• Organization Overview - Heartland Alliance
• Philosophy of Care
• Heartland Health Outreach Overview
• Sites, Programs, and Services
• Health Neighborhood Program Conception and Model
• Health Neighborhood Implementation
• Toolkit
• Questions
HEARTLAND ALLIANCE

Poverty, Homelessness, Injustice End Here

Heartland Alliance pairs direct services with research and advocacy to achieve lasting change.

12 countries
100 communities
400K served yearly
7 mil. impacted

Trauma-Informed Mental Health ->
Access to Justice ->
Human Rights and Gender Equality ->
Stigma-Free Health Care ->
PHILOSOPHY OF CARE

• Human rights
• Strength-based assessment and intervention
• Harm reduction
• Trauma-informed care organization
• Invite, recognize, and embrace differences
Heartland Health Outreach’s mission is to transform healthcare for the most vulnerable – particularly people experiencing homelessness, mental illness or substance use issues, or struggling with multiple chronic illnesses – improving health for all and the well-being of our community.

- HHO delivers integrated medical and behavioral healthcare to people with complex health needs

- HHO’s core strength is serving people experiencing homelessness who have chronic health conditions, serious mental illness and co-occurring substance use challenges
The Chicago Coalition for the Homeless estimated that there were nearly 140,000 people experiencing homelessness in Chicago during their 2013-2014 count.

The U.S. Conference of Mayors’ 2013 Hunger and Homelessness Survey, including Chicago, found that 22% of homeless persons needing assistance did not receive it.

HHO recognizes 32 years of receiving HRSA funding to deliver comprehensive primary care, mental health and substance use, & oral care through the HCH program.

HHO serves nearly 10,000 individuals annually.
SITES & PROGRAMS

- **PRIMARY CARE**: 3 HCH Health Centers located on the North, South, and West sides of Chicago

- **OUTREACH**: Delivers primary medical care to approximately 40 outreach sites, and also provides extensive mental health street outreach care

- **COMMUNITY HOUSING**: Provides supportive housing for nearly 275 individuals annually across metropolitan Chicago

- **BEHAVIORAL HEALTH**: Provides comprehensive outpatient mental health and substance use services
SERVICES

– Primary Care Services
  • Health Centers
  • Labs
  • Medical Outreach
– Mental Health and Substance Use
  • Psychiatric
  • Medication Assisted Therapy
  • Psychotherapy
  • Assertive Community Treatment (ACT)
  • Community Support Individuals (CSI)
  • Psychosocial Rehabilitation Drop-In Center
  • Projects for Assistance in Transitions from Homelessness (PATH)
  • Refugee Mental Health
– Oral Health Care
– Chronic Disease Management (RWCA Funding)
– Residential Programs
  • Mental health and MISA (mental illness and substance use) supportive services
  • TB / Direct Observational Therapy
– Heartland Center for System Change
  • Midwest Harm Reduction Institute
  • Cross-Cultural Interpreting Services

Through provision of these comprehensive services over 30 years, we developed extensive community partnerships which led to the development of the Health Neighborhood.
Heartland Health Outreach
Health Neighborhood

Innovative Service Delivery Model
Regardless of the status of the Affordable Care Act, the American healthcare system is in a period of reform. A core element of all approaches is a shift in reimbursement from fee-for-service to value-based arrangements.

The Health Neighborhood positions HHO and its partners at the cutting edge of this transformation. This model seeks to improve outcomes through addressing the social determinants of health.

The improved outcomes of the population will reinforce the value of the interventions, positioning the organizations to negotiate value-based payment arrangements with payers.
## Social Determinants of Health

<table>
<thead>
<tr>
<th>Economic Stability</th>
<th>Neighborhood and Physical Environment</th>
<th>Education</th>
<th>Food</th>
<th>Community and Social Context</th>
<th>Health Care System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment</td>
<td>Housing</td>
<td>Literacy</td>
<td>Hunger</td>
<td>Social integration</td>
<td>Health coverage</td>
</tr>
<tr>
<td>Income</td>
<td>Transportation</td>
<td>Language</td>
<td>Access to healthy options</td>
<td>Support systems</td>
<td>Provider availability</td>
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<tr>
<td>Expenses</td>
<td>Safety</td>
<td>Early childhood education</td>
<td></td>
<td>Community engagement</td>
<td>Provider linguistic and cultural competency</td>
</tr>
<tr>
<td>Debt</td>
<td>Parks</td>
<td>Vocational training</td>
<td></td>
<td>Discrimination</td>
<td>Quality of care</td>
</tr>
<tr>
<td>Medical bills</td>
<td>Playgrounds</td>
<td>Higher education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support</td>
<td>Walkability</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Health Outcomes**
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations
HEALTH NEIGHBORHOOD MODEL

• **Systems level approach** to integrating services with community partners to **improve population health** of low-income and people who are experiencing homelessness.

• Inspired by the patient-centered medical home model, that is **participant-centered, comprehensive, team-based, data-driven, coordinated and collaborative care**.

• Incorporates **ongoing training** and **technical assistance** from HHO’s Midwest Harm Reduction Institute, which provides expertise in harm reduction and trauma-informed care.

• Sustained through **patient revenue, fee-for-service billing** and potential **value-based contracts**.
HEARTLAND HEALTH OUTREACH, INC.

COLLABORATION

PSH ppt. receives enhanced care/support by choosing the Health Neighborhood

Shared Behavioral Health Personnel/Billing for LCPC/LCSW support of co-served PSH ppt.

Shared Care Coordinator Personnel/Training/supporting PSH case managers to improve health outcomes of co-served ppt.

Future Plan Leasing/Training/Supporting PSH staff to deliver Rule 132 services to co-served PSH ppt.
• Leverage existing community partnerships

• Initial discussions and meetings with administration and clinical teams

• Tailor the project to meet unique needs of each community partner

• Draft, review and finalize Sharing Agreement, including hourly rate and FTE for each position

• Transition to Program Director for implementation
The implementation checklist includes:

- Identify partner-specific implementation process and timeline
- Identify and confirm list of mutual participants
- Complete credentialing
- Review billing process and provide sample invoice to partner agency
- Issue laptop and Orientation Manual to shared staff
- Send welcome letters to Health Neighborhood participant
- Schedule first check-in meeting
- Onboard shared staff and begin orientation to EHR
ELECTRONIC HEALTH RECORD (EHR)

- Shared staff access
- Security and confidentiality
- Training on use
- HN identification
Inspired by Institute for Healthcare Improvement’s Triple Aim

I. Experience of Care
   1. Participant satisfaction survey - Likelihood to recommend to others
   2. Patient portal - Participants accessing their chart summary

II. Population Health
   3. Depression - Use of PHQ-9 tool for assessment and monitoring
   4. Follow-up after behavioral health hospitalization – 30 days

III. Per Capita Cost
   5. Appointments - Participant show rate for all scheduled appointments
   6. Emergency department utilization
   7. Inpatient hospital utilization

HEDIS - Healthcare Effectiveness Data & Information Set
<table>
<thead>
<tr>
<th>Problem</th>
<th>Not At All</th>
<th>Several Days</th>
<th>More Than Half the Days</th>
<th>Nearly Every Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling asleep, staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself - or that you’re a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
HEARTLAND HEALTH OUTREACH, INC.

TOOLKIT

- Project charter
- Sharing agreement
- Job descriptions
- Orientation checklists
- Dashboard
- Welcome letter
QUESTIONS
• Katy Kelleghan, 312-735-9080  
  kkelleghan@heartlandalliance.org

• Cara Pacione, 773-315-1866  
  cpacione@heartlandalliance.org
THANK YOU