Fairfield County, CT
H^2 Action Plan

Building Housing and Healthcare Systems that Work Together

This action plan emerged from the March 18 and 19, 2015 Fairfield County H^2 Action Planning Session held in Norwalk, Connecticut 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

Healthcare and Housing (H^2) Systems Integration Initiative

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.

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.

Fairfield County, Connecticut's H^2 action planning session was conducted March 18-19, 2015 in Norwalk, attended by approximately 80 people, representing federal and local government; homeless, HIV/AIDS and veterans providers; housing and healthcare agencies; and other interested parties. The Fairfield County H^2 Leadership Team, formed from the session's planning committee, 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.

Connecticut H^2 Target Population

People who are experiencing homelessness and/or who are living with HIV/AIDs, with a focus on those who are active substance users, in recent relapse, or facing eviction related to their use, and/or those with persistent mental illness.

Overview of Goals and Strategies

Goal I: Fill Key Gaps in Housing, Treatment, and Services To Improve Health and Housing Outcomes For Target Population.

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Strategy IV-B. Maximize use of Medicaid to finance services that support stable housing.

Strategy IV-C. Identify funding for non-Medicaid-covered services that promote housing stability and improved health.

Symbol Legend

Requires major change by Department Head or Policy Maker.

This work has been started by others. The H^2 Leadership Team will align with and support that work.

New work that is fundamental to success. Needs someone or some agency to take the lead.

Goal I. Fill Key Gaps in Housing, Treatment and Services To Improve Health and Housing Outcomes For The Target Population.		
Responsible Parties: Led by H^2 Leadership Team. **Key parties identified to implement:** Liberation Programs, Recovery Network of Programs (RNP), New Reach, Connecticut Counseling, Community Care Teams (CCTs), CCT Regional Leadership Team, Coordinated Access Network (CAN), BH-SA Steering Committee, DMHAS, Opening Doors Fairfield County (ODFC) (Coordinating Council, various committees), Secure Jobs Initiative, Norwalk Community Health, Connecticut Community for Addition Recovery (CCAR), Reaching Home (RH) Hospital Workgroup, Southwest Regional Mental Health Board, Regional Councils, Housing First Collaborative Teams (HF Teams), Economic Security Workgroup **Term: Starting immediately. 18 months to check in.**		
Strategies	**Actions to Carry Out Strategies and Indicators of Progress**	
Strategy I-A. Build A Substance Abuse Continuum Of Care That Is Easily Accessed, Adequately Resourced, And Connected To Health Care And Housing.		
	PRIORITY ACTION STEPS / KEY SYSTEM IMPROVEMENTS to be undertaken by H^2 Leadership Team	
	I-A-1. Enhance outreach capacity for people with substance abuse problems, using multiple teams and access points. ○ Link clients with existing outreach, engagement and assessment teams. ○ Work with state agencies and grant sources to create substance abuse outreach teams. ○ Target high users of emergency departments, clients who repeatedly miss appointments, and people are actively using or who have relapsed. Develop capacity to track and monitor this sub-population. **I-A-2. Add substance abuse peer specialists/recovery coaches to community health teams and other appropriate teams in order to support identification,**	Partners: Liberation, RNP, New Reach, Connecticut Counseling, CCAR

	intervention and recovery that is integrated with primary care. ○ Fully integrate primary care with behavioral health care. ○ Promote necessary cross-training as work force development for the para-professional pipeline. ○ Consider using CDBG public services dollars and SAMHSA grants for funding. ○ Utilize recovery support specialists already in community for this work. ○ Monitor Western Connecticut's pilot program (modeled on Cherokee Health Systems Model in Tennessee) aimed at integrating behavioral health with primary care.	Achievable in short term Partners: Community Care Teams; New Reach, CCAR
	FUNDAMENTAL WORK TO ENSURE SUCCESS **H^2 Leadership Team will Support Ongoing or New Efforts**	
	I-A-3. Facilitate linkages w/ housing. ○ Educate health and behavioral health workers about the effectiveness of Housing First in order to reduce barriers to access, building on ongoing efforts (e.g. members of Housing First teams attend CCT meetings and vice versa; Reaching Home Hospital Initiative highlights positive impacts housing has on health and access to care).	CCTs, RH Hospital Workgroup
Strategy I-B. Identify Gaps In Services And Other Barriers To Meeting The Housing And Health Care Needs Of The Target Population.		
	FUNDAMENTAL WORK TO ENSURE SUCCESS **H^2 Leadership Team will Support Ongoing or New Efforts**	
	I-B-1. Conduct a communitywide, system level review of gaps and other barriers that must be addressed in order to effectively serve the target population.	CCT Regional Leadership Team, CAN, community hospitals,

	○ Evaluate gaps in housing, health care, behavioral health care and other services. ○ Consider barriers to integrated care, including provider communication and collaboration as well as issues about Medicaid reimbursement.	Southwest Regional Mental Health Board, Regional Councils Include as standing agenda item for CCT Regional Leadership Team.
Strategy I-C. Expand Access To Other Key Health And Behavioral Health Care Services.		
	FUNDAMENTAL WORK TO ENSURE SUCCESS **H² Leadership Team will Support Ongoing or New Efforts**	
	I-C-1. Expand access to mental health services. ○ Conduct outreach to state and county leadership, emphasizing urgent need. ○ Reallocate psychiatric evaluations and medication management services resources, using non-clinic-based models where appropriate. Explore and incorporate different models for different situations. (e.g. mobile psychiatrist, mental health specialist, APRN) ○ Explore setting mental health appointments based on preferences/priorities. ○ If integration of behavioral health care and primary care is accomplished, this will be also. ○ Work to incorporate the Behavioral Health Homes Model to each community in a meaningful way **I-C-2. Expand/replicate Norwalk Community Health mobile van elsewhere as alternative to emergency departments for health care.**	BH-SA Steering Committee, DMHAS, Southwest Regional Mental Health Board Norwalk Community Health

Strategy I-D. Facilitate Housing Access And Retention.		
	PRIORITY ACTION STEPS / KEY SYSTEM IMPROVEMENTS to be undertaken by H^2 Leadership Team	
	I-D-1. Incentivize housing stability in managed care. ○ Share SIF or other existing data with hospitals that shows better linkages to housing and services for high-utilizers of emergency and other high-cost health care will prevent re-admissions and save them money. ○ Where there are already protocols in place to identify patients with housing needs and connect them to 2-1-1 or other housing resources, implement/improve training and educate for staff to ensure protocols are followed.	Lead: Lisa Bahadosingh. Support: Dr. Tait Michael; Staci Peete Include on CCT Regional Leadership Team's agenda.
	FUNDAMENTAL WORK TO ENSURE SUCCESS H^2 Leadership Team will Support Ongoing or New Efforts	
	I-D-2. Make a full spectrum of Affordable Housing choices accessible to the target population. ○ Create a Landlord Liaison program to recruit and retain a wide network of private-sector landlords who will rent to voucher holders. ○ Work to increase affordable housing units in Fairfield County. ○ Encourage shared housing and boarders. ○ Explore opportunities for creating a recuperative care program in Fairfield County. ○ Increase availability of housing vouchers. ○ Identify housing barriers and develop strategies for addressing them.	 ODFC Housing Committee, Communications Committee

	I-D-3. Coordinate housing access and assessment through the 211 Housing Unit. ○ Use information from state system to identify who needs what. ○ Update referral information regularly (more often than annually) and whenever programs change. ○ Support ongoing work to eliminate shelter wait list. ○ Implement Housing First and harm reduction approaches to housing access. **I-D-4. Prioritize housing access for people who are long time, but not chronically homeless.** ○ Support work of program-level staff together to jointly problem solve and place people in housing. [Regularly housing placement meetings are underway.] **I-D-5. Increase movement out of Permanent Supportive Housing (PSH) for those who no longer need (or utilize) that level of services and support.** ○ Work with PHAs to create priority, incentives and pathways for voluntary exits to Affordable Housing from PSH. ○ Examine other subsidies to help incentivize moving on from PSH when ready. **I-D-6. Increase household income to foster greater housing stability.** ○ Link clients with specialized employment assistance. Build strategic partnerships with employers and employment support specialists to provide employment opportunities. Put a priority focus on young adults, especially those with families. ○ Link clients with mainstream benefits (e.g. SSI/SSDI, TANF, SAGA) to increase income.	 ODFC, CAN  CAN, (Regional matching meetings/housing placement team)  Housing First Collaborative Teams and other PSH providers, CAN  Secure Jobs Initiative, Economic Security Workgroup

	I-D-7. Remove barriers for people needing PSH that have lost eligibility. ○ Progressive Engagement ○ Advocate/lobby for people needing PSH to be able to move into some sort of housing without losing opportunity/eligibility to get into PSH when unit opens up.	ODFC Coordinating Council
Goal II. Facilitate Expanded System And Service Level Integration And Coordination Of Care.		
Responsible Parties: Led by H^2 Leadership Team. **Key parties identified to implement:** ODFC (Coordinating Council, various committees), CAN, Coordinated Access, Connecticut Hospital Association, Primary Care Association, hospitals, Community Health Network (CHN), HF Teams and other Permanent Supportive Housing (PSH) providers, Catholic Charities, CCTs, Regional data specialists, Partnership for Strong Communities (PSC), RH Health and Housing Committee and Youth Workgroup, Corporation for Supportive Housing (CSH), Local Youth Taskforce **Launch phase: Communicate with identified partners – Summer 2015**		
Strategies	**Actions to Carry Out Strategies and Indicators of Progress**	
Strategy II-A. Establish structures to promote integration of health care and housing.		
	PRIORITY ACTION STEPS / KEY SYSTEM IMPROVEMENTS to be undertaken by H^2 Leadership Team	
	II-A-1. Establish a regional Leadership Structure to oversee implementation of H^2 Plan. ○ Regularly review data and progress in Plan implementation.	Partner: ODFC Coordinating Council
Strategy II-B. Ensure that clients are able to access the full range of assistance they need, no matter where they enter the system.		
	PRIORITY ACTION STEPS / KEY SYSTEM IMPROVEMENTS to be undertaken by H^2 Leadership Team	
	II-B-1. Implement a protocol that housing workers ask residents about status of healthcare connections and healthcare workers ask about housing	

	stability. ○ Develop standard questions to be used by providers, the coordinated assessment/entry system, and emergency departments. Track status as clients move through the system of care, and share data throughout the system. • On health care side, incorporate questions about housing status in interactions with clients, and build capacity to link clients with housing assistance resources. • On housing side, incorporate questions about health insurance and health access (including frequency of hospital admissions), and build capacity to link clients with insurance and health care resources. ○ Link standard questions to protocols for connecting identified clients to needed services. • On health care side, where patients are identified as needing housing assistance, protocols should include connecting those patients to 2-1-1 or other housing resources. • On housing side, where clients are identified as needing insurance, access to health care, care management, or other health services, protocols should include connecting those clients to enrollment and/or health care services. ○ Train staff on both housing and health care side on how to implement protocols (including education on what linkages/resources exist) and connect patients/clients to services in other system. ○ Follow best practices for supporting housing stability, such as Emergency Department diversion and 'no wrong door' policies. **II-B-2. Develop intervention protocols to guide the response to the answers to the standard questions about housing status and health insurance coverage.**	Partners: Housing side: CAN Chairs, Coordinated Access, Crisis Response Committee staff from CAN Health side: hospital network (admissions); Connecticut Hospital Association; Primary Care Association (for FQHCs); Community Health Network (already asking housing questions at hospitals) Partners: Same as II-B-1.

	○ Develop varying response protocols to address the range of need, from least needy to highest need clients. Protocols should be used by all providers, including the coordinated assessment/entry system and emergency departments. ○ Use best practices from the Veterans Affairs, Community Care Teams, and HIV one-stop centers. **II-B-3. Build capacity to link clients and patients identified as needing health care or housing services, respectively, to needed resources.** • Reach out to HRSA for additional training for SOAR. • Develop list of housing resources (including who to contact) for health care system staff. Develop list of enrollment and health care resources (including who to contact for which services) for housing system staff. • Create one-pager decision-tree tool for frontline workers with various pathways and provider contacts. Share with 2-1-1 and post around shelters, food banks, navigator agencies, etc. so it is visible to clients and potential clients as well. Create parallel tool for emergency departments and triage departments.	Partners: Same as II-B-1 and II-B-2.
	FUNDAMENTAL WORK TO ENSURE SUCCESS **H² Leadership Team will Support Ongoing or New Efforts**	
	II-B-4. Strengthen communication and coordination between the housing and healthcare systems to support integrated planning and care provision. ○ Explore best practices. ○ Engage more partners. ○ Housing and Healthcare representatives should maintain active participation on Community Care Teams. **II-B-5. Build work force capacity to deliver integrated housing and health**	 ODFC Health and Housing  ODFC Health and Housing,

	care. ○ Continue efforts to secure funding for housing navigators in hospitals. ○ Continue work to expand the number of patient navigators, health navigators, coordinated care teams and community health workers. Target those who have missed two appointments and/or are not in stable housing. ○ Support Medicaid 1915 (i) amendment underway. ○ Review Social Innovation Fund (SIF) model and replicate it. **II-B-6. Increase awareness of effective protocols in working with members of the Target Population.** ○ Help to inform both housing and health care systems. ○ Use technology, such as Internet-based platforms, for training and education. ○ Involve homeless and HIV/AIDS providers who have experience with the target population to provide training for mainstream health and behavioral health providers. Educate health systems workers regarding the effectiveness of Housing First.	CCT Regional Leadership, PSC, Reaching Home Health and Housing Committee, CSH  Health side: hospital network (admissions); Connecticut Hospital Association; Primary Care Association (for FQHCs); CHN (already asking housing questions at hospitals) Housing side: CAN
Strategy II-C. Develop coordinated approaches to improve quality and cost-effectiveness of care.		
	FUNDAMENTAL WORK TO ENSURE SUCCESS **H² Leadership Team will Support Ongoing or New Efforts**	
	II-C-1. Implement best practice Emergency Department diversion models to reduce costs. ○ Educate clients and providers on use of community health centers. ○ Incorporate prevention/diversion staff with access to transportation resources to help clients access the assistance they need. Use navigators	 CCTs

	to connect clients with housing resources. **II-C-2. Expand Frequent Users Systems Engagement (FUSE) project which targets people who cycle through the homeless service and corrections systems and places them in permanent supportive housing.** **II-C-3. Engage all community-based providers in Second Chance discharge planning, including a warm hand-off at release.** ○ Provide discharge planning upon release from foster care and other institutions, and return to community from other states. ○ Assess current system serving unstably housed and homeless youth (resource mapping). **II-C-4. Document cost-savings from these strategies and reinvest upstream.**	 HF Teams and other PSH providers  HF Teams, Catholic Charities, Local Youth Taskforce, RH Youth Workgroup  CCTs, Hospitals

Goal III. Enhance Data Quality, Analysis And Sharing To Improve Client Outcomes And System Efficiency.		
Responsible Parties: Led by H^2 Leadership Team (with Dr. Tait Michael spearheading). **Key parties identified to implement:** ODFC (Coordinating Council, various committees), CAN, Coordinated Access, hospital network, Connecticut Hospital Association, Primary Care Association, CHN, data specialists, Value Options (VO), CCT Regional Leadership Team, 211/United Way **Launch phase: Communicate with identified partners – Summer 2015**		
Strategies	**Actions to Carry Out Strategies and Indicators of Progress**	
Strategy III-A. Develop A Process For System-Level Data Collection And Analysis To Provide The Foundation For Data-Driven Services, Treatment And Housing Provision.		
	PRIORITY ACTION STEPS / KEY SYSTEM IMPROVEMENTS to be undertaken by H^2 Leadership Team	
	III-A-1. Identify what data is currently being collected and what additional data should be collected. ○ Understand what each system needs to know from the others. ○ Achieve shared definitions of key words (e.g. "homeless"). ○ Train staff on how to effectively and accurately collect and enter desired data. ○ Work with CCTs that are already looking into enhanced data collection.	Partners: Connecticut Hospital Association; Primary Care Association (for FQHCs); CHN (already asking housing questions at hospitals)
	III-A-2. Identify stakeholders to align this effort with data work being done under other initiatives. ○ Work with state hospital association and primary health care association to	Partners: Value Options (VO), Hospitals, Standards and Evaluations Committee, ODFC

	engage their members in this effort	Coordinating Council, CCT Regional Leadership; 211
	FUNDAMENTAL WORK TO ENSURE SUCCESS **H^2 Leadership Team will Support Ongoing or New Efforts**	
	III-A-3. Identify existing and potential data collection points, including for gathering intake data, tracking client progress, documenting outcomes, and measuring system inefficiencies.	
	III-A-4. Develop data collection standards and data sharing protocols for HMIS, CAREware, and other data systems.	
Strategy III-B. Use Data To Inform Efforts For Policy And System Change To Improve Care And Outcomes For Vulnerable Populations.		
	FUNDAMENTAL WORK TO ENSURE SUCCESS **H^2 Leadership Team will Support Ongoing or New Efforts**	
	III-B-1. Analyze data collected at regularly scheduled intervals, at a system-wide level to determine what new programs or other interventions are needed. ○ Use data to identify and define resource gaps. ○ Track and monitor vulnerable populations that are not accessing services, including undocumented individuals, medically-vulnerable, substance users (active and relapsed), and young adults (18-24). ○ Using CCTs as a base, develop inter-system and inter-program "alert" mechanisms based on agreed upon criteria.	 ODFC Coordinating Council; Health and Housing

	III-B-2. Collect and analyze data that documents effectiveness and cost savings. ○ Review viability of transitional housing and congregate-type housing, including data on service models, client characteristics and outcomes. ○ Develop strategies for reinvesting identified cost-savings where there is most need and they will have most impact. Work with existing advocacy groups and funders to make these recommendations.	
Goal IV. Secure Stable Funding To Support Provision Of Integrated Housing And Health And Behavioral Health Services And Treatment.		
Responsible Parties: Led by H² Leadership Team. **Key parties identified to implement:** New Reach, Norwalk Community Health, Statewide Health Care and Housing Committee, DSS, State Medicaid, ODFC (Coordinating Council, various committees), Supportive Housing Works, CCTs, Connecticut Coalition to End Homelessness (CCEH), PSC, CSH, Social Innovations Fund (SIF) Initiative, Primary Care Association, FQHCs, Health Resources and Service Administration (HRSA), Access to Benefit Online (ABO) Centers **Launch phase: Communicate with identified partners – Summer 2015**		
Strategies	**Actions to Carry Out Strategies and Indicators of Progress**	
Strategy IV-A. Ensure that eligible members of the target population have health coverage that will pay for their services and treatment.		
	PRIORITY ACTION STEPS / KEY SYSTEM IMPROVEMENTS to be undertaken by H² Leadership Team	
	IV-A-1. Involve all programs serving the target population in effort to ensure 100% enrollment in Medicaid. ○ This includes mobile vans, Care Teams, Navigators, Outreach Workers, Eligibility Workers, staff trained in the Vulnerability Index, Coordinated Entry and 2-1-1 staff, Housing First Collaborative, School Health Center Nurses, PATH Teams, SIF, Hospital Emergency Department, Police Department,	Partners: New Reach; Norwalk Community Health (mobile vans); Health Care and Housing Group; DSS; point of

	HOPWA-funded agencies, GBHI, CABHI and DSS. o All should identify clients in need of enrollment or renewal assistance, and either provide assistance directly or link with assistance by another agency. o Advocate for presumptive eligibility. **IV-A-2. Expand successful SOAR enrollment assistance strategies throughout the County.** o Expand the number of SOAR-trained workers, including community health workers, who can assist with the SSI/SSDI and DSS Medicaid application processes. [See above.] Ideally, SOAR specialists should assist with benefits generally, including Medicaid, SNAP, etc. o Place SOAR-trained workers in key locations, including Emergency Departments. o Identify locations for SOAR training throughout the County with the goal of maximizing participation. o Create drop-in center with stationed SOAR specialists. **IV-A-3. Advocate for increased transparency and access to DSS, expedited processes, designated eligibility workers, and out-stationed eligibility workers to facilitate enrollment.** o Explore out-stationing of a DSS eligibility worker at the Norwalk Community Health Center and other high volume locations. o Advocate for specific DSS worker to be assigned to be point of contact for Homeless Outreach Teams in key places. (Currently exists for Homeless Outreach Team in Bridgeport.)	contact for on-line benefits eligibility, hospitals and emergency rooms, FQHCs. Partner: New Reach Identify State Medicaid regional staff member to work with Leadership Team on this.

	ADDITIONAL WORK TO ENSURE SUCCESS **H² Leadership Team will Support Ongoing or New Efforts**	
	IV-A-4. Promote client awareness and education about expanded Medicaid eligibility requirements and enrollment resources. ○ Create Work Group or Task Force to implement. ○ Explore how McKinney-Vento funds are currently used and whether we can influence how outreach/enrollment is being conducted.	Access to Benefit Online (ABO) Centers, McKinney-Vento funded FQHCs, Primary Care Association, HRSA
Strategy IV-B. Maximize use of Medicaid to finance services that support stable housing.		
	PRIORITY ACTION STEPS / KEY SYSTEM IMPROVEMENTS **to be undertaken by H² Leadership Team**	
	IV-B-1. Investigate Medicaid funding for services and treatment for the target population and for services that support housing access and retention, including through State Plan amendments. ○ Engage experts/people already trained on billing Medicaid to train housing providers on how to become Medicaid billable/build infrastructure to bill Medicaid. ○ Research what billing codes may apply to services provided; whether and how to bill for care coordination; etc. Review CMS's June 29, 2015 Program and Policy Alert, "Medicaid Financing for Housing-Related Services." Seek out research already done in this area at state level. ○ Explore changes needed to improve coverage and reimbursement rates for: client assessment, case management/care coordination/navigator services, crisis intervention, therapeutic rehabilitation skills development, illness management, and peer support services. ○ Consider a 1915(i) Home and Community-Based Services State Plan	Lead: Dr. Michael Partners: Partnership for Strong Communities; CSH, Statewide Health and Housing Committee

	amendment to allow reimbursement for services in supportive housing.	
	FUNDAMENTAL WORK TO ENSURE SUCCESS **H² Leadership Team will Support Ongoing or New Efforts**	
	IV-B-2. Facilitate community-based agency capacity to bill Medicaid for services. ○ Support agencies in making necessary changes in structure, staffing and operations. Facilitate staff training in billing and improvements in technology. ○ Facilitate partnerships between agencies or identify a central agency to handle the back-office administrative functions needed by community-based agencies to bill Medicaid.	Lead: Dr. Michael Partners: Partnership for Strong Communities; CSH
Strategy IV-C. Identify funding for non-Medicaid-covered services that promote housing stability and improved health.		
	FUNDAMENTAL WORK TO ENSURE SUCCESS **H² Leadership Team will Support Ongoing or New Efforts**	
	IV-C-1. Aggressively pursue federal, state, local and private funding options. ○ Set up Fairfield County Funding Collaborative. ○ Explore use of Federal and State block grant funding. Participate in development of plans and need statements in order to align use of funds with needs. Incorporate consumer input. ○ Advocate for HRSA and SAMHSA support for integrated housing/health efforts. ○ Identify philanthropic funding sources. ○ Continue advocacy work on the state level to maintain and increase funding for housing first and value based care models.	Coordinating Council

	IV-C-2. Enter into cross-agency strategic partnerships and pool fundraising staff for collaborative housing/health projects. ○ Explore strategies to blend or braid funding for collaborative projects. **IV-C-3. Engage in public education and public advocacy efforts to build political will and raise community awareness.** ○ Determine what specifically to push for to address known issues. ○ Advocate to local and state elected officials (e.g. circulate white paper).	 ODFC, Supportive Housing Works  ODFC Communication Team, CCTs, CCEH, PSC, CSH, SIF

Appendix

The following ideas were also discussed at the planning session, and validated as useful and necessary, but are not being prioritized for action under the H^2 Initiative at this time. The Leadership Team hopes that these ideas will find traction in many other arenas, both planning and program development, while H^2 attention is focused on achieving the cornerstone strategies enumerated above.

Fill Gaps in Housing, Treatment, and Services

- Increase local rehab and detox beds in geographic areas where need exists.
- Identify resources for dental care.
    - Engage universities and community health centers to sponsor dental/medical camps.
    - Engage private providers in providing volunteer services.
    - Explore Medicaid waivers and changes to the State Medicaid Plan.
    - Look for philanthropic support.
- Improve access to care in rural areas by addressing transportation issues.
- Create a landlord assistance fund to provide payments for damages to units and maintain a 24-hr on-call person to provide mediation and problem-solving assistance.
- Maintain existing Transitional Housing and other congregate models and target these units to priority populations.
- Facilitate on-going housing stability.
    - Link with community-based supports to help to maintain housing after Rapid Re-housing resources expire. (CTI training underway.)

Facilitate Expanded Systems and Service Level Integration and Coordination of Care

- Integrate health care and housing planning, goal setting and outcome measures.
    - Ensure that healthcare providers participate in Consolidated Planning, PHA, LIHTC and Housing Trust Fund processes, and that housing providers participate in Medicaid/Behavioral Health and other healthcare planning.

Enhance Data Quality, Analysis, and Sharing

- Create a data repository and cross-system data analysis capacity.

    - Conduct analysis to identify where system/programs are working well and should be brought to scale and where new interventions are needed in order to address unmet needs and improve outcomes.
- Explore ways to incorporate sharing of data from domestic violence shelters.
- Use data to engage providers outside the homelessness system and build collaboration.
- Engage agencies serving households with incomes below the poverty line, including working poor households (about 37% of Fairfield County Households are at risk of homelessness).
    - Identify the targeted providers that need to be involved (e.g. DOC, DOL, DCF, DSS, etc.)
    - Identify the relevant data to present to each identified provider to inspire their engagement and participation. (e.g. hospital Emergency room data, United Way's ALICE Constrained, Employed) data, cost-savings data, etc.)

Secure Stable Funding

- Analyze DSS data to see who is receiving benefits and who is not, to better target outreach efforts.
- Identify funding for expanded enrollment activities.
    - Explore involvement of hospitals to underwrite some of the costs.
    - Investigate possibilities for billing Medicaid, as was done in Bridgeport with the school health centers.
    - Include Medicaid enrollment staff and sites as part of proposed State Medicaid Plan amendments, including substance abuse amendment.
- Increase number of medical practices that accept Medicaid.
    - Educate general public and professionals that homelessness is an issue that affects all in community.
    - Reduce stigma/fears about homelessness & Medicaid clients.
    - Develop voluntary, provider-controlled model where third-party screens & refers based on provider's willingness to take more patients.
- Partner with the Department of Corrections to address loss of benefits while in jail or prison. Explore strategies for enrollment or reinstatement of benefits before release.
- Address the coverage needs of those who fall into the coverage gap, not eligible for Medicaid but with incomes too low to access a decent health plan through the Exchange.

Glossary of Key Terms

Behavioral Health-Substance Abuse (BH-SA) Steering Committee: A taskforce of key stakeholders from the Greater Bridgeport Region who work to increase the understanding of mental health and substance abuse as public health issues in order to achieve equal access to prevention and treatment.

Community Care Team (CCT): A collective of invested parties from the local community who share the belief that community collaboration is necessary to improve outcomes for vulnerable populations including those who are chronically physically and/or mentally ill, homeless or abusing substances. The goal is to improve care, increase community safety and reduce costs by developing wrap around services through multi-agency partnership. CCTs have had proven success in reducing emergency department (ED) utilization and hospital admissions.

Community Care Team Regional Leadership: A working group made up of the Chairs from CCTs throughout Fairfield County, as well as representatives from Community Health Network, Value Options, and Middlesex Hospital, who meet quarterly in order to learn from one another and continue to improve practices related to data collection, data sharing, and patient navigation/care coordination.

Connecticut Coalition to End Homelessness (CCEH): An organization that represents more than 75 members – emergency shelter providers, transitional housing providers, community and business leaders, and strategic partners – who share the goal of ending homelessness. In partnership with communities throughout the state, CCEH advances this goal through leadership, community organizing, advocacy, research, and education.

Coordinated Access Network (CAN): The regional body that develops and governs the implementation strategies used to improve access to housing resources for those experiencing housing crises. CAN is made up of service providers throughout Fairfield County, and has created a new access system that ensures one point of entry with a standardized response that works to align each family and individual with the level of intervention that can most quickly return the household to stability.

Federally Qualified Health Centers (FQHC): Any health care organization receiving grants under Section 330 of the Public Health Service Act (PHS). FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.

Health Resources and Services Administration (HRSA): An agency of the U.S. Department of Health and Human Services. It is the primary Federal agency for improving access to health care by strengthening the health care workforce, building healthy communities and achieving health equity. HRSA's programs provide health care to people who are geographically isolated, economically or medically vulnerable.

Housing First Collaborative (HFC) Teams: Locally developed, multi-agency programs in which members work to align the necessary resources to end chronic homelessness in their communities and create the service infrastructure to ensure those who are most vulnerable will remain stably housed long-term.

Opening Doors Fairfield County (ODFC): The merger of three distinct Continua of Care (CoC) – Opening Doors Stamford/Greenwich, Opening Doors Greater Norwalk, and Opening Doors Greater Bridgeport – that represents the committed efforts of civic, religious, political, business and non-profit leaders to prevent and end homelessness throughout Fairfield County. ODFC is led by a Coordinating Council and has numerous workgroups that have each aligned their goals with the federal and state Opening Doors Plan.

ODFC Health and Housing Workgroup: A workgroup of ODFC that focuses on improving access to housing and healthcare for 3 priority populations - those who are deemed the most vulnerable (by an indicator such as the VI-SPDAT or high utilization of emergency services), those re-entering the community after incarceration, and youth.

Partnership for Strong Communities (PSC): A statewide nonprofit policy and advocacy organization dedicated to ending homelessness, expanding the creation of affordable housing, and building strong communities in Connecticut.

Project for Assistance with Transitioning from Homelessness (PATH): A program, which is nationwide and federally-funded, that provides assertive outreach to persons who are homeless to connect them with case management. services.

Reaching Home (RH) Hospital Workgroup: Partnership for Strong Communities received funding from the CT Health Foundation to partner with the CT Hospital Association on a housing and healthcare integration initiative aimed at reducing re-hospitalizations and readmissions for people who are homeless or unstably housed through better identification, discharge planning, and connections to community supports. The initiative works with Community Care Teams in 6 hospitals throughout CT. These include Yale-New Haven, Hartford Hospital, St. Francis Hospital, Middlesex, Norwalk and New London.

Reaching Home (RH) Runaway and Homeless Youth Workgroup: Partnership for Strong Communities and The Center for Children's Advocacy have brought together key stakeholders in CT who are working to:

- Examine and understand the scope of experiences of unaccompanied homeless children and youth and identify the needs of unaccompanied homeless children and youth in Connecticut.
- Raise awareness and collect data on homeless youth.
- Advocate for service recommendations to solve the problem.

Substance Abuse and Mental Health Services Administration (SAMHSA): The agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

Secure Jobs Initiative: A local effort that is part of a statewide program called Secure Jobs Connecticut, a $700,000 investment that uses state aid and private donations through the Melville Charitable Trust to help combat homelessness. The funds will help connect 25 families with workforce training, education and support programs to help them find competitive, long-term employment.

Social Innovation Fund (SIF) Program: National pilot project led by the Corporation for Supportive Housing (CSH), funded through a Social Innovation Fund grant from Corporation for National and Community Services (CNCS). It provides supportive housing and enhanced healthcare navigation for high utilizers of acute medical services.

SSI/SSDI Outreach, Access, and Recovery (SOAR) Initiative: A national program designed to increase access to the disability income benefit programs administered by the Social Security Administration for eligible adults who are experiencing or at risk of homelessness and have a mental illness, medical impairment, and/or a co-occurring substance use disorder.

Fairfield County H^2 Leadership Team

Those who led the effort to convene the Action Planning Session have been proposed to continue, as follows.

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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 the initial 90 days post action-planning session.

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