Housing – Healthcare Integration (H^2) Initiative

Lessons Learned

Implementation Planning and Structure

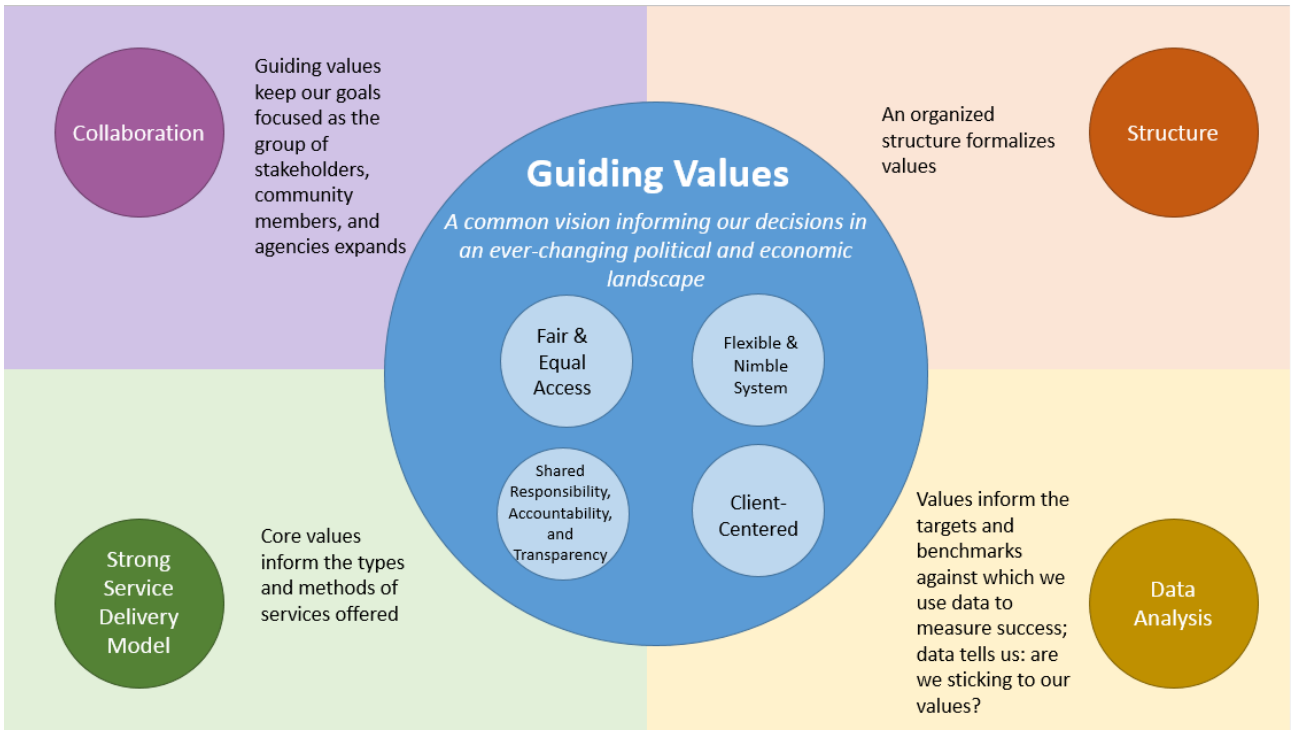
- Incorporate H^2 Leadership Team or plan element into existing state level structures, such as interagency councils or state plans
- Create work groups to focus on discrete plan sections or strategies
- Leverage large ongoing efforts, such as emerging Coordinated Assessment/Entry systems, by prioritizing H^2 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.

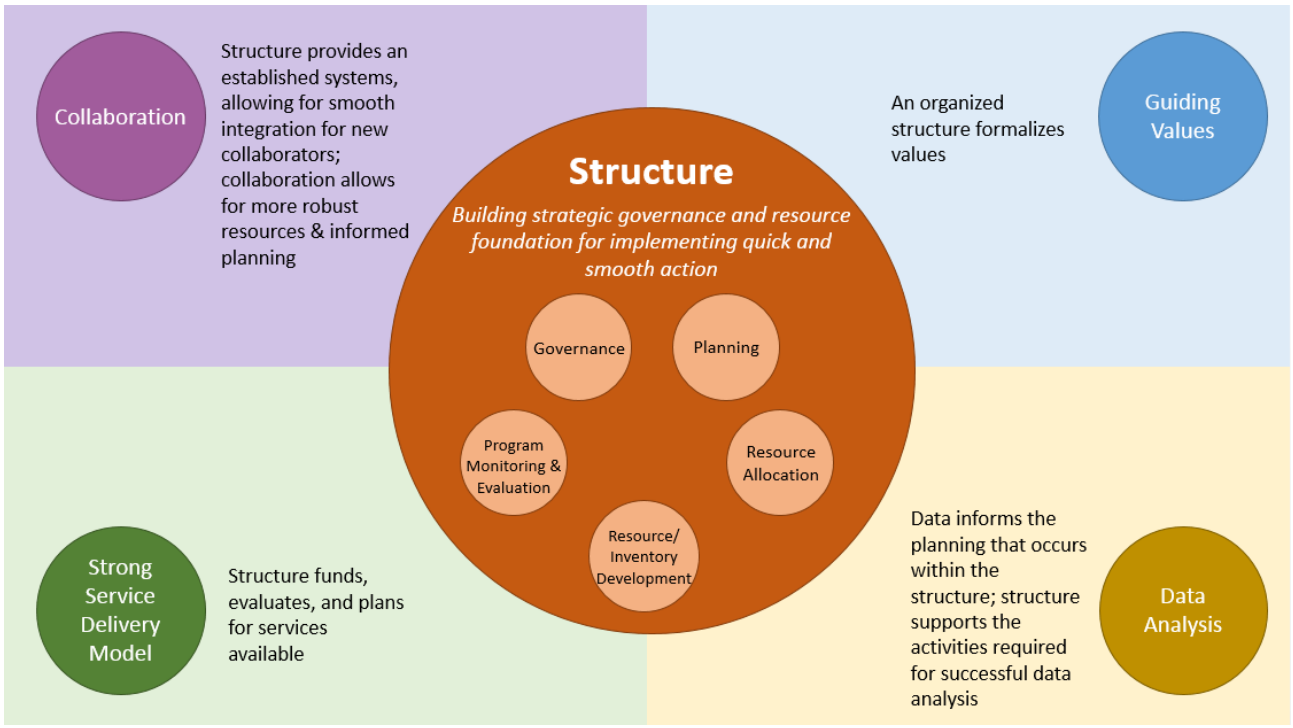
Facilitating Coordination Between Housing and Health Care Providers

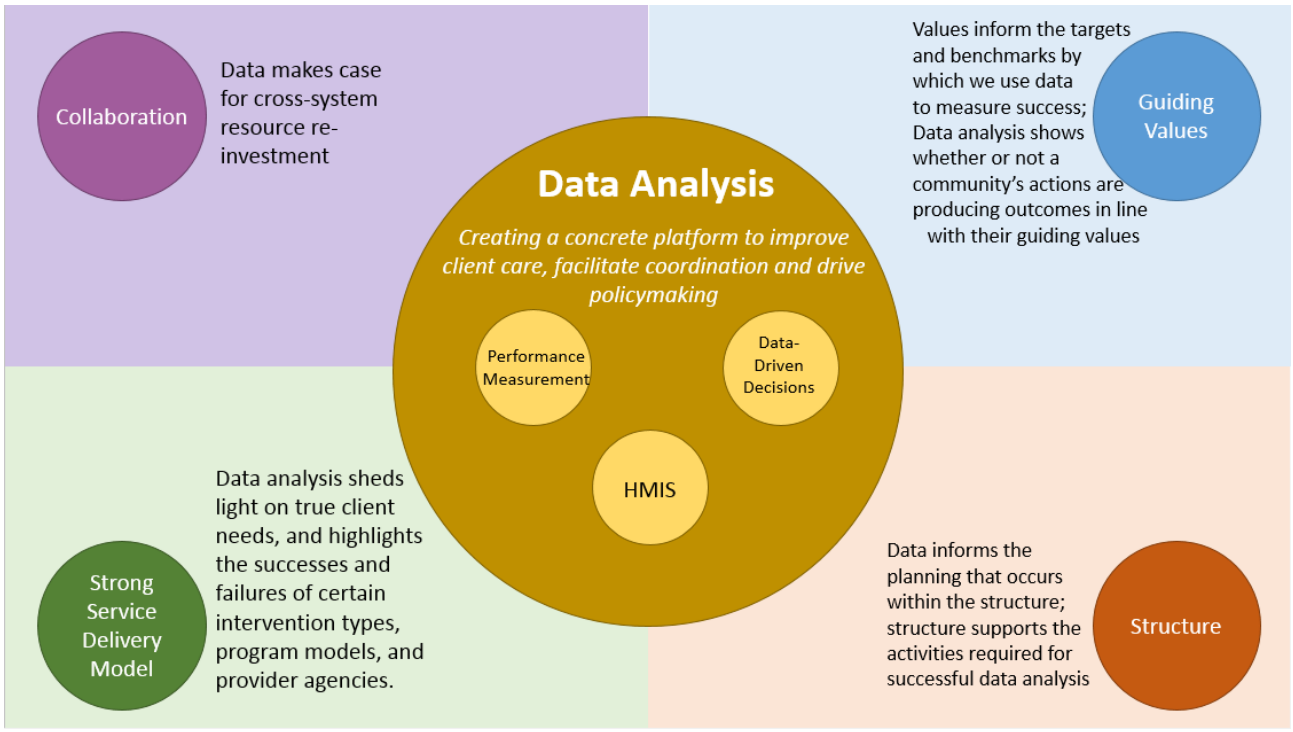
- Regular meetings with housing and health care (and other supportive services) providers, preferably building upon existing forums or coalition meetings. A portion of each meeting can be devoted to an in-depth conversation about a specific topic (e.g. Coordinated Entry; obligations of Managed Care organizations 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.

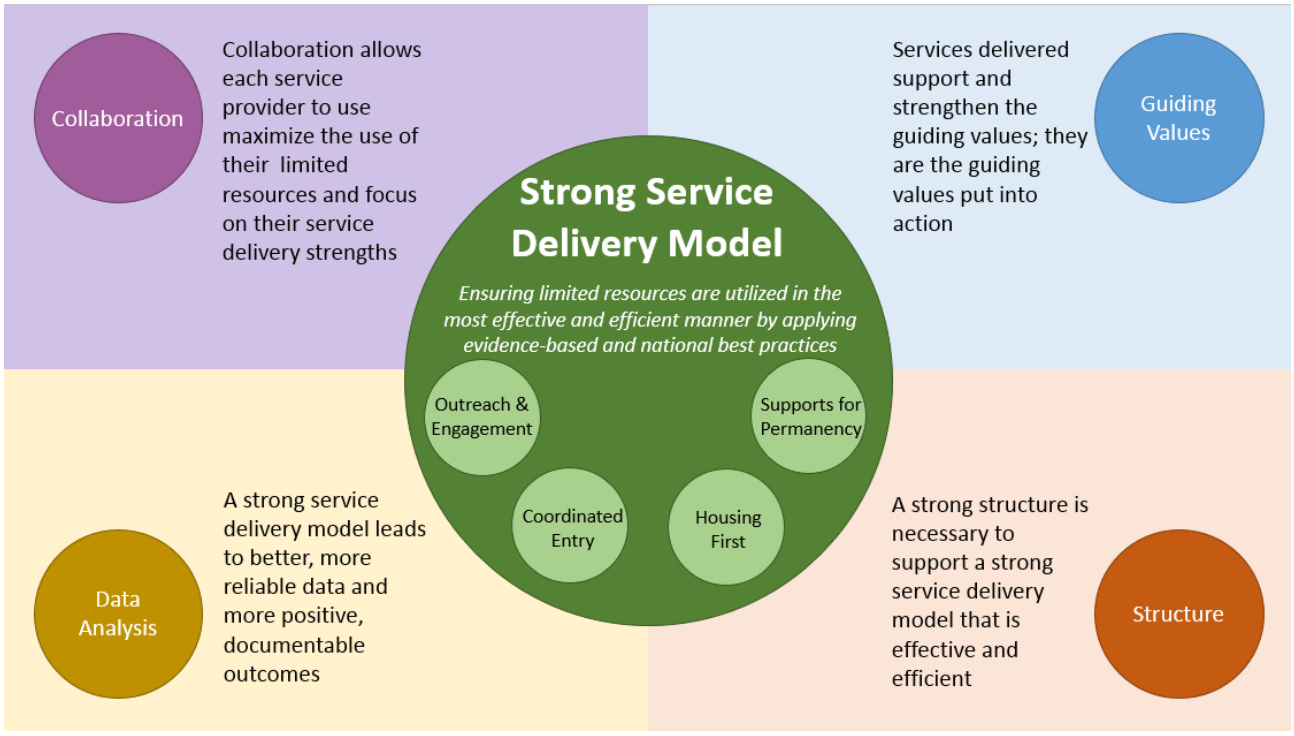
- Improved discharge planning protocols at hospitals, jails/prisons, psychiatric institutions. Discharge planning process should begin at point of admission and include housing element/connection to CoC.
- Partnerships between CoC and FQHCs, including locating FQHC clinics on-site at shelters and/or 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

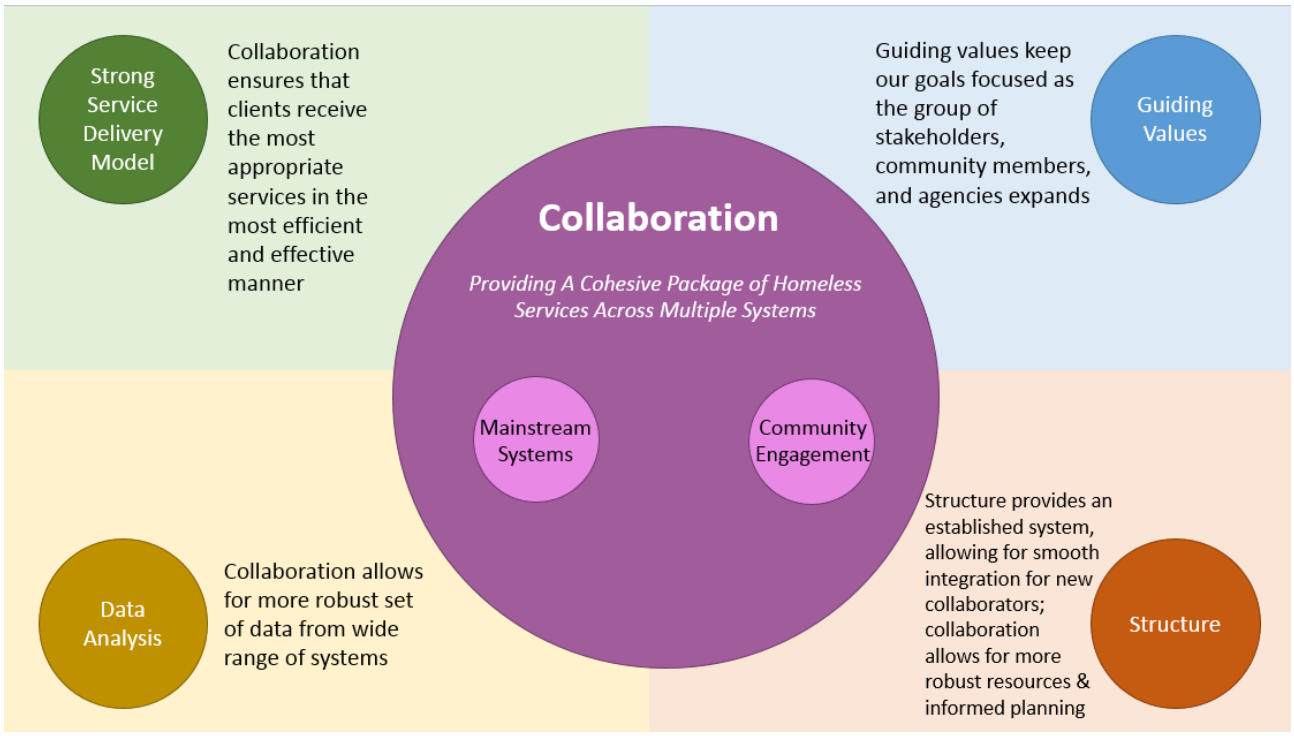

Guiding Values
Collaboration
Circles of Success
Structure
Strong Service Delivery Model
Data Analysis


Collaboration
Guiding values keep our goals focused as the group of stakeholders, community members, and agencies expands
Guiding Values
A common vision informing our decisions in an ever-changing political and economic landscape
Fair & Equal Access
Flexible & Nimble System
Shared Responsibility, Accountability, and Transparency
Client-Centered
An organized structure formalizes values
Structure
Strong Service Delivery Model
Core values inform the types and methods of services offered
Values inform the targets and benchmarks against which we use data to measure success; data tells us: are we sticking to our values?
Data Analysis


Collaboration
Structure provides an established systems, allowing for smooth integration for new collaborators; collaboration allows for more robust resources & informed planning
Structure
Building strategic governance and resource foundation for implementing quick and smooth action
Governance
Planning
Program Monitoring & Evaluation
Resource Allocation
Resource/ Inventory Development
An organized structure formalizes values
Guiding Values
Strong Service Delivery Model
Structure funds, evaluates, and plans for services available
Data informs the planning that occurs within the structure; structure supports the activities required for successful data analysis
Data Analysis


Collaboration
Data makes case for cross-system resource re-investment
Guiding Values
Values inform the targets and benchmarks by which we use data to measure success; Data analysis shows whether or not a community's actions are producing outcomes in line with their guiding values
Data Analysis
Creating a concrete platform to improve client care, facilitate coordination and drive policymaking
Performance Measurement
Data-Driven Decisions
HMIS
Strong Service Delivery Model
Data analysis sheds light on true client needs, and highlights the successes and failures of certain intervention types, program models, and provider agencies.
Structure
Data informs the planning that occurs within the structure; structure supports the activities required for successful data analysis


Collaboration
Collaboration allows each service provider to use maximize the use of their limited resources and focus on their service delivery strengths
Guiding Values
Services delivered support and strengthen the guiding values; they are the guiding values put into action
Strong Service Delivery Model
Ensuring limited resources are utilized in the most effective and efficient manner by applying evidence-based and national best practices
Outreach & Engagement
Supports for Permanency
Coordinated Entry
Housing First
Data Analysis
A strong service delivery model leads to better, more reliable data and more positive, documentable outcomes
Structure
A strong structure is necessary to support a strong service delivery model that is effective and efficient


Strong Service Delivery Model
Collaboration ensures that clients receive the most appropriate services in the most efficient and effective manner
Guiding values keep our goals focused as the group of stakeholders, community members, and agencies expands
Guiding Values
Collaboration
Providing A Cohesive Package of Homeless Services Across Multiple Systems
Mainstream Systems
Community Engagement
Data Analysis
Collaboration allows for more robust set of data from wide range of systems
Structure provides an established system, allowing for smooth integration for new collaborators; collaboration allows for more robust resources & informed planning
Structure