WHEN HOUSING AND DATA MEET
Some Things are Just Better Together
Session Abstract

- Homeless service providers and Medicaid agencies share a common goal — to provide services for the most vulnerable individuals in their communities. Though both Medicaid agencies and homeless service providers frequently serve these same individuals, traditionally there has not been a lot of collaboration between them.

- In this session, we will discuss the success of three different organizations in using housing and Medicaid data to coordinate care for individuals experiencing homelessness. We will also discuss best practices for getting started with sharing data between housing and Medicaid programs.
Homelessness is a Public Health Crisis

- Many homeless individuals struggle with multiple serious health conditions
- When combined and treated inconsistently, these problems become compounded

45% have at least one serious health condition
45% have a mental health condition
57% have a substance abuse condition
22% live with all three conditions

Source: Institute for Healthcare Improvement, Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs, 2011
It Takes a Village…

- Health and housing providers must join forces to fight the crisis
- Providing housing and supportive services plays a key role in improving outcomes for homeless individuals
You Can’t Treat the Whole Person with Only Part of the Data

- Successful communities have open data sharing among health and community service providers
- A patient’s interaction with all types of providers is recorded and shared
The Human Services Value Curve

Goal: Develop innovations that enable organizations to deliver broader and more valuable services

- Encounter data only
- Communicate with other providers but no data sharing
Payment Reform

- Within this evolution about patient outcomes, we also have payment reform
- Fee for service
- Integrative care
- Pay for populations
Payment Models

- Value-Based Care
- Fee-for-Service
- 1115 Waiver programs
- Medicaid ACOs (Regional Care Organizations)
- Community partnership between:
  - Federally Qualified Health Center (FQHC)
  - Housing provider
  - Residential behavioral health
  - Fire department
Where Does Your Organization Fit?
Case Study
Partnership for Successful Living
What is Safe Station?

- Nashua, New Hampshire had a very high rate of overdoses.
- In November 2016 the following community leaders and organizations came together:
  - The mayor of Nashua
  - Local fire stations
  - Harbor Homes (emergency shelter & FQHC)
  - Keystone Hall (residential treatment)
Anyone seeking treatment or recovery from addiction to opioids or other substances may visit a fire station at any time

Trained firefighters determine if the individual is medically cleared

Two options

• Go immediately to the emergency room or
• Contact Harbor Homes for transport to a safe facility
- A representative from Harbor Homes immediately responds, arrives at the Safe Station, and enrolls the individual in the Safe Station Program

- If medically cleared, Harbor Homes representative transports them to:
  - Maple Street Emergency Shelter
  - Keystone Hall

- A Licensed Alcohol and Drug Counselor conducts a comprehensive assessment
  - Enrolls the individual in one of the following programs
    - Medical respite
    - Keystone Hall Comprehensive Residential and Outpatient Center
Data Sharing

- All participating organizations use the same care coordination platform
- Administrators can track progress from initial enrollment to when a participant is referred to different programs
Initial Findings

- Over 270 individuals have sought help*
  - More than 225 have been brought to the Partnership agencies
- Already saved the community a collective amount of $1.9 million
- 97% of program participants have been evaluated by an LADC
- 80% have gone on to receive at least one service from the Partnership for Successful Living
- Of the sample, 56% of the individuals who have seen a medical provider have Hepatitis C

*As of April 1, 2017
Case Study
LA County Whole-Person Care
- An integrated, county-wide health system that coordinates health, behavioral health, and social services

- Includes 50,000 of the most vulnerable and high-risk individuals living in LA County
  - Homeless
  - Serious mental illness
  - Substance use disorder
  - Justice involved
- Bring together health and social services across the county with eleven innovative programs
- Achieve the Triple Aim

LA County Whole-Person Care Goals

THE TRIPLE AIM
Care Coordination Infrastructure

- An integrated, county-wide health system
  - Client encounter documentation
  - Enhanced care team collaboration
  - Continuity of care
  - Disease and case management
  - Data sharing across providers
Population Health Management

- Identification, measurement, and reporting for target populations
  - Identification of eligible clients, profiles, and subpopulations
  - Development of services for target subpopulations
  - Measurement of success and outcomes
  - Performance feedback
Support Data-Driven Decision Making

- Process-driven intelligence within care coordination platform
  - Care prompts, alerts, and reminders
  - Evidence-based knowledge
  - Standardized forms and templates
  - Streamlined data presentation
Data Sharing in Same System

Sharing data to coordinate care management regardless of community access point

Providers using the same information system designed to share data and drive workflow

Application and Screening

- Housing for Health
- SUD High-Risk
- Re-Entry
Interoperability Between Systems

- HIEs
- EHRs
- Referral Systems
- HMIS
- Client/Provider Portals
Case Study
Community Health Partners
Who is Community Health Partners?

- Coalition of more than 25 providers
- Pioneer in community-based, Medicaid-funded ACOs
- Contracted with Colorado to manage a Region 7 of their Accountable Care Collaborative
- Coordinates care for special populations, including homeless, children in foster care, and patients who over-utilize the emergency department
Anticipate needs and collaborate with a wide array of providers to deliver preventative care for high-risk populations
- Physical health
- Behavioral health
- Housing
- Justice
- Education

Create one point of contact and clear accountability for treating the whole person

Develop infrastructure that supports coordination between providers in the Health Neighborhood
Care Coordination Model

- A single platform that can be used concurrently for clients
  - With multiple episodes of service
  - Who enter the systems through different agencies
- Business intelligence and data management system that collects, consolidates, and organizes data from multiple sources
- Data-driven decision making improves member health and enables CHP to measure performance and control costs
Longitudinal Care Plans

- Holistic plan shared between multiple providers to coordinate care and evaluate progress
- Care plans include
  - Client information
  - Enrollment review
  - Medications
  - Depression screening
  - Education assessment
  - Risk assessment
  - Referrals
  - Goals (including those for self-management)
  - Communications and case notes
Care Management Platform
Automated care coordinator assignments, risk assessment and prioritization, program routing, other workflow (e.g. contact, case closure, etc)
Getting Started with Data Sharing
Develop a strategic planning initiative for the organization’s overall goals. During the development process, consider:

- Aligning the goals around population health, and special groups that the organization would like to target for intervention
- Providing leadership with initiatives to optimize local health care and social services delivery
- Focusing on improving patient engagement/activation measures by pulling together multiple community resources
Integrate care coordination in the communities you serve

Identify opportunities where collaborating with other health neighborhood providers improves the health of the individual and the whole community

Connect providers with a care coordination platform
- Data governance
- Data sharing
- Consent management
- Coordinated system administration

Best practices
- **HMIS**
  - Coordinated entry
  - DS & exports

- **HL7**
  - HIEs
  - EHRs

**Important systems and standards**
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