provided Health Insurance:	No
State Health Insurance for Adults:	No

For More Info

Program information – including card design, benefits, and eligibility criteria – are subject to change. use the contacts below to find the most up-to-date information.

Enrollment: (415) 777-9992
Customer Service: (800) 288-5555
TDD/TYY: (888) 883-7347
Available Monday - Friday
from 8:30 am to 5:30 pm

<http://www.sfhp.org/visitors/medi-cal/>

Silverscript Choice PDP

A Part D prescription drug plan to add on to Medicare

FRONT OF CARD



BACK OF CARD



Program Eligibility & Cost

This plan is only available for senior citizens, i.e., people over the age of 65. Premiums cost about \$23 / month.

Drugs are grouped into five ‘tiers’, ranging from “Preferred Generic” to “Specialty.” Costs can be as low as \$7.50 for a 3-month supply of a preferred generic drug. The Medicare ‘donut hole’ will apply when patients try to spend between \$3,310 and \$4,850 per year (including both co-pays and insurance reimbursements) on drug costs, increasing the cost borne by the patient.

Program Benefits

Silverscript Choice PDP complements Medicare Parts A + B by paying most of the cost of certain prescription drugs (mostly generics) when purchased from in-network pharmacies.



Primary Care



Family Planning



Dental



Rx Drug



Mental Health



Vision

HMIS Data Entry

Data Element 4.4: Health Insurance

Covered by Health Insurance:	Ask
Medicaid/MediCal:	No
Medicare:	Yes
State Children’s Health Insurance Program (CHIP):	No
Veteran’s Administration (VA) Medical Services:	No
Health Insurance obtained through COBRA:	No
Private Pay Health Insurance:	No
Employer-Provided Health Insurance:	No
State Health Insurance for Adults:	No

For More Info

Program information – including card design, benefits, and eligibility criteria – are subject to change. use the contacts below to find the most up-to-date information.

Members: (866) 235-5660 [TTY: 711]
Non-Members: (866) 235-5660 [TTY: 711]
Phone numbers are open 24/7.

<http://www.silverscript.com>

Sutter Health Plus HMO/CC

A private, nonprofit HMO plan covering northern and central California

FRONT
OF
CARD



BACK
OF
CARD



Program Eligibility & Cost

Sutter Health Plus is most commonly offered through a patient’s employer. There is no guaranteed public access to Sutter Health Plus.

Sutter Health does not directly participate in Covered California, but most of the individual Sutter facilities and doctors participate in the Covered California plans run by Blue Shield, CCHP, Anthem Blue Cross, and United HealthCare.

Program Benefits

Sutter Health Plus is a regional HMO that provides hospitalization, outpatient services, prescription drug coverage, pregnancy care, and free preventative health care to members at centralized locations. Patients can choose from traditional co-pay plans, deductible plans, and high-deductible plans. Dental and mental health services can be added to the plan for an additional monthly fee.



Primary Care



Family Planning



Dental



Rx Drug



Mental Health



Vision

HMIS Data Entry

Data Element 4.4: Health Insurance

Covered by Health Insurance:	Yes
Medicaid/MediCal:	No
Medicare:	No
State Children’s Health Insurance Program (CHIP):	No
Veteran’s Administration (VA) Medical Services:	No
Health Insurance obtained through COBRA:	Ask
Private Pay Health Insurance:	Yes
Employer-Provided Health Insurance:	Ask
State Health Insurance for Adults:	No

For More Info

Program information – including card design, benefits, and eligibility criteria – are subject to change. use the contacts below to find the most up-to-date information.

Account Services: (855) 325-5200
Plan Selection: (855) 320-2350

<http://www.suttterhealthplus.org>

Office Hours: Mon-Fri, 8 am to 5 pm.

Veteran Health ID Card

Used for identification and check-in at VA health centers only



Program Eligibility & Cost

This plan is only available for veterans of the United States Armed Forces.

Veterans must first apply for benefits, and will be assigned to one of eight 'Priority Groups' based on the extent of their service, income, and/or disabilities in order to determine what services will be provided for free, provided with co-pays, or not provided at all.

Program Benefits

The federal Veterans' Administration offers direct, comprehensive medical and mental health services to veterans at their centers by appointment, or on a walk-in basis for urgent care.

Dental care (and eyeglasses) may be available to homeless veterans if needed to assist a job search or because of a medical condition associated with military service. Abortion and gender surgery are not covered.



Primary Care



Family Planning



Dental



Rx Drug



Mental Health



Vision

HMIS Data Entry

Data Element 4.4: Health Insurance

Covered by Health Insurance:	Yes
Medicaid/MediCal:	No
Medicare:	No
State Children's Health Insurance Program (CHIP):	No
Veteran's Administration (VA) Medical Services:	Yes
Health Insurance obtained through COBRA:	No
Private Pay Health Insurance:	No
Employer-Provided Health Insurance:	No
State Health Insurance for Adults:	No

For More Info

Program information – including card design, benefits, and eligibility criteria – are subject to change. use the contacts below to find the most up-to-date information.

Enrollment & Benefits (877) 222-8387
Homeless Vets: (877) 424-3838

Available Monday - Friday
from 8 a.m. - 8 p.m. **Eastern** Time

<http://www.va.gov/healthbenefits/apply/>

MAKING A HEALTH INSURANCE BENEFITS DECODER

What is a Benefits Decoder?

- A pocket reference to help line workers easily identify, understand, and take advantage of their clients' healthcare coverage and benefits
- A tool for improving both data quality and service delivery
- Part of the H2 Healthcare and Housing Data Enhancement Initiative

Summary

The Benefits Decoder is a tool to help case workers quickly and accurately:

- Evaluate the scope of their clients' current health care coverage
- Determine which health care plans their clients are eligible for
- Recommend health insurance plans that meet their clients' financial and medical needs
- Enter data about their clients' health insurance into an HMIS database.

By combining photos of health insurance ID cards with icons that summarize the scope of coverage and HMIS "Answer Keys" that explain how to code any given plan in HMIS, the Benefits Decoder elevates health insurance counseling from guesswork to proper social work. The Decoder is available online, as a legal-sized booklet, and as a single-page poster.

HUD's H² Initiative on APR Data Collection Tools and Materials funded a pilot project for the Health Insurance Benefits Decoder in San Francisco, CA, Albuquerque, NM, and Shasta County, CA. This instructional pamphlet explains how the Pilot Projects were created, and how you can create your own Decoder for your local community.

San Francisco Health Insurance Benefits Decoder

Excerpted examples from the San Francisco Health Insurance Benefits Decoder follow on page 2-3 of this guide. To view the San Francisco Health Insurance Benefits Decoder in its entirety, please visit the HomeBase website under the Resources tab:

http://homebaseccc.org/hb/application/files/6714/6257/8127/Compressed_SF_Benefits_Decoder.pdf

AARP UnitedHealth Rx Plan

A Part D prescription drug plan to add on to Medicare

FRONT OF CARD



BACK OF CARD



Program Eligibility & Cost

This plan is only available for senior citizens, i.e., people over the age of 65.

AARP UnitedHealthCare Rx Plan is a relatively affordable prescription drug plan (with premiums of about \$31 / month). Co-pays can drop as low as \$1 for generic drugs, or even \$0 on mail-order generics, but patients gave the plan low ratings for “high risk medication” and “medication therapy management services.”

Program Benefits

This is a Medicare Part D prescription-drug plan only. It covers most types of generic pills, creams, and injectables when purchased from in-network pharmacies, but does not cover doctors, nurses, or physical therapy. Medicare Part D is meant to go alongside a general-purpose health insurance policy like Medicare Parts A+B.



Primary Care



Family Planning



Dental



Rx Drug



Mental Health



Vision

HMIS Data Entry

Data Element 4.4: Health Insurance

Covered by Health Insurance:	Ask
Medicaid/MediCal:	No
Medicare:	Yes
State Children’s Health Insurance Program (CHIP):	No
Veteran’s Administration (VA) Medical Services:	No
Health Insurance obtained through COBRA:	No
Private Pay Health Insurance:	No
Employer-Provided Health Insurance:	No
State Health Insurance for Adults:	No

For More Info

Program information – including card design, benefits, and eligibility criteria – are subject to change. use the contacts below to find the most up-to-date information.

Members: (866) 460-8854
Non-Members: (888) 867-5564
Phone service available 8 am - 8 pm,
7 days/week

<http://www.AARPMedicareRx.com>

Kaiser Permanente HMO/CC

A private HMO plan available through Covered California.

FRONT OF CARD



BACK OF CARD



Program Eligibility & Cost

Anyone living in California who doesn't have health insurance through an employer can sign up for this plan through Covered California.

The Bronze 5000/60 plan offered through Covered California includes three free visits for primary care, urgent care, and/or substance abuse counseling, one free post-natal visit, and unlimited free preventative care, prenatal care, and immunization. Visits outside the annual limits have a co-pay of \$60 each.

Program Benefits

Kaiser Permanente is a major HMO (health care management organization) that provides a variety of primary care services to members at centralized locations (see Eligibility & Cost, on the left, for details).

Care is coordinated through a designated primary care physician, who must authorize most other types of visits, as well as through an electronic medical records system.



Primary Care



Family Planning



Dental



Rx Drug



Mental Health



Vision

HMIS Data Entry

Data Element 4.4: Health Insurance

Covered by Health Insurance:	Yes
Medicaid/MediCal:	No
Medicare:	No
State Children's Health Insurance Program (CHIP):	No
Veteran's Administration (VA) Medical Services:	No
Health Insurance obtained through COBRA:	No
Private Pay Health Insurance:	Yes
Employer-Provided Health Insurance:	Ask
State Health Insurance for Adults:	No

For More Info

Program information – including card design, benefits, and eligibility criteria – are subject to change. Use the contacts below to find the most up-to-date information.

New Member Orientation: (415) 833-2562

Plan Selection: (800) 488-3590 TTY: 711

<https://thrive.kaiserpermanente.org/care-near-you/northern-california/sanfrancisco/>

Veteran Health ID Card

Used for identification and check-in at VA health centers only



Program Eligibility & Cost

This plan is only available for veterans of the United States Armed Forces.

Veterans must first apply for benefits, and will be assigned to one of eight 'Priority Groups' based on the extent of their service, income, and/or disabilities in order to determine what services will be provided for free, provided with co-pays, or not provided at all.

Program Benefits

The federal Veterans' Administration offers direct, comprehensive medical and mental health services to veterans at their centers by appointment, or on a walk-in basis for urgent care.

Dental care (and eyeglasses) may be available to homeless veterans if needed to assist a job search or because of a medical condition associated with military service. Abortion and gender surgery are not covered.



Primary Care



Family Planning



Dental



Rx Drug



Mental Health



Vision

HMIS Data Entry

Data Element 4.4: Health Insurance

Covered by Health Insurance:	Yes
Medicaid/MediCal:	No
Medicare:	No
State Children's Health Insurance Program (CHIP):	No
Veteran's Administration (VA) Medical Services:	Yes
Health Insurance obtained through COBRA:	No
Private Pay Health Insurance:	No
Employer-Provided Health Insurance:	No
State Health Insurance for Adults:	No

For More Info

Program information – including card design, benefits, and eligibility criteria – are subject to change. use the contacts below to find the most up-to-date information.

Enrollment & Benefits (877) 222-8387
Homeless Vets: (877) 424-3838

Available Monday - Friday
from 8 a.m. - 8 p.m. **Eastern** Time

<http://www.va.gov/healthbenefits/apply/>

HOW TO CREATE A DECODER IN YOUR COMMUNITY

Step 1: Identify the Low-Income Health Plans

Any community will have a few predictable sources of health plans that are accessible to people with low income. The most obvious sources are Medicare, Medicaid, the Affordable Care Act, and the Veterans' Administration.

Medicare

Medicare provides health insurance for people over 65 years of age. Medicare is available in "Original" form (also called Parts A + B), in the alternative "Medicare Advantage" form (Part C), and as a stand-alone Prescription Drug benefit (Part D). Original Medicare is available in all 50 states and should always be included in a Benefits Decoder. Medicare Advantage is a public-private partnership that allows private health care companies to offer comprehensive health insurance plans to Medicare beneficiaries, with slight modifications that may allow the plans to earn a profit and/or provide a more appropriate collection of medical services to their particular clientele. Your community may have zero, one, or multiple Medicare Advantage plans, depending on its size and demographics. The Medicare Plan Finder, at <https://www.medicare.gov/find-a-plan/questions/home.aspx>, can help you find out which plans are available in your community. It is not necessary to include every single Medicare Advantage plan in your Decoder. Instead, you can sort the available plans by price, and choose the two or three lowest-cost plans.

Similarly, you can use the Medicare Plan Finder to find out which stand-alone prescription drug benefits are offered in your community, and then select one or two of those plans to include in your Decoder based on which plans have the lowest price. Try to strike a balance between plans with low monthly premiums, and plans with low co-pays. For example, if the plan with the lowest monthly premium has \$20 co-pays for generic drugs, it may be of limited use to homeless clients, and so you may want to choose another Part D plan to feature in your Decoder.

Medicaid

Medicaid provides health insurance for people who have low-income. In states that have accepted the Medicaid expansion as part of the Affordable Care Act, *anyone* who is earning less than 133% of the federal poverty line can be eligible for Medicaid, depending on the state's Medicaid Plan. In states that have rejected the Medicaid expansion, Medicaid eligibility is limited to low-income parents, low-income children, and low-income people who are suffering from a particular disease, like tuberculosis or HIV. For more information on Medicaid eligibility, read <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/eligibility.html> or search online for [Your State] Medicaid State Plan. For example, in New York, you would search for "New York Medicaid State Plan."

Some states provide Medicaid insurance directly, through a "fee-for-service" model. In a fee-for-service model, beneficiaries visit a doctor of their choice, and the doctors bill Medicaid for their services on an *a la carte* basis. If your county offers this option, you should include it in the Decoder. However, many counties either allow or require Medicaid

beneficiaries to join a type of managed care plan. Like the Medicare Advantage plans, these managed care plans are a public-private partnership that channels state and federal government benefits through local health care companies. Check your state's Department of Health Care Services, Department of Health and Human Services, and Department of Commerce for an index of which Medicaid plans are offered in your community.

Affordable Care Act

States that are participating in the Affordable Care Act will have an “exchange” or “marketplace” that offers one or more state-approved private health plans. The plans are guaranteed to offer a certain minimal level of coverage, and subsidies are often available to help low-income residents purchase coverage under those plans. You can look up your state's policies at <https://www.healthcare.gov/get-coverage/>.

Once you access your state's health care marketplace, try to evaluate the options available. If there are only two or three plans, you may as well include all of those plans in your Decoder. If there are several plans, then it probably makes more sense to sort the plans by “tier.” Each marketplace describes its health plans as belonging to the Bronze, Silver, Gold, or Platinum tier. The Bronze tier of plans have the lowest monthly premiums and are most likely to be affordable to the clients who would be served by a Benefits Decoder.

Step 2: Gather Information about the Low-Income Health Plans

Once you have a list of the plans you will feature in your Decoder, you need to gather five key pieces of information about each plan:

- a. Photographs of the plan's member ID cards,
- b. Information about who is eligible for the plan,
- c. Information about what services are covered under the plan,
- d. An estimate of how much major services will cost under the plan, and
- e. Contact information for people who want to ask a specific question about the plan.

Member ID Cards

Member ID cards are often available via a Google Images search; if you type in the name of the plan combined with “front of card” or “back of card,” many plans will have a publicly available image that you can use to help your readers quickly identify a plan by the photo of its ID card. If this does not work, you can try to find a copy of the plan's Explanation of Benefits or New Member Orientation Brochure, which may have photos of the card embedded in the document. After downloading the longer document, you can take a screenshot of the card and then paste the screenshot into your Decoder. When a plan requires multiple ID cards for participation (e.g., a State Medi-Cal ID card and a local health insurance card), try to obtain photos of both types of cards, so that case workers will know what kinds of cards their clients need in order to receive care.

Eligibility

Information about eligibility is usually available on an insurance company's website, which will offer a general description of the plan. Some plans are described using shorthand,

e.g., the plan is available to “middle-income families,” or the plan is available to seniors who are “eligible for Medicaid.” Where possible, research the exact definitions of these terms in your state, so that you can provide concrete, ready-to-use guidance to your busy case workers and front line staff.

Services Covered

Information about what services are covered by a plan is also usually available on an insurance company’s website. Summaries may also be available on your state’s Affordable Care Act marketplace or health care exchange. Coverage summaries may be vaguely worded - try to confirm your interpretation of major coverage provisions by reading multiple sources and comparing provisions across similar insurance policies.

Service Costs

Similarly, information about service costs is often available both under the insurance company’s website and from your state’s health insurance exchange. When assessing the costs of elements under the plan, it is not necessary to prepare a detailed budget. Instead, a sampling of prices for services that homeless clients are most likely to need, or for services that are most attractively priced, is sufficient. This allows the Decoder to be used to identify an affordable source for a particular service and/or to quickly give clients feedback on what kinds of services will be affordable based on their income.

Contact Information

Try to include multiple forms of contact information – including phone, web, e-mail, and options for hearing-assisted devices or multiple languages – for each plan in the Decoder. This provides clients and case workers with the ability to reach out to health plans with targeted questions about issues such as eligibility, service delivery, and service costs that may be relevant to the client.

Step 3: Assemble the Information into at least one Convenient Document

After you have adequately described all of the relevant information about your region’s health insurance plans, you will need to assemble that information into a convenient, easy-to-read format. Plans may be sorted alphabetically, by company, by funding source, or by another important characteristic. Whichever ordering system you use, be sure to include a table of contents, and, if appropriate, an index that lists all of the plans with various characteristics (e.g., available to seniors or including dental coverage).

Another useful technique to make the document accessible and easy to use is to develop icons that graphically indicate which major categories of services are included in a plan. For the San Francisco Pilot Project, six basic icons were used: primary care, mental health care, prescription drugs, family planning, vision, and dental. Icons were filled solid black for available services, and gray for services that are unavailable, available only for minors, or that require a significant monthly premium. Some plans offer only a handful of services in a category, or offer services only to certain types of clients, or only for the payment of a significant additional fee. Whenever possible, try to describe these exceptions in the text of the plan summary as well.

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