Partnering to Improve Health Care for People Experiencing Homelessness: Lessons from California

June 16, 2022
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Made possible through support from the California Health Care Foundation
Questions?

To submit a question online, please click the Q&A icon located at the bottom of the screen.
Agenda

• Welcome and Introductions
• Coordinating Care for People Experiencing Homelessness in a Medical Respite Program
• Leveraging a Community Information Exchange to Connect Health Care and Homeless Partners
• Q&A
Meet Today’s Presenters

Meryl Schulman, MPH
Senior Program Officer
Center for Health Care Strategies

Michelle Schneidermann, MD
Director, People-Centered Care
California Health Care Foundation

Pooja Bhalla, DNP, RN
Executive Director of Healthcare Services
Illumination Foundation

Hannah Kim
Director of Healthcare Services
Molina Healthcare

Camey Christenson
Chief Business Development Officer
211 San Diego

Tamera Kohler
Chief Executive Officer
Regional Task Force on Homelessness
Center for Health Care Strategies

Dedicated to strengthening the U.S. health care system to ensure better, more equitable outcomes, particularly for people served by Medicaid.

Together with our partners, our work advances:

- **Effective models for prevention and care delivery** that harness the field’s best thinking and practices to meet critical needs.

- **Efficient solutions for policies and programs** that extend the finite resources available to improve the delivery of vital services and ensure that payment is tied to value.

- **Equitable outcomes for people** that improve the overall wellbeing of populations facing the greatest needs and health disparities.
CHCF is an independent, nonprofit philanthropy. We work to improve the health care system for Californians with low incomes and those not well-served by the status quo.

Our big priorities:

1. Get everyone covered
2. Deliver care better
3. Make care just
Homelessness & Health Care

On any given day, more than 150,000 people experience homelessness in California. Being homeless is dangerous to your health: People who live on the streets die an average 20 years earlier than people who are housed. CHCF is launching work to improve the delivery of health and social services to people experiencing homelessness, with the goal of promoting care that is responsive, person-centered, and focuses on the patient’s emotional, physical, and psychological needs.

Sign up for CHCF updates on Homelessness & Health Care ➔
This year-long statewide initiative brought together twenty-eight organizations to promote innovative approaches to improving health outcomes for people experiencing homelessness.
Partnerships for Action: California Health Care & Homelessness Learning Collaborative

APRIL 20, 2022

With the launch of CalAIM (California Advancing and Innovating Medi-Cal) in January 2022, the California Department of Health Care Services is focused on transforming health care delivery for high-need populations, including people experiencing homelessness.

To address the challenges related to improving health care access for those experiencing homelessness, the Center for Health Care Strategies (CHCS), with support from CHCF, is launching Partnerships for Action: California Health Care & Homelessness Learning Collaborative. This two-year initiative will support partnerships between health care and homeless service organizations to pilot projects focused on improving care delivery for Californians experiencing homelessness.

The objectives of Partnerships for Action are to:

- Build the capacity of health care organizations, managed care plans, community-based organizations, and other stakeholders to collaborate on the creation of a more robust support network for people experiencing homelessness
- Foster peer-to-peer learning through virtual and in-person learning sessions, convenings, site visits, and affinity groups
- Spread best practices related to health care and homelessness across California and nationally
Coordinating Care for People Experiencing Homelessness in a Medical Respite Program

Pooja Bhalla, DNP, RN, Executive Director of Healthcare Services, Illumination Foundation and Hannah Kim, Director of Healthcare Services, Molina Healthcare
Pooja Bhalla, DNP, RN, Executive Director of Healthcare Services

Hannah Kim, Director of Healthcare Services, Molina Healthcare
Coordinating Care for People Experiencing Homelessness in a Medical Respite Program
Street 2 Home System of Care

1. Street/Homeless
   - Funded by the city or county

2. Navigation Center/Family Emergency Center
   - Funded by CalAIM and hospitals

3. Medical Respite Recuperative Care & Short Term Post Hospitalization
   - Funded by HUD (Housing Urban Development), Private Funding, Self-Pay

4. Micro-Community (Permanent Supportive Housing)

5. Permanent Housing

Supportive Services • Case Management • Behavioral Health Services • Housing Navigation and Retention

Ifhomeless.org
1091 N Batavia St. Orange, CA 92867 • (949) 273-0555
Recuperative Care

Fullerton
Whittier

Anaheim
Olive View-UCLA Medical Center, Sylmar

Unity House, Fullerton, St. Jude
Riverside
CalAIM Provider

- Orange County - Community Supports
- Los Angeles County - Community Supports, Enhanced Care Management
- Inland Empire - Community Supports, Enhanced Care Management
Partnership

- Community Supports Recuperative Care:
- Bi-weekly meeting with Molina
  - Molina Physician
  - Molina CS Team Member
  - Illumination Foundation Case Manager assigned to client
  - Medical Team
  - Illumination Foundation ECM Lead Care Manager
  - Applicable other CS Team Members
Case Conferencing

- Build rapport with client
  - Increase engagement, set goals
- Update on housing
- Update on client’s medical appointments and compliance
- Need to extend the monthly authorization for CS is discussed.
Case Study
Challenges/Barriers of CalAIM

● Signing clients up for CalAIM
● Keeping clients within our care for continuity
● Staffing
● Availability of step down housing
Challenges/Barriers of CalAIM

- Concerns about capacity
- CS restrictions on length of stay
- Income barriers
- Housing resources
Lessons Learned

- When people have access to the care they need it saves cost and improve quality of care.
- Working together with managed care plans speeds up the process of providing care for clients.
Future Opportunities

● Short-term Post-Hospitalization (roll-out July 1 in Inland Empire)

● Day Habilitation (roll-out July 1 in Inland Empire)
Connect With Us

Visit Us Online: www.ifhomeless.org
Follow us on Social Media: @IFHOMELESS
Leveraging a Community Information Exchange to Connect Health Care and Homeless Partners

Camey Christenson, Chief Business Development Officer, 211 San Diego and Tamera Kohler, Chief Executive Officer, Regional Task Force on Homelessness
Leveraging San Diego’s HMIS & Community Information Exchange (CIE)

Tamara Kohler
CEO - RTFH
tamera.kohler@rtfhsd.org

Camey Christenson
Chief Business Development Officer – 211SD/CIE
ccchristenson@211sandiego.org
**GENERAL LINE**

- 24/7 phone line
- 10 minute information and referral
- 300+ languages
- Use CIE to document all interactions with callers and consent into CIE (85% of callers)
- CRM integrated with CIE platform

**NAVIGATION**

- Specialty line with case management
- Contracted partnership
- In-depth assessment and coordinated referrals via the CIE
- CRM integrated with CIE platform

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**CIE Network Partners**

Connect to 120+ organizations through direct system access or leveraging data integration between systems

**Individual User Access**

- Secure login
- Individual level PII & CIE profile information (CASCA)
- Electronic Referrals

**System to System Integration**

- Secure member matching
- API connections
- Eligibility prioritization
Person-Centered Care

- Employment
- Personal Care
- Education
- Transportation
- Utilities & Technology
- Disaster and Safety
- Legal
- Housing
- Primary Care
- Health Management
- Nutrition
- Financial Wellness
- Activities of Daily Living
- Social Connection

REAL PEOPLE. REAL CONNECTIONS. REAL HELP.
A Community Information Exchange (CIE) is a community-led ecosystem comprised of multidisciplinary network partners using a shared language, a resource database, and integrated technology platforms to deliver enhanced community care planning.

A CIE enables communities to have multi-level impacts by shifting away from a reactive approach towards proactive, holistic, person-centered care. At its core, CIE centers the community to support anti-racism and health equity.
What is our Goal?

A locally built and led infrastructure that supports initiatives, collective efforts, and coordination across our community to improve health and wellness outcomes for people.

- Care Management
- Bi-directional and Closed loop Referrals
- Data Insights and Analytics
Community Information Exchange
Core Components

Network Partners
Collective approach with standard Participation Agreement, Business Associates Agreement and participant consent with shared partner governance, ongoing engagement, and support.

Shared Language (SDoH)
Setting a Framework of shared measures and outcomes through 14 Social Determinants of Health Assessments and a Risk Rating Scale: Crisis, Critical, Vulnerable, Stable, Safe Thriving

Bidirectional Closed Loop Referrals
Updated resource database of community, health, and social service providers. Ability to accept/return referrals and to provide outcomes and program enrollment.

Technology Platform and Data Integration
Technology software that integrates with other platforms to populate an individual record and shapes the care plan. Partners access the system. System features include care team communication feeds, status change alerts, data source auto-history and predictive analytics.

Community Care Planning
Longitudinal record with a unified community care plan that promotes cross-sector collaboration and a holistic approach.
Currently 292,223 Active Consents

34% food insecurity

25% homeless or housing insecure

13% homeless at some point in CIE participation

Majority have an extremely low income

85% have health insurance (primarily Medi-Cal)
Client Record Sample

Client Profile
  • Demographic and important information about the client

Domains
  • Examples like Housing, Food & Nutrition,
  • Categorization of Needs (SDOH) & Risk Level
  • Shared Assessments and Values across agencies

Care Team
  • Case Managers working with client across agencies
  • Contact Information

Referrals & Program Enrollment
  • Agencies or programs client is referred
  • Connection to Services

Alerts
  • Notification of emergency services & jail
  • Ability to notify Care Team Members of changes

Feed
  • Ability to communicate with Care Team members (twitter-like feed)
Shared Social Determinants of Health: **Example Housing Assessment***

- Each assessment is built to as an algorithm to plot clients on a crisis to thriving scale
- Shared across all agencies and can be updated by agency data through integration
- Shows a history of client change and by which agency to move up on the continuum
- Examine client need by domain accounting for the follow factors:
  1. The nature, severity, & immediacy of the need
  2. The barriers and supports available to client in meeting that need
  3. The client’s knowledge and capacity to utilize resources to meet that need

Resource Database and Bi-directional Referrals

- Agency makes referral to another Agency
- Agency Referral Manager receives email and responds to referral
- Accepts or Declines Referral
- Outcome of Referral (Program Enrollment/Care Team)
Technology & Data Integration

ETL (Intelligent Informatica Cloud)
Extract Transform Load
1. Reads data from a database
2. Converts the data for the new database
3. Loads into the new database

MDM – Installed on top of SF (created by Informatica)
Master Data Management
- Detects and merges duplicate records
- Ensures the accuracy, completeness, and consistency of multiple domains of enterprise data

CIE
shared client record

Alerts
Primary CIE Uses

1. **Searching for a client record to see historical use of social services**
   - Tailor services accordingly
   - Reach out to existing care team member or agency for support

2. **Make referrals to external community and healthcare organizations**
   - Ability to track referrals to partners
   - Send client profile directly to agency (outcomes of referral)

3. **Shared screening or prioritization of resources**
   - Example--Homeless Prevention resources
   - Prioritize access to services (history or acuity)

4. **Receive alerts to be proactive or response**
   - Join as care team member and receive alerts
Data Integration and Interoperability

Social Service Providers
- Examples include Regional Taskforce on Homelessness’ Management Information System (HMIS), multi-party agreement with CIE with 60+ homeless providers
- San Diego Food Bank, and other social service providers with program enrollment, demographic, social and referral data

Healthcare Partners
- Integrated into federally qualified health centers, for example, able to make referrals like orders in EHR
- Matching health plan members with CIE participants to better assist those at-risk or experiencing complex social needs
- Connection with Health Information Exchange

Government/County
- Bidirectional data sharing with County of San Diego, joining consent and referrals between County’s ConnectWell (central hub of information for County departments)
Data Integration with local CoC

WHAT WE DO

RTFH is the Lead agency for the San Diego Continuum of Care (CoC)

A CoC is a regional planning body that coordinates housing and services for homeless families and individuals and promotes a community-wide commitment to the goal of ending homelessness.

- Conduct annual Point-In-Time Count
- Administer Homeless Management Information System (HMIS)
- Promote best practices, trainings, and standards for assistance
- Operate Coordinated Entry System (CES)
- Policy, advocacy, and research
- Fund homeless services
- Collaborative Applicant for HUD CoC funds
- Monitor system and program performance
Path to a Single Consent for HMIS and CIE

1. 211 San Diego and RTFH/CoC always have had strong relationship and partnership

2. Initially three agencies were sharing data into CIE

3. Reached critical mass: Most HMIS users were also CIE users and filling out two consents with clients

4. CIE Legal team worked collaboratively with CoC and HMIS legal team to design consent

5. CoC Board adoption of common consent
Why combine the Multi-Party Agreement with CIE Authorization?

Recognizing that homeless individuals and families experience co-related hardships, and can benefit from holistic care, in October 2019, the RTFH board voted to approve a joint HMIS-CIE Client Authorization form.

As of 4/1/2020, clients who opt-in to HMIS/Clarity will be opted in to CIE as well.
HMIS Integration & Single Joint Consent

To Receive Coordinated Care, Referrals and Services, Please Review and Sign this Authorization Form.

ABOUT HMIS AND 2-1-1 San Diego: San Diego County HMIS and 2-1-1 San Diego provide referral services to social services agencies for individuals with healthcare, housing, food, transportation, financial and other needs. This authorization will allow HMIS and 2-1-1 participating agencies to collect information from you and your care team to assess your needs and put you in touch with social services agencies (Participating Agencies) they work with. Information will be shared with those Participating Agencies that provide services that can address your needs, to coordinate referrals and services, track your progress and evaluate our success, among other things.

We are committed to protecting your information from unlawful disclosure. This Authorization permits a Participating Agency to re-disclose health information to another Participating Agency and the information may no longer be protected under applicable health privacy laws. Even if the Participating Agency is not subject to health privacy laws, RTFH, 2-1-1 San Diego and their Participating Agencies are still required to employ administrative, technical, and physical safeguards to protect all information collected under this Authorization and use and disclose information in accordance with federal and state law.

• Contact/PII Information:
  • First Name
  • Last Name
  • Middle Name
  • Email
  • Mobile
  • Home Phone
  • Home Address
  • Physical Address Line 2
  • Other City
  • Other State
  • Other Postal/Zip Code
  • Mailing Address
  • Mailing Address Line 2
  • Mailing City
  • Mailing State
  • Mailing Postal/Zip Code

• Demographics: 14 fields
  • Ethnicity
  • Gender Identity
  • Race
  • Language
  • Military Branches
  • Military Discharge Status
  • Military Service Status
  • Head of Household
  • Number of Children in the Household
  • Household Size
  • Monthly Income Amount / FPL
  • Sources of Income
  • Non-Cash Benefits
  • Accessed Supplemental Benefits

• Health Data:
  • Pregnancy Status
  • Disabling Condition

• Health Insurance

• Housing/Enrollment Data:
  • Chronic Homelessness
  • HMIS Assessment Name, Date, Score
  • Program Enrollment Name, Entry, Exit, Destination

• Care Team Members Created
Worked with CIE to map and align HMIS and CIE data elements. A lot of prep work done which is extremely important.

Created custom HMIS report with CIE data elements.

Initially used manual report but now is auto generated. Internal RTFH data team created report – not HMIS vendor.

Report sent to CIE on daily basis. Only sends refreshed data daily (only changes) not entire record.

Work with CIE when changes are made in HMIS (ie HUD Data Standards updates, etc..)
Success and Areas for Growth

Enhanced Coordination with Housing/Eviction Prevention System

“Ch they went there a few months ago and now they’re here with us. When they called 2-1-1 in the past what were they asking for? Having this info helps me better understand their story and saves me time.”
Veronica Blea, Interfaith Community Services

“The prevention screening tool has been super easy to use for the pilot. Also it’s really nice to be able to use the CIE to see if the individual or family has called other prevention resources for help before coming to us. Allows us to do more digging with them.”
Yvonne Araujo, Alpha Project

Enhanced Coordination with Criminal Justice System

“Last week I received a CIE jail alert informing me of a client in our Whole Person Wellness program who was also staying at the shelter had been arrested over the weekend. As a result, we were able to notify the shelter staff and our Whole Person Wellness teams working with the client immediately, so her housing was not jeopardized while we watched for the disposition of her charges. She was released two days later, and both teams were able to resume work with her immediately.”
Glen Hilton, PATH San Diego

Enhanced Coordination with Healthcare System

“The CIE was extremely helpful for us with locating patients for our Health Homes Program (Medi-Cal initiative that provides health, behavioral health, and other services such as housing navigation and housing tenancy supports to people with chronic conditions including homelessness). We were able to search for them and find out if and where they were connected, so then we could be proactive and reach out.”
Al Galka-Gonyeau, Family Health Centers of San Diego
Questions?

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Visit CHCS.org to...

- **Download practical resources** to improve health care for people served by Medicaid.

- **Learn about cutting-edge efforts** from peers across the nation to enhance policy, financing, and care delivery.

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