Healthcare and Housing (H^2) 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:

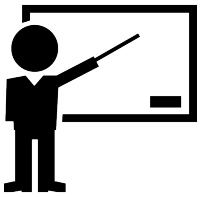
- Training: What training will be needed for staff?
- Partnerships: What partnerships are needed and how can they be forged?
- Targeting: Should particular sub-populations be targeted and how should they be identified?
- Scale: What will be needed to bring the strategy to a scale appropriate to meet 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 H^2 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



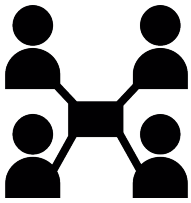
Identify Clients in Need

Assist with Enrollment

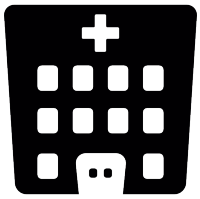
Advocate for Homeless Enrollment

MODEL STRATEGY 2: ACCESS & ENGAGEMENT

Expand/Transform Activity

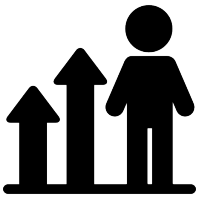


Reduce ER/Inpatient Use



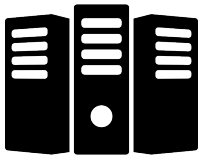
MODEL STRATEGY 3: INTEGRATION OF SERVICES

Build Capacity & Partnerships



MODEL STRATEGY 4: DATA-DRIVEN INTERVENTIONS

Integrate Data Across Systems



MODEL STRATEGY 5: MEDICAID AND OTHER FINANCING OPTIONS

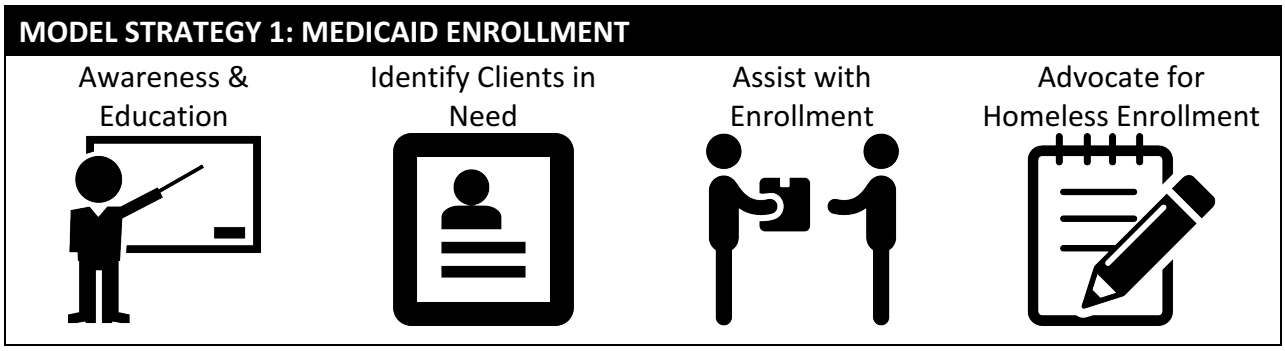
State/County Level Action

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.

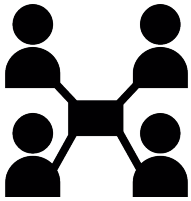
☐D. ADVOCATE FOR ENROLLMENT PROCEDURES THAT FACILITATE HOMELESS ENROLLMENT.

☐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

MODEL STRATEGY 2: ACCESS & ENGAGEMENT

Expand/Transform Activity



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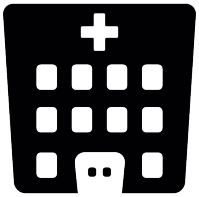


☐ **A. FACILITATE ACCESS TO SERVICES AND EFFECTIVE MANAGEMENT OF HEALTH CONDITIONS – EXPAND OR TRANSFORM EXISTING ACTIVITY AND/OR INITIATE NEW EFFORTS.**

☐ 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

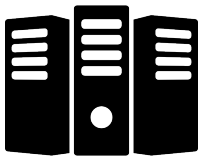
☐4. Develop recuperative care programs for medically fragile.
   a. Define program structure and service delivery models.

☐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, Heath 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.

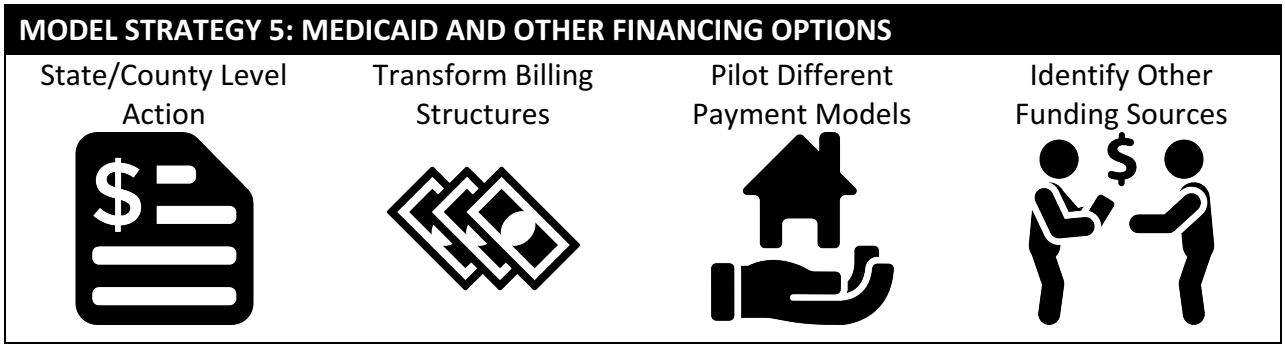
☐ 3. Track health outcomes, service utilization, and costs to facilitate continued quality improvement and make the case for additional funding for successful interventions.

☐ 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