# Pittsburgh, Pennsylvania $H^2$ Action Plan

## Building Housing and Healthcare Systems that Work Together

**April 2016**

*This action plan emerged from the December 15-16, 2015 $H^2$ Action Planning Session held in Pittsburgh, Pennsylvania as part of the U.S. Department of Housing and Urban Development's Healthcare and Housing ($H^2$) Systems Integration Initiative.*

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## *Executive Summary*

*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. Similarly, it has become increasingly clear that stable housing is a fundamental base both for maintaining good health and controlling costs due to unnecessary emergency room utilization and hospital admissions. The ongoing national discussion surrounding health care has created unprecedented opportunities to increase coverage and link health care, supportive services, and housing, which in turn creates opportunities to realize better outcomes for the people served. The connection between housing and health care needs is clear:*

**Housing Is a Key Determinant of Health.** Poor living conditions, caused by poverty and homelessness, affect both people's vulnerability to illness and disease and their ability to benefit from treatment and manage their conditions. People who are homeless have to contend with contact with communicable disease and infection, exposure to extreme weather, malnutrition, stress, lack of running water to maintain cleanliness, and lack of refrigeration for medication.

**People Who Are Homeless Are at Greater Risk for Poor Health.** They have high rates of infectious and acute illnesses (skin diseases, TB, pneumonia, asthma); chronic diseases (diabetes, hypertension, HIV/AIDS, cardiovascular disease); poor mental health and/or substance abuse; and being victims of violence. In addition, their mortality rate is 3-4 times higher than for the general population.[1]

**Health Issues Are Likely to Increase as The Homeless Population Ages.** The number of homeless people in the U.S. between the ages of 51-61 increased 32% from 2007 to 2013.[2] Rates of chronic health conditions and potential for extended stays in nursing homes increase with age.

**Homelessness Is Correlated with High Health Care Costs.** The high proportion of complex health needs and co-occurring health and behavioral health disorders increases the number, intensity, and scope of the services needed. Homelessness inhibits the long-term, consistent care needed for many of these conditions, with the result that problems are aggravated, making them more dangerous and more costly. Homelessness also increases the likelihood of excessive use of the ER, inpatient treatment, and crisis services.

- A Philadelphia homelessness cost study found that the top 20% of individuals experiencing chronic homelessness plus substance abuse cost the City approximately **$22,000 per person per year** in behavioral health services, homeless services, prison, and jail.[3]
- A report in the New England Journal of Medicine documents that homeless people spent an average of four days longer per hospital visit than comparable non-homeless people at an **extra cost of approximately $2,414 per hospitalization**.[4]
- A 2009 study in Chicago found that without healthcare or housing interventions, 204 homeless adults with chronic medical illnesses experienced **743 hospitalizations** and 3.77 emergency room visits per person per year over an 18-month period.[5]

**Permanent Supportive Housing (PSH) Improves Health Outcomes and Reduces Health Care Costs.** PSH, affordable housing linked with comprehensive health and support services, serves people with severe and complex needs, including those who have been chronically homeless. Research and experience repeatedly document that PSH results in reductions in costs for hospitalization, emergency room visits, crisis services, shelter, jail, and detox; high rates of housing stability and retention; and improved health and recovery. Importantly, changes under the ACA **expand opportunities to use Medicaid to fund key services needed by people in PSH.**[6]

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[1] http://www.cdc.gov/features/homelessness/ and Kaiser Commission on Medicaid and the Uninsured, "Medicaid Coverage and Care for the Homeless Population: Key Lessons to Consider for the 2014 Medicaid Expansion", September 2012, available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8355.pdf

[2] End Chronic Homelessness Policy Academy Team presentation delivered at Washington Legislature Adult Behavioral Health System Task Force Meeting on September 19,2014. For more information, please contact Gillian Morshedi (gillian@homebaseccc.org) at HomeBase.

[3] Stephen R. Poulin, Marcella Maguire, Stephen Metraux, and Dennis P. Culhane. "Service Use and Costs for Persons Experiencing Chronic Homelessness in Philadelphia: A Population-Based Study" *Psychiatric Services* 61.11 (2010): 1093-1098.

[4] Salit S.A., Kuhn E.M., Hartz A.J., Vu J.M., Mosso A.L. Hospitalization costs associated with homelessness in New York City. New England Journal of Medicine 1998; 338: 1734-1740.

[5] AIDS Chicago, "Studies on Supportive Housing Yield Results for Health of Homeless and Cost Savings, "2009. http://www.aidschicago.org/resources/legacy/pdf/2012/chhp_data_sheet_2012.pdf

[6] ASPE, Medicaid and Permanent Supportive Housing for Chronically Homeless Individuals: Emerging Practices from the Field, available at: http://aspe.hhs.gov/daltcp/reports/2014/EmergPrac.pdf

## Healthcare and Housing ($H^2$) Systems Integration Initiative

*To better meet the needs of people who are homeless and those who are low income and living with HIV/AIDS, HUD's Office of Special Needs Assistance Programs (SNAPS) and the Office of HIV/AIDS Housing (OHH), in collaboration with the U.S. Interagency Council on Homelessness (USICH) and the U.S. Department of Health and Human Services (HHS) are sponsoring technical assistance (TA) to support states and communities in undertaking the systems changes needed to enhance integration and collaboration between housing and healthcare systems. The goal is to maximize care coverage for the target populations and increase access to comprehensive healthcare and supportive services that can be coordinated with housing.*

*TA providers, including expert facilitators and subject matter experts, support interested states and communities in convening 2-day planning sessions focusing on integrating healthcare and housing systems and services. Planning session participants include representatives from Continuums of Care and ESG programs, HIV/AIDs providers and networks, local/state healthcare agencies, HUD and HHS regional and field offices, and others.*

*Pittsburgh's $H^2$ action planning session was conducted December 15-16, 2015, attended by approximately 70 people, representing federal, state and local government; homeless, HIV/AIDS and veterans providers; housing and healthcare agencies; and other interested parties. The Pittsburgh $H^2$ Leadership Council, formed from the session's planning committee, along with additional stakeholders, carefully reviewed the strategies, action steps, and ideas that emerged from the planning session and its diverse participants. The following document represents a concise, strategic, and prioritized presentation of the recommended actions put forth by the session's participants.*

**Overview of Goals**

I. Collect and use data to catalyze systems change by: demonstrating cost effectiveness; remaining client focused; informing future system planning; and informing resource allocation.
II. Create a person-centered, integrated system to improve health outcomes, housing stability. and access to social services.
III. Redesign care delivery system to be trauma-informed, recovery-oriented, and strength-based, to increase and improve access to needed care by members of the target populations.
IV. Increase and improve opportunities for people to access and retain stable housing through promotion of Housing First and maximized understanding and utilization of Medicaid and other resources in Allegheny County.

**Leadership Council and Work Groups**

*An $H^2$ Leadership Council has been established to coordinate and administer this initiative in Allegheny County. The Leadership Council, comprised of the group that planned the $H^2$ action planning session, along with additional participants from the planning session and other key stakeholders interested in this work, oversees the implementation. The Leadership Council's objective is to provide leadership, oversight, coordination, and support for implementation of this Plan, as well as to keep the community informed and engaged. Work Groups have formed to oversee and implement discrete portions of the Plan.*

## *Pittsburgh H² Action Plan*

## Vision

The work of H² is guided by a shared vision that calls for comprehensive services for those experiencing a housing crisis, including:

- Rapid access to decent, safe housing
- Resources and supports to ensure housing sustainability
- Care and services that address the issues that led to the housing crisis
- Opportunities to achieve one's desired quality of life

## Underlying Implementation Strategies

- Create a strong planning team. This could be both an implementation team and an advocacy team, but needs to have decision makers.
- Get more and better data (both qualitative and quantitative) into a central system, probably DHS data warehouse
- Find more money by leveraging Medicaid and other pots to provide services/additional housing. Use savings in HUD programs to create more housing options or use new Medicaid/Health Care funding to create permanent supportive housing for high users or other eligible populations. Be innovative.
- Launch at least 3 new initiatives per year. There were a lot of good models mentioned in this document. We should pick the ones that we like or feel hold the most promise and incubate/grow them to scale. We may get a few that fail or that cannot be replicated here, but we should at least set a goal to launch a few a year and see which ones stick.
- Include additional parties in discussions/planning going forward:
    - Consumers
    - MCOs
    - Criminal Justice
    - Department of Health
    - State Medicaid
    - Insurers/Payers
    - Foundations
    - Drug and alcohol treatment providers
    - Landlords
    - Additional hospitals and primary care providers
    - Additional mental health providers
    - CYF (especially for transition-age youth)
    - Faith based communities - Christian Associates of SW Pennsylvania, Jewish Community, e.g. (Rev. Mike Wurschmidt has relationships religious leaders)

## Priority Strategies Outline

### I. Develop Data-Driven Service Interventions.

**I-1.** Create a county-wide $H^2$ Data Leadership Team.

**I-2.** Get more and better data (both qualitative and quantitative) into a central system, such as the DHS data warehouse.

### II. Integrate Housing, Health, and Other Services for Housing Retention and Ongoing Wellness.

**II-1.** Assess local best practices.

**II-2.** Research other tools.

**II-3.** Understand mechanisms to establish/implement an integrated system.

**II-4.** Develop an integration model to be presented to the community.

### III. Improve Access to and Utilization of Services and Treatment.

**III-1.** Improve discharge planning processes/protocols county-wide.

**III-2.** Develop/Expand service coordinators (connectors) to engage and assist individuals to navigate through the systems of care to get the services and resources they need, with the following recommendations:

**III-3.** Rethink what primary care looks like for people experiencing homelessness, at least until they are in permanent, sustainable housing.

### IV. Maximize Use of Medicaid and Other Existing Resources to Support Housing Access, Retention, and Stability.

**IV-1.** Develop Medicaid planning group including Allegheny County, FQHCs, Behavioral Health, and MCOs.

**IV-2.** Increase Medicaid and disability benefits enrollment for eligible members of population.

**IV-3.** Determine opportunity for increasing access to services and follow through for clients.

## I. Develop Data-Driven Service Interventions

**Goal/Objective:** Collect and use data to catalyze systems change by:

- Demonstrating cost effectiveness
- Remaining client focused
- Informing future system planning
- Informing resource allocation

### Priority Strategies and Action Steps

**I-1.** Create a county-wide $H^2$ Data Leadership Team to focus on:

- Mission bridging, matching the needs of both housing and healthcare providers
- Improving outcomes
- Shared access to data
- Cost efficiency
- Making the case for additional funding for successful interventions
- Developing discharge criteria/processes
- Determining what information we need to share to serve our common clients
- Why and what data do the systems need to collect and for what purpose; Where would matching or integration be helpful
- Is the self-reported health care information collected by housing providers helpful? What else could it be used for?
- Possible members
    - DHS: Erin Dalton
    - AHN:
    - UPMC Health Plan: John Lovelace (already involved in CoC/HAB)
    - Gateway: Michael Madden
    - iCount: Michael Blackwell, Kate Dewey, Karen Feinstein or another member of the leadership team
    - Consider inviting Allegheny HealthChoices to help with identifying possible members
- Determine whether it is beneficial and possible to create a system in which providers (including health care and ER) can access a client's service utilization data (homeless, behavioral health, etc.)
- Create targeted PR campaign around the need for and benefits of housing/health care integration, especially aimed at getting health care system buy-in.
    - Goal is to work toward a paradigm shift.
    - Frame as recovery story. We aren't "bailing people out." We're getting them on the road to self-sufficiency.
    - Emphasize effectiveness of interventions such as Housing First/PSH and resulting cost savings across systems.
    - Include aggregate data as well as narrative success stories.
    - Explore existence of documentaries, news stories, etc.

- Highlight other cities doing more, particularly cities with which Pittsburgh feels competitive. This could be particularly effective with respect to getting community and/or political support.
- As part of marketing campaign, engage Mayor's Office and County Executive
- Include faith based organizations. Need the faith based community to create a moral imperative in community.

- Align $H^2$ plan/work with Homeless Advisory Group's efforts to create new comprehensive plan to end homelessness by 2020.
  - Include as part of agenda for Homeless Advisory Group if possible

**I-2.** Get more and better data (both qualitative and quantitative) into a central system, such as the DHS data warehouse.

- Conduct data match between HMIS (using housing prioritization list) and Medicaid and/or MCO data.
  - Erie Co. did a similar match between HMIS (using by-name list) and VA. Helped to get to functional zero for veteran homelessness.
  - Replicate United Healthcare model in Texas, where the CoC shared HMIS data, United Healthcare matched to member data, and United Healthcare contracted with CoC to find high users, house them, and connect them to United Healthcare services. If no Money Follows the Person, do a data match to see if the shelter can make a warm handoff to introduce United Healthcare and talk about additional Medicaid benefits that the client may be eligible for.
  - Need to jump on this quickly. MCOs will be focusing on the transition to Managed Long Term Services and Support rollout in Jan 2017 and making a number of changes all at once. Data sharing like the UHC example might have a roll to play.
- Seek participation from health care system in Data Warehouse to develop a more complete cross systems view for data analytics and planning.
  - Start with State Medicaid. Goal is to determine who is eligible but not enrolled to target enrollment outreach and services to them. If we already receive that data, focus on creating an enrollment strategy for those individuals.
  - Consider adding health information on clients within the data warehouse
  - Review and better understand parameters around the sharing of health information and the need for informed consent
  - Review release of information forms
  - Engage managed care organizations
  - Continue working with Allegheny County Health Department on data exchange
  - Negotiate MOUS to share information among clinics and hospital Emergency Departments
- Consider collecting first-person feedback from homeless clients on their experience of services and system barriers, matching individual's experience in the system with their quantitative data in healthcare systems as information for future strategies.
  - NAMI - CART could do some sampling and initial analysis.
  - DHS could do a second level of analysis.

- Individual's experience should be monitored continuously.
- Might become a more important strategy in the future if we have an integrated system, since the health system is getting more involved in collecting patient satisfaction information.
- Leadership Team to determine how to use this information.

- Improve information sharing across health and behavioral health systems (Medicaid managed care programs) to reduce duplication and improve service delivery
  - Create a tracking system for homeless patients within health care system.
    - Possibly similar to CES in housing side
    - Reduce burden on clients of having to tell multiple providers the same things over and over.
    - If someone presents at one place, that provider should be able to tell where else the person has been, what they were treated for, etc.
    - HCH uses electronic medical records (eMR) but other providers are not there yet.
    - Ensure use of housing and homelessness-related ICD-10 codes.
  - Link hospital discharge planning to housing system/CES. At the very least, include in discharge planning process a determination of whether patient should look into applying for SSI/SSDI. If so, link to SOAR.
    - To get buy-in from hospitals, focus on 30-day readmission penalty, and how linkages to housing, services, income (such as SSDI) could prevent readmissions.

## II. Integrate Housing, Health, and Other Services for Housing Retention and Ongoing Wellness

Goal/Objective: Create a person-centered, integrated system to improve health outcomes, housing stability, and access to social services.

### Priority Strategies and Action Steps

**II-1.** Assess local best practices.

- VA Health Care for Homeless Veterans (HCHV), VA Domiciliary Case Workers models and Homeless PACT team for healthcare
- Community Human Services and UPMC "Cultivating Health for Success"
- WPIC and Community Care "Neighborhood Living Project"
- Mercy "New Lease on Life" program
- HOCC (Homeless Outreach Coordinating Committee) and lessons learned from previous Homeless Engagement Center effort
- Allegheny General "Center for Inclusion Health"
- Chartiers "Hestia"

**II-2.** Research other tools.

- Engage Managed Care Organizations and Insurers in process/planning.
  - State Association of Managed Health Care plans.
  - Kim Nettleton and United Healthcare's support of integrated care
- Hennepin County's efforts
- Identify other national models

**II-3.** Understand mechanisms to establish/implement an integrated system.

- Understand potential resources available to support integrated system
- Engage county's Coordinated Access
- Engage Managed Care Organizations and Insurers
  - Review existing contracts with MCOs to determine necessary changes that would include housing-related outcomes and outcomes related to serving target population

**II-4.** Develop an integration model to be presented to the community.

- Identify and recruit stakeholders and community leaders.
- Organize community event(s) and solicitation for support.
- Use existing meetings and conferences as a vehicle for education and awareness.

## III. Improve Access to and Utilization of Services and Treatment

Goal/Objective: Redesign care delivery system to be trauma-informed, recovery-oriented, and strength-based, to increase and improve access to needed care by members of the target populations.

### Priority Strategies and Action Steps

**III-1.** Improve discharge planning processes/protocols county-wide.

- Goal: Within 2-3 years, no one will be discharged to the street or shelter.
- Create a county-wide process targeting at improving discharge planning.
    - Look into best practices that would apply to Pittsburgh
    - Design a packet of information for entities at transitional phase (hospitals; jails, recovery treatment centers)
    - Emphasize need to start at admission. Need to determine homelessness (or risk) at both intake and discharge.
    - Include faith based community in this planning. Many faith-based orgs would like to at least help provide emergency short-term shelter while the rest is worked out.
    - Identify hospitals and jails that need training on identifying people that are homeless (AGH does a good job).
    - Train on how to identify people at risk of homelessness (shelter addresses, etc.) + cultural sensitivity.
    - Create process that triggers a notification to either the OSN or HCH other appropriate services in a timely fashion so that OSN (or other provider) can connect that person to appropriate services upon discharge. Ideally do this at intake point.
    - Include the following issues in discussions:
        - Health and behavioral health needs
        - Enrollment (or re-enrollment) in Medicaid
        - SOAR connection
        - Connections to supportive services
        - For housing side – link to coordinated entry
- Address underlying issue that CES can currently only can accept someone into system if they'll be on the street that night; no real ability to do planning for follow-up care until it's known where discharged person will be going.
    - Look into creating an exception to day-of requirement of CES for people being discharged.
    - Determine the impacts (positive and negative) of making a policy change to the way CES operates
    - Creating a medical respite program is another possibility. AHN has a program. PMHS has investigated multiple respite models; has a great link to OSN and integrated primary care.
- <u>From hospitals:</u>
    - Monitor Allegheny Health Initiative's new 10-bed medical respite pilot program – particularly outcomes – to determine replicability and use for

getting buy-in for additional programs from major health care providers/payers.
    - Examine barriers to placement in Orr Center to determine how to reduce them. Currently, Orr Center won't accept person with a post-treatment housing plan already in place.
    - Educate hospital discharge planning staff:
        - Encourage use of ICD-10 codes for homelessness – right now they're only interesting in coding what will get reimbursed. Make sure they are aware that if someone gets readmitted, that person will already be coded. RESOLVE uses these. Approach RESOLVE about helping to educate hospitals on benefits.
        - Emphasize cost savings; focus on 30-day readmission penalty
        - Expand awareness of Operation Safety Net consultation services.
            - For people being discharged to the street, OSN will come talk to individuals about medicine, other needs.
            - Also available 24/7 to come to emergency rooms.
- From jail:
    - Research status of criminal justice discharge planning now around country.
    - Engage Jail Collaborative in planning, as well as Department of Corrections, Allegheny County, and judges/court system (including mental health court).
    - Look into adaptation of TSI model for reentry population.
    - Explore re-starting jail reintegration team that Goodwill used to run.
    - Use data warehouse to run report to match HMIS to identify inmates who may need housing support upon release.
    - Ensure jail has a point of contact for people with housing/healthcare needs.
    - Ensure connection to health services, Medicaid, medications, etc. Ohio example: Identify people who were eligible before jail and likely to be eligible after jail; prior to discharge, create Medicaid application. MCO comes into the jail and does the assessment while they are still in jail. Maybe SOAR staff need to help with that.
    - Create database of landlords who are amenable to housing reentering ex-offenders
- From drug and alcohol treatment centers:
    - Focusing on HUD priorities means this particular group isn't often prioritized.
    - Possible funding source: County currently has about $800K to go toward bridge housing for drug and alcohol recovery.
    - Incorporate substance treatment programs into shelters. Currently a lot of bridge and transitional housing has substance treatment, but that does not currently exist in shelters.
    - People to include in planning: County Administrator, Bureau of drugs and alcohol.

**III-2.** Develop/Expand service coordinators (connectors) to engage and assist individuals to navigate through the systems of care to get the services and resources they need, with the following recommendations:

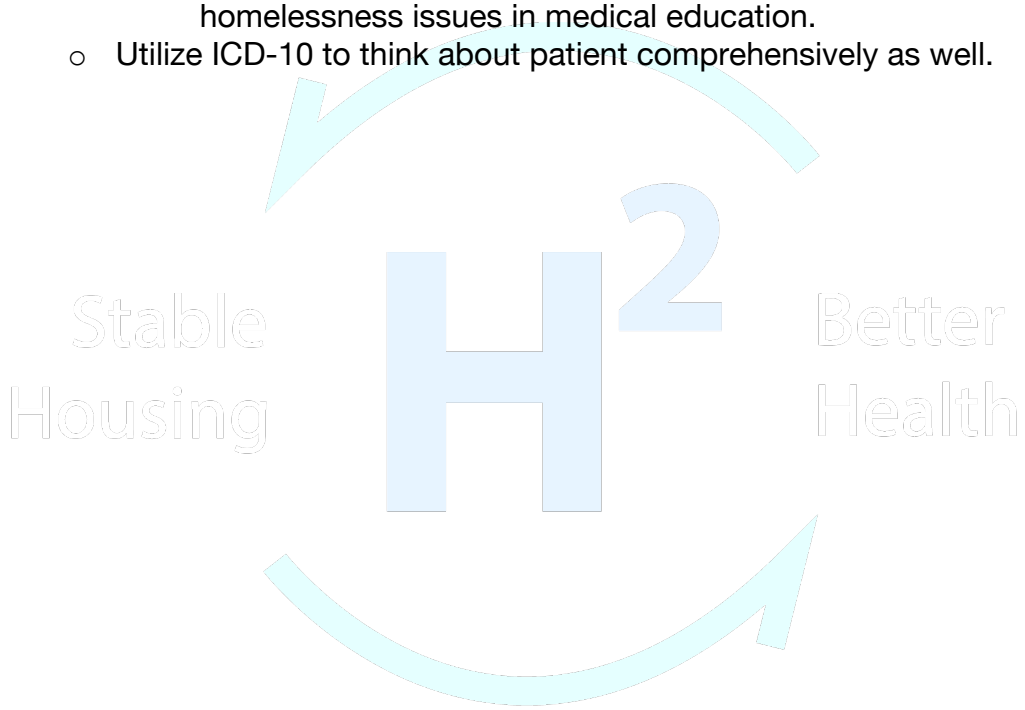
- Expand number of dedicated street outreach staff. Use dedicated model rather than general street outreach, with small case loads (~10 person case loads).
    - With no end date to assist individuals through their transition

    - Individualized with level of intensity to match individual's needs to help prevent individuals from reentering the homeless system; and
    - Available to individuals who may not always meet HUD's definition of homeless.
    - Improve follow up, especially following referrals to other agencies/programs.
        - Educate clients on how to use benefits
        - Bethlehem clinic used to make regular phone calls with everyone that wasn't otherwise getting more intensive (that was an SSO program that got cut) – need to make up with other funding (Medicaid, etc.)
            - HCH could do that follow up for its clinic sites and bill (at least partially) for it
            - Need to track outcomes
- Look at Western Psych, Center for Inclusion, Chartiers, Community Health Services, and UPMC HealthPlan for models of integrated care – "so we're creating better silos." Now we have to figure out how to track those and also replicate; make sure people know about that.
- Streamline services and housing referral processes
    - Make referral process more appropriate, accessible, user friendly, less time consuming and easier for both consumers and providers
    - Explore existing models for individuals exiting jail
- Develop service and housing options for people participating in treatment programs (such as drug/alcohol rehabilitation programs) who do not complete the program.

**III-3.** Rethink what primary care looks like for people experiencing homelessness, at least until they are in permanent, sustainable housing.

- Think of it as more of a critical time intervention.
- Convene FQHCs in county to discuss homelessness. Ultimate goal is to create system whereby people experiencing homeless have access to primary health (which includes behavioral health care), not just primary medical care, which is currently all that exists.
- Create new behavioral health infrastructure, particularly focused on people living on the street or in shelters, that includes walk-in behavioral health services.
    - HCHP has 3 hours every other week at one location. Expand upon this. Needed with more consistency and located at more sites.
        - Talk to PCA rep who was at this meeting
        - Let HRSA know about this issue: FQHCs not willing to get into behavioral health
        - Involve Estelle Richman
- Expand services available via HCH programs and other health care clinics on site at shelters.
- Include follow up once person is housed to assist with transition to using regular primary care and specialty services.
    - [Issue: primary care referrals often are followed up; people continue to use HCH anyway.]
- Shift focus of initial health care appointments from focus solely on problem that brought person in to taking time on the front end to learn about person as a whole, assess a person's needs more comprehensively.

- Utilize strength-based treatments (particularly in context of drug and alcohol treatment) and trauma-informed care. Note: This will require training across the system.
- Use Center for Inclusion (where social worker is in room with physician) and HCH programs (where nurses conduct more holistic evaluation/discussion) as examples to review and possibly expand and/or replicate. Monitor performance outcomes.
- Spending more time on the front end will save time/resources in the long term (including reductions in ER). Need to document this with data to get major health care players on board with this shift.
- Increase numbers of medical providers willing/trained to serve target populations.
  - Need better leadership in Medical School.
  - Center for Inclusion Health is starting a residency program to introduce homelessness issues in medical education.
- Utilize ICD-10 to think about patient comprehensively as well.



## IV. Maximize Use of Medicaid and Other Existing Resources to Support Housing Access, Retention, and Stability.

Goal/Objective: Increase and improve opportunities for people to access and retain stable housing through promotion of Housing First and maximized understanding and utilization of Medicaid and other resources in Allegheny County.

### Priority Strategies and Action Steps

**IV-1.** Develop Medicaid planning group including Allegheny County, FQHCs, Behavioral Health, and MCOs.

- Educate relevant stakeholders and providers about ability to bill Medicaid for homeless and housing-related services.
    - Education will vary based on whether stakeholders/providers are already set-up to bill Medicaid and/or will need to partner with Medicaid providers.
- Engage State Medicaid Office. Since the savings seen by MCOs go back to the state, the State is the party realizing savings resulting from successful interventions.
    - Determine best person to contact state health care financing agency.
    - Use $H^2$ plan to demonstrate the need for coordination.
- Identify interventions (by type of service, program, eligibility category) needed to support target populations that are eligible for Medicaid reimbursement.
- Research funding opportunities for integrating Behavioral Health and Primary Care.
- Research how to implement savings reinvestment strategies when Medicaid is a bifurcated system, with separated acute and behavioral health care.
- Longer Term Goal: Develop system to ensure warm hand-offs: throughout entire process there is an advocate working one-on-one with client.
    - Beginning with outreach workers, ER case managers from intake/assessment.
    - Break down silos between forms of case management.
    - Link to services, housing placement, housing stability.
    - Incorporate weekly case conferencing.
    - Consider how this could be done incrementally with existing supports and then expanded by using Medicaid dollars. Specifically, for this population, how might Managed Long Term Services and Supports lend itself to implementation of this?

**IV-2.** Increase Medicaid and disability benefits enrollment for eligible members of population.

- Explore partnerships between enrollment agencies (like YWCA) and agencies that have trusting relationships with consumers on the street (like Operation Safety Net) to engage consumers in enrolling for Medicaid, since it can take 3-4 encounters for a person to apply for Medicaid.
    - This is already happening on some level between OSN and Consumer Health Coalition. Could be expanded.
- Replicate Erie program of local FQHC coming to shelters to enroll folks into Medicaid/ Medicare
- Expedite Medicaid enrollment for homeless clients.
    - Decrease time for processing enrollment.

    - Improve coordination to determine eligibility and enroll clients on the spot (at multiple service providers/locations across the community).
    - Research Massachusetts process.
- Redesign the Compass application for low-income individuals to flag that an individual is homeless, at-risk of homelessness, or otherwise unstably housed.
- Expand the number of SOAR trainers and SOAR trained staff (including dedicated staff and staff at additional locations). Increase the number of benefits workers trained in the SOAR model to decrease number of clients rejected from Medicaid (from not submitting proper paperwork, missing deadlines, workers not understanding the process, etc.)
    - Pursue creation of one or more additional full-time SOAR workers (Mercy currently has 2 full-time SOAR workers, and there is still a waitlist). Emphasize ROI and approach entities that will see that return to fund position(s).
    - Explore use of interns from school of social work.
    - Approach financial assistance offices in hospitals, which currently only do Medicaid applications, to do SOAR training/do disability applications as well.
    - Increase number of people trained using 16-hour online training
- Expand the number of trained Medicaid Navigators.
    - Reach out to Just Harvest

**IV-3.** Determine opportunity for increasing access to services and follow through for clients.

- Using healthcare navigators as a model, increase opportunity for housing navigator /support service navigators (i.e., community support specialists)
- Develop policy / guidelines for integrated coordinated care model
    - Beyond simply enrolling in services
    - Model Practice: Children's Hospital Adolescent and Young Adult Medicine and Integrated Care Model
- Utilize peer support workers and CHWs (both of which could be billed under Medicaid) volunteers to increase benefits enrollment (on the spot) and serve as support service navigators
- Determine benefits eligibility and enrollment on-site – at point of services in lieu of sending client to a different location.

# Appendix A: Additional H$^2$ Strategies and Action Steps

The following strategies emerged from the planning session as part of the initial and second drafts of the Pittsburgh H2 Action Plan, but have not been identified as immediate priorities for the initial phases of implementation. The Leadership Team may revisit these ideas in the future as time and resources allow.

## I. Develop Data-Driven Service Interventions

1. Ensure that data collection and integration efforts include all users of data, including:
    - Payers
    - Providers
    - Policy makers
2. Monitor FUSE outcomes, including reduction in recidivism and cost savings. Use outcomes data to replicate and/or create similar programs aimed at targeting other people frequently using high cost public services, such as emergency services for non-emergency care.
    - Replicate successful UPMC/ Community Care partnership to determine high utilizers.
3. Consider collecting and analyzing data on homeless deaths to:
    - Formulate a plan to prevent future deaths on the street
    - Publicize the tragedy of death on the street.
    - Implement a review panel for people who die on the streets, similar to those that occur in child welfare when there's a death.
    - Start tracking outcomes, to be able to show decrease in mortality.
4. Encourage use of homeless/housing-related ICD-10 codes by health care agencies; ensure it is used in tandem with on-site interventions, because in isolation it may stigmatize and pre-dispose clients to poor outcomes in the system.
    - Will allow targeting of high users.
    - If health care agencies implement a comprehensive screening tool (is in discussion at AHN), providers could provide a real time intervention if someone shows up as homeless or housing vulnerable.
    - Research ICD-10 codes before approaching healthcare provider to develop a precise understanding of labor cost for administering screening and any associated reimbursement.
    - There is currently a comprehensive screening tool model in the Allegheny Health Network, which could be expanded. VA Pittsburgh also has one. Consider both models.
    - Potential work group around ICD-10/other payments for Community Health work?
5. Research lessons learned from I-Count model.

## II. Integrate Housing, health, and other services for Housing Retention and Ongoing Wellness

6. Develop robust centralized resource center from existing United Way/211 data base
7. Create alternatives to current options when police interact with unsheltered people with alcohol and drug issues. Current options are: police do nothing or take person to jail.
    - Increase education among police about Central Recovery Center.
    - Continue current training with law enforcement
    - Research San Diego serial inebriate program.
    - Partner with criminal justice center.
    - Explore need for and feasibility of creating a wet shelter.
    - Demonstrate cost benefits of engaging people experiencing homelessness and providing alternative options.

8. Research successful relationships between hospitals and foundations who work together to address issues of housing and homelessness.
    - Review Florida hospital model. $H^2$ Worksheet 3B, page 3.
    - Bring John Lovelace to the table.

## III. Improve Access to and Utilization of Services and Treatment

9. Build relationships at the agency level (not just between individuals) so that relationships aren't severed as a result of one staff person leaving.
    - Creating new and strengthening current committees will assist with the goal of building relationships at the agency level
    - Develop programming and staff training to reduce staff burnout and staff turnover.
    - Have agencies include in their job descriptions for anyone who networks with other agencies a list of the agencies/relationships that the position is responsible for maintaining. (e.g. Within first 2 months, make contact with every one)
        - Convene regular case management/coordination meetings across housing system (possibly including health care representatives as well) to discuss small group of vulnerable and/or difficult to serve clients and problem solve. Involve health care providers.
            - Each agency brings list of clients to discuss.
            - Perhaps start with a few housing programs and HCHP.
            - Existing groups to possibly build from:
                - HOCC (Homeless Outreach Coordinating Committee) – subcommittee of HAB - meetings – every 3rd Wednesday at 9:30 am at Community Human Services 5th avenue – maybe build off that
                    - Chris Roach will look into whether adding skype or some other type of conference option would be possible.
                    - Maybe research some master email lists to re-build HOCC list.
                - HOCC emergency responders subcommittee - quarterly emergency provider meetings (police commanders, community police liaisons, emergency services working with homeless (Chris Roach from OSN is chairing that)
                - OSN attends Mercy's complex care meetings once a month. 30% of their highest utilizers are in OSN database.
                - Could also consider building from Operation Safety Net's weekly Tuesday outreach team meetings. (First question is: "Who are you worried about?") or expand OSN weekly case conferencing meetings to include other relevant stakeholders (PD, EMS, HAWC, etc.)
10. From a consumer perspective, analyze where consumers are falling out of connecting to services (Calcutta example) – where does it actually fall apart for the people we're working for? OSN is starting to do this
11. Conduct research regarding scope of people experiencing homelessness exiting Pittsburgh to other parts of Allegheny County (particularly to places in the county with less accessible health care services.
    - One way: find out from public housing authorities where Section 8 vouchers are being used. (Jane Miller (HUD) will look into this)
    - Compare placement of people with available health care services in those areas.
12. Determine scope of need for palliative care program from people experiencing homelessness that are not a good fit for nursing homes (e.g. because of behavioral health issues). Currently, CoC programs are housing them, because placement elsewhere is not successful, but there is a real medical need as well.
    - If scope of need is large, consider creating a program to address the need.

- Look to The Open Door as an example to replicate *(Open Door is Housing First model).*

## IV. Maximize Use of Medicaid and Other Existing Resources to support Housing Access, Retention, and Stability

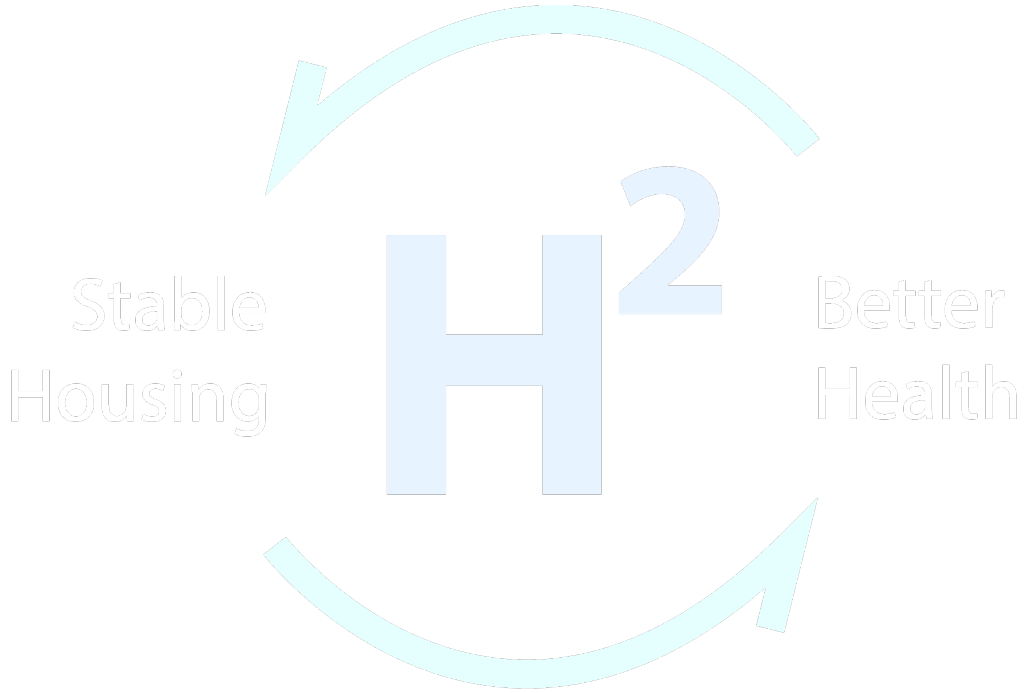
13. Incorporate $H^2$ plan into Homeless Advisory Board's messaging campaign to local foundations.
    - Leadership Team to present the Final Pittsburgh $H^2$ Action Plan to Homeless Advisory Board.
14. Publicize/communicate available resources in community.
    - Including fact that all veterans can be sent to VA, even those not eligible, and the VA will connect them to appropriate services
    - Awareness that Operation Safety Net can do free follow-up work to health care services, that they work with everyone who is living outside, and that they should be called when someone living outside is admitted to the hospital
    - Allow staff to spend time touring programs and understanding what's out there (which UHC does)
    - Use existing Health Committee?
    - FOCUS: [Create technology/social media strategy; full-time job to keep people updated on resources available. Should be part of CES charge.]
        - PHCUP has social work intern that has full time job of updating their HealthLink database.
        - 211 is working on an app
        - DHS is creating an app that includes an "ask an expert" and the experts can turn on or off like Uber drivers.
            - There's a resource guide that DHS puts out every year that has contact and eligibility criteria. Includes homeless programs.
            - That's what is being used to create the app.
        - Also an app in development aimed at consumers to navigate homeless system.
        - Ultimately make sure hospital social workers have access to these kinds of resources.
        - Consider creating apps aimed at both providers and consumers. CMU is really interested in this kind of stuff.
        - Texting is huge for this population. Can use for appointment reminders, etc. Could do general "blasts" whether bad weather shelter is open etc.
        - Emphasize online options because it's constantly changing.
        - Have agencies create better, more specific description of what they actually provide and to whom; who's eligible.
        - [Issue – are all of these solutions accessible to their intended end-users?]
    - Implement options for increasing education outreach/awareness among agencies about available resources
    - Develop policy that moves from silos to integration of care
    - Increase knowledge on housing options – especially rapid rehousing
    - Client Centered Approach
        - Triage and assess client based on need
        - Being mindful of cultural diversity and cultural barriers to access of services
    - Raise awareness about Medicaid expansion and support services covered by Medicaid.

# Appendix B: Additional Ideas

The following ideas were discussed at the planning session, and validated as useful and necessary, but are not being prioritized for action under the Pittsburgh $H^2$ initiative. The Leadership Team hopes these ideas will find traction in other planning and program development arenas, while $H^2$ attention focuses the key strategies enumerated above.

- Improve data collection methods from under-represented populations
  - Youth – Runaway youth, unaccompanied youth, LGBT (Project Silk: local program geared towards youth 13 – 29)
  - People living with HIV/AIDs
    - HOPWA programs, but not reporting in HMIS
  - Immigrants, undocumented persons, refugees, non-English speakers
  - Rural areas / suburban areas
    - Engage faith community, feeding programs, clothing
- Increase participation by school districts in data collection and reporting efforts.
  - Currently there are 40+ school districts in Allegheny County and the CoC has MOU's with 14 districts.
- Increase efforts/outreach during the annual point in time count.
  - Explore expansion of count to full registry week
  - Explore use of VI-SPDAT as part of PIT count
- Increase opportunity for utilizing VI-SPDAT for intake/assessment and creating a by-name registry for prioritizing housing and services for vulnerable populations
  - Utilize data from the VI-SPDAT to tell the full story to the community
  - Maximize use as a coordinated entry tool
    - Expand use by a wider array of providers – including hospital Emergency Department
- Create programs aimed at people experiencing homelessness in the 40-62 age range. Many such individuals have decades' worth of issues built up, but are not yet able to take advantage of programs aimed at seniors.
  - Incorporate meaningful activity (at least 15-20 hours of work)
  - Consider peer support as possible activity (RESOLE has peer support positions open)
  - Need to rebuild sense of dignity and belonging (social workers can help here)
  - Include physical activity
- Increase Permanent Supportive Housing Capacity.
  - Look to expansion and/or replication of Neighborhood Living Program (Housing First through Western Psych)
- Assure presumptive eligibility is available for length of time needed for assertive outreach
- Increase affordable housing and access to housing
  - Engage local government for use of funding for CDBG/HOME and Housing Trust Fund (PHARE)
  - Utilize the Allegheny Health Network (short-term housing/respite program) and mobile units to engage clients in need of housing and supportive services.
  - Continue to promote the Housing First approach and remove high barrier eligibility requirements.
  - Create a program for the rehab/renovation of "rundown" property through a public-private partnership.
    - Utilize Allegheny County list of housing stock that has been condemned or in need of rehabilitation to become habitable.
    - Develop training program and structure for participants.

        - Look to faith-based organizations as potential partners.
        - Examples: Habitat for Humanity (engaging Veterans); Mission Continuous (6-month program for veterans to participate in community service and receive a stipend)
- Expand landlord engagement and landlord negotiation/mediation to assist individuals in retaining their housing (particularly for clients with behavioral health needs)
    - Recognize/publicize "hero" landlords
    - Create "damage risk fund"/enhanced security deposit fund, so landlords worried about damage feel protected.
    - Educate landlords about supportive services/case management/etc. that would accompany a tenant where that's the situation.
    - Need to create strategy to persuade landlords to accept clients transitioning from housing programs to section 8 and will no longer have case management.
    - Build from Housing Alliance's current efforts:
        - Recent event in October to outreach to landlords; will be another next year.
        - In the meantime, consider webinars.



# Appendix C: Pittsburgh $H^2$ Leadership Council

Those who led the effort to convene the Action Planning Session have been proposed to continue, along with others identified at and after the Session, as follows:

**WORK GROUP LEADERS**

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$H^2$ Federal Partners will work to support and inform the state effort. The $H^2$ TA Team will provide support and function as liaison for at least the initial 90 days post action-planning session. Point of Contact: Gillian Morshedi, HomeBase, 415.788.7961 ex 301 gillian@homebaseccc.org.