USICH – HHS/CMCS Listening Session
with Supportive Housing Providers using Integrated Care Models

October 21, 2010
2:00 – 5:00
Center for Medicaid, CHIP, and Survey & Certification
Conference Room B
7500 Security Blvd, Baltimore, Maryland

Participants:

FEDERAL PARTNERS

Center for Medicaid, CHIP, and Survey and Certifications – HHS

- Barbara Edwards, Director of Disabled and Elderly Health Programs Group
- Kate King, Health Insurance Specialist
- Claudia Brown, Health Insurance Specialist

US Interagency Council on Homelessness

- Barbara Poppe, Executive Director
- Jennifer Ho, Deputy Director
- Marie Suzuki, Executive Administrative Assistant
- Nicole Pexton, Research Intern

Office of the Assistant Secretary for Planning and Evaluation – HHS

- Emily Rosenoff, Policy Analyst
- Susie Sinclair-Smith
- Kelsey McCoy, Social Science Analyst
- Martha Burt, Consultant

Substance Abuse and Mental Health Services Administration – HHS

- Michelle Daly, Public Health Advisor
- Gretchen Stiers, Branch Chief, Homeless Programs Branch

Department of Housing and Urban Development

- Anne Fletcher, Social Science Analyst
- Sarah Ray, Special Assistant to Senior Advisor Fred Karnas
- Michelle Sternthal, Society for Research in Child Development Fellow

Department of Veterans Affairs

- Susan Angell, Director, Homeless Veterans Programs
- Michael Lumpkin, Senior Advisor to the Secretary

NATIONAL AND PROVIDER PARTICIPANTS

National Health Care for the Homeless Council - a membership organization comprised of people who have experienced homelessness, clinicians, administrators of Health Care for the Homeless projects and other service providers. Nashville, TN.

- John Lozier, Executive Director
- Barbara DiPietro, Policy Director

Baltimore Health Care for the Homeless – a provider of health-related services, education, and advocacy to reduce the incidence and burdens of homelessness. Baltimore, MD.

- Jeff Singer, President & CEO

Boston Health Care for the Homeless Program - a provider of high quality, comprehensive health care for Boston's homeless men, women and children. Boston, MA.

- Monica Bharel, Medical Director

Central City Concern – a provider of pathways to self-sufficiency through active intervention in poverty and homelessness. Portland, OR.

- Rachel Solotaroff, Medical Director

Colorado Coalition for the Homeless - a multi-service organization whose mission is to create lasting solutions to homelessness through the provision of integrated health care and supportive housing for homeless and at risk families and individuals throughout Colorado. Denver, CO.

- John Parvensky, Executive Director

Heartland Alliance - a comprehensive human service agency serving Chicago since 1888, advances the human rights and responds to the human needs of the poor, the isolated, and the displaced through the provision of comprehensive and respectful services. Chicago, IL.

- Karen Batia, Chief Clinical Officer

LifeLong Medical Care - a Federally Qualified Health Center which has served the low income communities in Berkeley and Oakland California for 35 years. Berkeley, CA.

- Marty Lynch, Executive Director/CEO

LA County Chief Executive Office - The Service Integration Branch – Homeless Services Unit is responsible for advising the five Los Angeles County Board of Supervisors on all homeless related policy, planning and programmatic issues that impact the County. Los Angeles, CA.

- Libby Boyce, Homeless Coordinator for CEO

Pathways to Housing – an organization widely credited as being the originator of the *Housing First* model of addressing homelessness among people with psychiatric disabilities. New York, NY.

- Georgia Boothe, Mental Health Administrator

San Francisco Department of Public Health - Direct Access to Housing program provides permanent supportive housing with on-site services for approximately 1,200 formerly homeless adults, most of whom have concurrent mental health, substance use and chronic medical conditions. San Francisco, CA.

- Josh Bamburger, Medical Director

Purpose:

USICH and the Center for Medicaid, CHIP, and Survey and Notification (Center for Medicaid) collaborated to co-host a listening session in order to learn about effective integrated care models for people who have experienced chronic homelessness, and to discuss the challenges and lessons learned from organizations that operate these programs as they relate to Medicaid expansion under health reform.

Framing

The listening session experts represent leading permanent supportive housing providers, Health Care for the Homeless providers (and the National Health Care for the Homeless Council), as well as a county leader, that have developed integrated care models to deal with the pervasive co-occurrence of health and behavioral health conditions in the population of people experiencing chronic homelessness. Many of the people being helped by these providers were not enrolled in Medicaid when they were homeless. Health Care for the Homeless and supportive housing providers often play a critical role in helping people navigate the disability determination and Medicaid enrollment process. Because people have residential stability from supportive housing, it is easier to maintain continuous enrollment in benefits than it is when someone is homeless.

For decades, the health care system has been challenged to find effective ways of delivering integrated care across all populations. The Center for Medicaid and USICH believe that successful models for this very sick and traditionally difficult to care for population could offer insights on broader efforts to integrate care for broader population groups. The chronic homeless population includes many who will

become entitled to Medicaid with health reform. Highlighting effective practices integrating care for people experiencing chronic homelessness could also encourage more permanent supportive housing providers to adopt integrated care models connected to the Medicaid program.

The listening session consisted of two parts: a facilitated conversation during which an outer circle of federal employees listened to an inner circle of local and county experts, followed by a small group breakout session in which both federal employees and these experts synthesized the insights gained from the prior discussion. The session ended with the whole group sharing insights and considering possible next steps.

Listening Session Guest Discussion

What are the key elements of integrated care when working with chronically homeless populations?

Establishing a relationship with patients and building trust are core components of integrated care. A solid relationship between the patients and their integrated care teams can lead those patients to other support services they previously would not have considered, such as substance abuse and mental health services.

Several providers cited the traumatic and isolating consequences of experiencing homelessness, which makes building trust and creating space for supportive peer relationships even more key. Building this trust requires adequate time to get to know the patient, determine patient needs and preferences, and be able to connect patients to their top priorities, including housing and employment.

Members of an integrated care team must also communicate and work together so resources are not wasted, but having enough time for team members to consult with each other is difficult under current Medicaid reimbursement policies. Having enough flexibility, staff, and funding to promote effective team care is essential for fostering effective integrated care for chronically homeless populations.

What have you learned about integration that you wish you had learned the day you started?

Providing integrated care is difficult—the visit-based culture of the current treatment system is not conducive to providing integrated care.

Control of the patient's treatment needs to be released from the primary care doctor to the entire team, in order to reduce the burden on primary care doctors and play to the strengths and knowledge of all clinicians on the integrated care team.

There are obstacles to creating team-based care, such as different languages, regulations, and training methods of the various disciplines represented in an integrated care team.

Flexible funding and personnel policies are necessary to prevent staff burnout from the pressure to conduct too many visits per day.

Is integrated care a specialized care model for chronically homeless populations or is it for everyone?

Intensive integrated care may be a strategy targeted at chronically homeless populations, but everyone could benefit from a higher degree of integration in their health care. The current U.S. system is expensive and produces poor health outcomes, so the broader view of health that integrated care emphasizes could produce better health at a lower cost.

A continuum of integrated care models is necessary to serve all types of patients, including chronically homeless populations with more complex health care needs. Specific methods for integrating care for chronically homeless populations include co-locating services to ensure higher service uptake, and adapting models of senior health care, such as in-home care and personal care assistants, to chronically homeless contexts in order to maintain housing stability.

Targeting patients before they become chronically homeless or frequent users of high cost services is also necessary, but difficult to achieve under current reimbursement policies.

What evidence is there that integrated care models work in terms of outcomes and cost effectiveness?

Integrated care models provide services that keep people housed, which is a key step toward reducing hospital stays, ER visits, and jail visits. Permanent supportive housing is effective for high users of emergency services, and integrated care can be thought of as a strategy for cost avoidance as well as a moral obligation for underserved chronically homeless populations.

What would you change to make your work easier?

Changing current Medicaid reimbursement policies in order to facilitate integrated care was a key theme voiced by several providers. Possibilities include providing incentives for introducing integrated care models, broadening the definition of what is medically necessary beyond strict traditional medical perspective, and providing a share of cost savings for providers if integrated care improves health outcomes.

There also needs to be an investment in training people to integrate care and work in teams as well as lessening the legal obstacles in the way of forming integrated care teams. Providers mentioned "making marriages" between health care providers with different specializations, such as connecting mental health and primary care professionals together in order to offer same day visits for both services.

What's the application of integrated care models in medical respite?

Providers mentioned specific circumstances where medical respite is a useful strategy for integrating care, including catching people on the brink of eviction, controlling chronic diseases, shortening hospital stays and connecting patients to care post-hospitalization, getting people onto disability to pay for services, and using medical respites to provide outpatient procedures such as chemotherapy or same-day surgeries. Medical respite is a key link in stabilizing health and facilitating transitions of care.

Listening Session Group Synthesis

What are the insights that have emerged from the discussion for you?

There is a need to educate people about the importance of integrated services, since not everyone believes in its effectiveness.

Integrated care must focus on building a relationship with an individual and tailoring service to that individual's needs instead of fulfilling the requirements of the place or institution. In order to focus on relationship and trust building, more flexible funding is necessary since, "there is no reimbursement code for building trust."

Facilitating more flexible funding means that integration needs to happen on the federal level as well as the community and patient level, which requires getting agencies together to coordinate funding, services, and care at federal, state, and local levels.

What lessons from this conversation should we at USICH be transmitting to people around the country?

The group emphasized the need for a core set of integrated care principles to be disseminated to agencies and providers who are at the beginning stages of developing an integrated care system. Those core principles have to be measurable and attainable in order to demonstrate their reimbursement value to funders. However, core evidence-based principles also need flexibility so they can be tailored to individual community needs.

Funding is a crucial message—communities need to seek opportunities to "braid funding" and federal agencies need to open opportunities for flexible funding for communities that can demonstrate success in integrated care. It is also essential to target intensive integrated care only to chronically homeless populations who really need it, as well as targeting populations at-risk of becoming chronically homeless and ill.

Anticipating the shortage of primary care doctors that are able and willing to serve Medicaid recipients will be an important step toward ensuring that integrated care models can continue in the future.

More generally, USICH needs to disseminate the message that we can end homelessness and spread the sense of urgency to other federal agencies and communities in implementing the Federal Strategic Plan to Prevent and End Homelessness.

What are the questions that you are left still asking yourself that we haven't had a chance to discuss?

Defining and measuring integrated care quality for complex populations is an important challenge, as is determining the role of integrated care in providing housing stability and supportive services.

A complex population that has not been thoroughly discussed here is homeless veterans, specifically how to integrate services with the VA in order to avoid doubling up services provided to homeless veterans.

Addressing the shortage of primary care workers and personnel trained in integrated care methods is also necessary, and incorporating community-based integrated care work into medical school curricula could be a possible solution. Before an integrated care training program can be implemented, a set of core competencies for becoming an interdisciplinary integrated care team needs to be developed.

Finally, providers asked what role federal agencies will play in encouraging community integrated care.

Next Steps

The need for flexible funding streams was reiterated, so that important intangible outcomes like trust and relationship building can take place.

It is also important for federal agencies to address integrated services as well as some communities have. HHS will consider how to provide guidance on funding integrated services in supportive housing.

Closing

Hearing about how other agencies and communities are addressing integrated care sparked enthusiasm and inspiration for the participants of this listening session. USICH and the Center for Medicaid sincerely thank participants for taking the time to travel out to Baltimore and contribute their valuable insight to this productive conversation.