Idaho
H^2 Action Plan

Building Housing and Healthcare Systems that Work Together

This Action Plan emerged from the May 27-28, 2015 H^2 Action Planning Session held in Boise, Idaho as part of the U.S. Department of Housing and Urban Development's Healthcare and Housing (H^2) Systems Integration Initiative.

August 2015

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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.

Idaho's H^2 state-wide action planning session was conducted May 27 and 28, 2015 and was attended by over 40 people, representing federal and local government; homeless, HIV/AIDS and veterans providers; housing and healthcare agencies; and other interested parties. The Idaho 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.

Priority Plan Outline

In this document, Priority Strategies identified by the Leadership Team have been separated out into a "Priority Plan," which is presented before the complete Idaho H² plan. The complete plan includes both priority strategies and additional strategies that emerged from the Planning Session. The Priority Plan represents the strategies and action steps on which the Leadership Team will focus its implementation efforts.

Objective I. Close the Gap in Housing and Health Care Services and Treatment by Increasing Services, Reducing Barriers, and Facilitating Access for Idaho's Most Vulnerable.

Strategy I-A. Connect people with chronic conditions to consistent care (e.g. FQHCs). Many use emergency departments and/or free clinics, which are not intended to provide ongoing primary or specialty care.

Strategy I-B. Review Model program: three-agency safety net provider collaboration in Northern Idaho, including County Health, County Hospital and FQHC. All uninsured patients at hospital are referred to social services where they are given a thorough intake and referral, follow-up, and support.

Strategy I-C. Educate public housing authorities (PHAs) and affordable housing developers and providers about benefits and success of PSH, including partnerships necessary for successful outcomes, and where to refer tenants for (1) enrollment and (2) care coordination.

Strategy I-D. Increase access to ongoing specialty care for better medication management and slowing progression of debilitating chronic illnesses, including HIV, diabetes, severe & persistent mental illness, substance use disorders, etc.

Objective II. Develop a robust, integrated data-driven system that uses data to understand and assess needs, evaluate program effectiveness, demonstrate cost savings and secure funding, and generate an accurate picture of homelessness in Idaho.

Strategy II-A. Determine what data is currently collected at various agencies/providers across the state. Specifically**:**

- **Housing data collected by health care providers (including hospitals, MCOs, Indian Health Services, etc.)**
- **Housing data collected (or just maintained) by local health districts**
- **Health care data (including insurance, access, health status info) collected by housing providers/agencies**

Strategy II-B. Develop crosswalk between terms and among programs' varying eligibility standards and cross-train staff.

Strategy II-C. Use data collected to:

- **Assess need and understand community;**
- **Evaluate/demonstrate cost savings resulting from successful interventions;**
- **Support funding requests and funding reports;**

- **Determine effectiveness of interventions (i.e. identify successful and unsuccessful programs and interventions) and improve processes on an ongoing basis; and**
- **Generate an accurate picture of homelessness that go beyond data collected during PIT count.**
- **Conduct Frequent User Data Matching.**

Objective III. Establish mechanisms for housing and health care systems to work cooperatively, thereby reducing barriers and improving health through greater access to, and maintenance of, health care and stable housing.

Strategy III-A. Develop Community-based Permanent Supportive Housing Solutions.

Strategy III-B. Establish funding priorities at both the county and state level for the development of permanent supportive housing for chronically homeless, with an emphasis on housing the most vulnerable and those most in need.

Strategy III-C. Launch H^2 permanent supportive housing Production Pipeline process.

Strategy III-D. Explore discharge planning options in each Region to reduce situations where people remain in hospitals and other institutions (mental health, jails, prisons) longer than medically necessary due to lack of housing and/or services available outside of the hospital/institution.

Objective IV. Minimize Homelessness by Maximizing all Funding Streams to Finance Services, Treatment, and Permanent Supportive Housing.

Strategy IV-A. Maximize use of current Medicaid program.

Strategy IV-B. Conduct gap analysis of Medicaid plan to determine need for waiver, partnering with Medicaid-reimbursable providers, using existing coverage, or seeking financing elsewhere to provide services that support housing stability to the Target Population.

Strategy IV-C. Incorporate housing stability in health plan contracts.

Strategy IV-D. Support continued identification of creative funding streams of Housing Trust Fund, including acceptance of federal resources. IHFA will participate, along with representatives from health service providers and development community.

Idaho's H^2 Priority Plan

Leadership/Coordination: Preliminary Strategies

Preliminary Strategy I. Form a Policy-Level Leadership Group to Implement the Strategies and Action Steps Identified in this Action Plan.

- Meets quarterly to review recommendations and set direction for H^2 implementation, including by identifying opportunities through existing infrastructure and modeling. (e.g. potential collaboration of Department of Health & Welfare's Housing Navigator program with other sub-programs to expand program to those experiencing homelessness).
- IHFA to provide leadership and staff support to collaboration (i.e. hosting, team building)
- Convene regional level meetings for community participation, setting local outcomes and implementing demonstration project
- Members to include: IHFA, City of Boise, primary care associations, FQHCs, health system, hospitals, Idaho Medical Association, Idaho Hospital Association, Behavioral Health collaborative, State Health and Welfare (Medicaid, Behavioral Health, SHIP), United Way, insurers, universities, PHAs, Entitlement Jurisdictions CD representatives, Governor's Redesign Committee.
- Leadership group to be informed by and possibly include members from existing Regional groups (e.g. Regional Housing Coalitions, Regional Behavioral Health groups, Public Health Districts)
- Seek involvement of: John Ruche in House; prominent Boise person (e.g. a physician); Richard Armstrong, State Dir. of Health & Welfare; unaffiliated 3rd party.
- Leadership Group to include an Executive Committee to take comments from entire membership and make decisions.

Preliminary Strategy 2. Develop a coordinated approach to educate decision-makers.

- Educate, collect and use stories, emphasize cost savings in hard dollar amounts.
- Identify web-based video/Prezi presentations that make the case effectively.
- Show that housing is healthcare.
- Convince the various boards and policy forums that housing is a big issue and in ending homelessness takes precedence over food, transportation, and other safety net services
- Build off H^2 planning session handouts
    - Align with IHFA Home Partnership Foundation fundraising campaign
    - Population data
    - Opportunity to invest in housing
    - Cost savings

Preliminary Strategy 3. Request a representative from Governor's Redesign Committee to participate in H^2 Leadership or Policy-Level Leadership Group.

- Communicate status of re-design efforts to H^2 constituencies.
- Include Medicaid representatives in Policy-Level Leadership Group (described in Preliminary Strategy 1) meetings.

Implementation Details for Preliminary Strategies
Responsible Parties: H^2 Leadership Team; Emerging Policy-Level Leadership Group
Timeline: 2015 Q3

I. Closing Service and Treatment Gaps, Removing Barriers, and Increasing Access

Objective: Close the Gap in Housing and Health Care Services and Treatment by Increasing Services, Reducing Barriers, and Facilitating Access for Idaho's Most Vulnerable.

Strategy I-A. Connect people with chronic conditions to consistent care (e.g. FQHCs). Many use emergency departments and/or free clinics, which are not intended to provide ongoing primary or specialty care.

- **Create resource listing Community Health Centers and FQHCs and how to use each. Include details about what types of services each provides (behavioral health, dental care, specialty care, etc.).**
- **Educate clients and program staff on how to use medical system appropriately, including what options are available to them.**
    - See: CMS website Toolkit: From Coverage to Care
    - Veterans Affairs (VA) conducts outreach/education events four times a year. Approach them about using one of those for this issue.

Implementation Details for Strategy I A
Responsible Parties: Theresa McLeod with partner TBD
Timeline: TBD
Measureable Outcomes: TBD

Strategy I-B. Review Model program: three-agency safety net provider collaboration in Northern Idaho, including County Health, County Hospital and FQHC. All uninsured patients at hospital are referred to social services where they are given a thorough intake and referral, follow-up, and support.

- **Find out details. How it was created; how it worked.**
- **Link to Coordinated Entry System point of entry.**
- **Make sure housing representative is part of Northern Idaho program and in any new similar programs.**
- **Make sure healthcare providers are part of the Coordinated Entry System planning that is starting to occur.**

Implementation Details for Strategy I B
Responsible Parties: Pam Thompson; Stephanie Bloom; Wyatt Schroeder; [Representative from St. Vincent de Paul]
Timeline: TBD
Measureable Outcomes: TBD

Strategy I-C. Educate public housing authorities (PHAs) and affordable housing developers and providers about benefits and success of PSH, including partnerships necessary for successful outcomes, and where to refer tenants for (1) enrollment and (2) care coordination.

- **Use IHCCs to provide education.**
- **Invite industry leaders and/or consultants to Idaho to educate developers on appropriate and necessary supportive services, and how those partnerships formed and services leveraged.**

Implementation Details for Strategy I C
Responsible Parties: Deanna Watson; Brady Ellis; Melanie Curtis; Anna Whitehead
Timeline: Beginning 2015 Q3 (e.g. Fall Housing Conference has sessions relating to this)
Measureable Outcomes: TBD

Strategy I-D. Increase access to ongoing specialty care for better medication management and slowing progression of debilitating chronic illnesses, including HIV, diabetes, severe & persistent mental illness, substance use disorders, etc.

- **Explore tele-case management and tele-medicine for mental health services (look into VA program and how to expand) [Gary Gant will send information on how this works in Alaska]. Ongoing efforts to bring this to Idaho. Support/join current effort rather than starting new. See Idaho Behavioral Health Planning Board.**
- **Explore use of paraprofessionals, navigators, community health workers.**
- Look into Direct Care for elderly and mentally ill and how to expand.
- Connect to Terry Reilly's database of specialists.
- Coordinate with hospitals to create Program for Assertive Community Treatment (PACT) Teams.
- Explore use of block grant for substance abuse resources. Many people that don't qualify for Medicaid qualify for assistance under this grant.
- [For those with HIV, connect to Ryan White programs regarding their medication management resources for PLWHA.]

Implementation Details for Strategy I D
Responsible Parties: Aimee Shipman; Gina Westcott; [Behavioral Health Planning Board] [Anna Whitehead to link to tele- people at the VA]
Timeline: TBD
Measureable Outcomes: TBD

II. Implementing Data-Driven Solutions

Objective: Develop a robust, integrated data-driven system that uses data to understand and assess needs, evaluate program effectiveness, demonstrate cost savings and secure funding, and generate an accurate picture of homelessness in Idaho.

Strategy II-A. Determine what data is currently collected at various agencies/providers across the state. Specifically:

- **Housing data collected by health care providers (including hospitals, MCOs, Indian Health Services, etc.)**
- **Housing data collected (or just maintained) by local health districts**
- **Health care data (including insurance, access, health status info) collected by housing providers/agencies**
- **Housing and/or health care data collected by other systems:**
  - Criminal justice/jails
  - Police and fire departments
  - EMS
  - Schools
  - Faith-based organizations
  - Community-based organizations (CBOs)
  - Mental Health Centers
  - Funders (e.g. United Way)
  - CMS
  - Education
- **For each, identify:**
  - How data is collected (what questions are being asked)
  - By whom
  - When in client engagement process
  - Where the data is stored
  - Who can access which data
  - What privacy/sharing requirements exist
  - What, if anything, is done with the data

Implementation Details for Strategy II A
Responsible Parties: Brady Ellis (monitor HMIS); Stephanie Bloom; Melanie Curtis; Anna Whitehead; Aimee Shipman; [representative(s) from hospital system – Theresa McLeod and Corey Surber to help identify]
Timeline: Beginning 2015 Q3 (e.g. Recovery Idaho purchased data system called Recovery Measures; in process of determining what questions to be asked in recovery centers)
Measureable Outcomes: TBD

Strategy II-B. Develop crosswalk between terms and among programs' varying eligibility standards and cross-train staff.

- **Educate health care providers on housing resources, including who is eligible, how to access, what is provided.**
- **Educate housing providers on health care resources, including who is eligible for what, how to access, and what is provided.**
- **Include education on various definitions of homelessness used across systems.**
- **Educate on the benefit of Coordinated Entry and the role health care providers can play in housing program referral, access, and education.**

Implementation Details for Strategy II B
Responsible Parties: Pam Thompson; Stephanie Bloom
Timeline: TBD
Measureable Outcomes: TBD

Strategy II-C. Use data collected to:

- **Assess need and understand community;**
- **Evaluate/demonstrate cost savings resulting from successful interventions;**
- **Support funding requests and funding reports;**
- **Determine effectiveness of interventions (i.e. identify successful and unsuccessful programs and interventions) and improve processes on an ongoing basis; and**
- **Generate an accurate picture of homelessness that go beyond data collected during PIT count.**
- **Conduct Frequent User Data Matching:**
    - **HMIS-Medicaid: Request TA from HUD for HMIS-Medicaid data matching**
    - Housing- Jails
    - Housing- EMS

Implementation Details for Strategy II C
Responsible Parties: Brady Ellis; Stephanie Bloom; Wyatt Schroeder
Timeline: Beginning 2015 Q3 (e.g. Request to HUD for HMIS-Medicaid data matching TA has been submitted)
Measureable Outcomes: TBD

III. Integrating Affordable Housing and Health Care

Objective: Establish mechanisms for housing and health care systems to work cooperatively, thereby reducing barriers and improving health through greater access to, and maintenance of, health care and stable housing.

Strategy III-A. Develop Community-based Permanent Supportive Housing Solutions.

- **Create a model for community-based systems.**
  - Teach fundraising.
  - Look at match support through the Home Partnership Foundation, other foundations or philanthropic groups, and local communities.
- **Launch demonstration program in local areas.**
  - Identify top utilizers who are homeless. [See Strategy II-F.]
  - Create PSH intervention pilot program.
  - Document effort through evaluation by university. [See Albuquerque, NM study.]
  - Include faith-based interdisciplinary support.
  - Explore community agency capacity to deliver Medicaid-eligible billable services.
  - Partner with hospital as investment opportunity with targeted vulnerable populations. (Fits with population health focus.)
  - Look at project-based vouchers.
- **Include consideration of Medicaid billing capacity.**

Implementation Details for Strategy III A
Responsible Parties: Deanna Watson; Stephanie Bloom; Melanie Curtis; Brady Ellis; Wyatt Schroeder; [Representative from Boise Mayor's office]
Timeline: TBD
Measureable Outcomes: TBD

Strategy III-B. Establish funding priorities at both the county and state level for the development of permanent supportive housing for chronically homeless, with an emphasis on housing the most vulnerable and those most in need.

Implementation Details for Strategy III B
Responsible Parties: Deanna Watson; Melanie Curtis; Wyatt Schroeder
Timeline: TBD
Measureable Outcomes: TBD

Strategy III-C. Launch H^2 permanent supportive housing Production Pipeline process.

- **Develop housing production targets for H^2 population in each region, working with health care districts.**
- **Identify SSI/Medicaid and other resources for tenants in project to maintain sustainability.**
- **Develop pilot, tools, and templates for replication.**
- Possible locations:
  - Vacant lot adjacent to Allumbaugh House (detox and crisis center) owned by public housing authority.

    - Former criminal justice site in Twin Falls
    - Nampa hospital retrofit site, available in 2017
- Identify other possible sites
- Identify resources through IHFA, including new Housing Trust Fund.
- Perform financial analysis for each project, resulting in viable development budgets.
- Identify legal and ownership structure for each project.
- Establish memorandum of understanding (MOU) between housing and healthcare entities to promote cross-system collaboration and take steps towards integration.
- Develop services and operations that are linked to the units for the H^2 population

Implementation Details for Strategy III C
Responsible Parties: Deanna Watson; Melanie Curtis; Brady Ellis; Wyatt Schroeder
Timeline: TBD
Measureable Outcomes: TBD

Strategy III-D. Explore discharge planning options in each Region to reduce situations where people remain in hospitals and other institutions (mental health, jails, prisons) longer than medically necessary due to lack of housing and/or services available outside of the hospital/institution.

- **Research models/best practices from similar states (e.g. Nevada, New Mexico).**
- **"Medical hotel" or "respite shelter" for those not needing institutional level care (potentially at the regional level), with costs shared by hospitals.**
- **Secure funding for discharge programs:**
    - Approach hospitals, highlighting cost savings that would result from reduced length of stays and recidivism
    - Hospital Associations and Hospital Foundations
    - Public Health Departments
    - Home Partnership Foundation (statewide)
    - Private funders (within Idaho and nationally), including CRA
    - Explore creation of public-private partnerships
- Develop discharge guidelines (minimum components). Note: CoCs are doing this currently.
- Rehabilitative services would be the core of this effort, perhaps as a path to enrollment.
- Explore voucher model, as well as site-based options for housing.

Implementation Details for Strategy III D
Responsible Parties: Deanna Watson; Corey Surber; Pam Thompson; Wyatt Schroeder; [Theresa McLeod to identify an additional representative]
Timeline: Beginning 2015 Q3 (e.g. Deanna Watson has research underway)
Measureable Outcomes: TBD

IV. Maximizing Resources

Objective: Minimize Homelessness by Maximizing all Funding Streams to Finance Services, Treatment, and Permanent Supportive Housing

Strategy IV-A. Maximize use of current Medicaid program.

- **Focus on eligibility/enrollment.**
  - **Use 211 line and existing Division of Welfare eligibility work group.**
  - **Access SSI/SOAR to get disability and/or Medicaid.**
  - **Track and monitor homeless enrollment with 100% target.**
- **Work to enroll any member of target population eligible under current plan and keep them enrolled.**
- **Identify Medicaid-reimbursable providers in state. (See provider link on website.)**
- **Determine what connections can be made between Medicaid-reimbursable providers and housing agencies to connect eligible/enrolled clients to Medicaid-reimbursable services**
- **Develop training and partnerships with MCOs and housing entities. [Resources: Medicaid website; SOAR training.]**

Implementation Details for Strategy IV A
Responsible Parties: Rosie Andueza/Dept. of Health and Welfare
Timeline: TBD
Measureable Outcomes: TBD

Strategy IV-B. Conduct gap analysis of Medicaid plan to determine need for waiver, partnering with Medicaid-reimbursable providers, using existing coverage, or seeking financing elsewhere to accomplish the following:

- **Provide services that support housing stability to:**
  - People with:
    - Primary mental health diagnosis (not limited to those reaching level of primary severe and persistent mental illness – SPMI)
    - Primary substance abuse diagnosis
    - Chronic illness (including HIV/AIDS)
    - Complex health needs
  - People who are:
    - Chronically homeless or at risk of chronic homelessness
    - Homeless
    - Unstably housed
- **Package of services to prioritize:**
  - Housing search assistance
  - Advocacy and engagement (necessary types/extent may vary by region)
  - Coordination with
    - Primary care and health homes
    - Substance abuse treatment providers
    - Mental health providers
    - Hospitals/emergency departments
  - Transportation to appointments

    - Independence living skills coaching
- Approach Medicaid Division to request an analysis, using CMS's June 29, 2015 Program and Policy Alert, "Medicaid Financing for Housing-Related Services," as a launching point.

Implementation Details for Strategy IV B
Responsible Parties: Aimee Shipman; Deanna Watson; [Sheila Pugatch; Tiffany Kinsler]
Timeline: TBD
Measureable Outcomes: TBD

Strategy IV-C. Incorporate housing stability in health plan contracts.

- Recommend that Department of Health & Welfare Medicaid Division consider:
    - **Reinvestment clause on Optum contract to target housing stability supports.** Add as agenda item to meeting of CoC and Optum staff.
    - **Add a performance measure to Idaho health care contracts on housing stability and access.** Look to Washington State as best practice model.

Implementation Details for Strategy IV C
Responsible Parties: Brady Ellis; Corey Surber; [Sheila Pugatch; Tiffany Kinsler]
Timeline: TBD
Measureable Outcomes: TBD

Strategy IV-D. Support continued identification of creative funding streams of Housing Trust Fund, including acceptance of federal resources. IHFA will participate, along with representatives from health service providers and development community.

- **Look to taxes/fees aimed at non-Idahoans (e.g. rental car taxes) and avoid efforts to advocate for other taxes/fees/bonds (which have not gained traction in past).**
- **Reach out to LDS, faith community, business community, and banks.**
- **Explore private companies and/or public-private partnerships.**
    - Ex: Starbucks creates "Idaho blend" of coffee for Idaho locations; portion of sales for that coffee go to fund
    - Explore other like-minded corporations (based in or just operating in Idaho) who would benefit from positive branding
- **Research other possible funders, within Idaho or elsewhere – either with connection to Idaho population, such as entities in Washington state, or history of philanthropic efforts. Include private foundations and corporations.**
- Investigate private funding sources for public/private partnership to secure resources.

Implementation Details for Strategy IV D
Responsible Parties: IHFA; Wyatt Schroeder; Theresa McLeod (participant; not leader) [Corey Surber to gauge interest from United Way representative]
Timeline: TBD
Measureable Outcomes: TBD

Idaho's Complete H^2 Action Plan

Leadership/Coordination: Preliminary Strategies

Preliminary Strategy I. Form a Policy-Level Leadership Group to Implement the Strategies and Action Steps Identified in this Action Plan.

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- Members to include: IHFA, City of Boise, primary care associations, FQHCs, health system, hospitals, Idaho Medical Association, Idaho Hospital Association, Behavioral Health collaborative, State Health and Welfare (Medicaid, Behavioral Health, SHIP), United Way, insurers, universities, PHAs, Entitlement Jurisdictions CD representatives, Governor's Redesign Committee.
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- Seek involvement of: John Ruche in House; prominent Boise person (e.g. a physician); Richard Armstrong, State Dir. of Health & Welfare; unaffiliated 3rd party.
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Preliminary Strategy 2. Develop a coordinated approach to educate decision-makers.

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- Show that housing is healthcare.
- Convince the various boards and policy forums that housing is a big issue and in ending homelessness takes precedence over food, transportation, and other safety net services
- Build off H^2 planning session handouts
    - Align with IHFA Home Partnership Foundation fundraising campaign
    - Population data
    - Opportunity to invest in housing
    - Cost savings

Preliminary Strategy 3. Request a representative from Governor's Redesign Committee to participate in H^2 Leadership or Policy-Level Leadership Group.

- Communicate status of re-design efforts to H^2 constituencies.
- Include Medicaid representatives in Policy-Level Leadership Group (described in Preliminary Strategy 1) meetings.

I. Closing Service and Treatment Gaps, Removing Barriers, and Increasing Access

Objective: Close the Gap in Housing and Health Care Services and Treatment by Increasing Services, Reducing Barriers, and Facilitating Access for Idaho's Most Vulnerable.

Priority Strategies

Strategy I-A. Connect people with chronic conditions to consistent care (e.g. FQHCs). Many use emergency departments and/or free clinics, which are not intended to provide ongoing primary or specialty care.

- Create resource listing Community Health Centers and FQHCs and how to use each. Include details about what types of services each provides (behavioral health, dental care, specialty care, etc.).
- Educate clients and program staff on how to use medical system appropriately, including what options are available to them.
    - See: CMS website Toolkit: From Coverage to Care
    - Veterans Affairs (VA) conducts outreach/education events four times a year. Approach them about using one of those for this issue.

Strategy I-B. Review Model program: three-agency safety net provider collaboration in Northern Idaho, including County Health, County Hospital and FQHC. All uninsured patients at hospital are referred to social services where they are given a thorough intake and referral, follow-up, and support.

- Find out details. How it was created; how it worked.
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- Make sure housing representative is part of Northern Idaho program and in any new similar programs.
- Make sure healthcare providers are part of the Coordinated Entry System planning that is starting to occur.

Strategy I-C. Educate public housing authorities (PHAs) and affordable housing developers and providers about benefits and success of PSH, including partnerships necessary for successful outcomes, and where to refer tenants for (1) enrollment and (2) care coordination.

- Use IHCCs to provide education.
- Invite industry leaders and/or consultants to Idaho to educate developers on appropriate and necessary supportive services, and how those partnerships formed and services leveraged.

Strategy I-D. Increase access to ongoing specialty care for better medication management and slowing progression of debilitating chronic illnesses, including HIV, diabetes, severe & persistent mental illness, substance use disorders, etc.

- Explore tele-case management and tele-medicine for mental health services (look into VA program and how to expand) [Gary Gant will send information on how this works in Alaska]. Ongoing efforts to bring this to Idaho. Support/join current effort rather than starting new. See Idaho Behavioral Health Planning Board.
- Explore use of paraprofessionals, navigators, community health workers.

- Look into Direct Care for elderly and mentally ill and how to expand.
- Connect to Terry Reilly's database of specialists.
- Coordinate with hospitals to create Program for Assertive Community Treatment (PACT) Teams.
- Explore use of block grant for substance abuse resources. Many people that don't qualify for Medicaid qualify for assistance under this grant.
- [For those with HIV, connect to Ryan White programs regarding their medication management resources for PLWHA.]

Additional Strategies

Strategy I-E. Assist members of target populations with accessing health insurance, accessing healthcare services, and managing their health conditions. Explore:

- Community Health Workers
- Peer paraprofessionals
- System navigators
- Mobile teams

Strategy I-F. Develop a work-around for unaccompanied youth who cannot access medical care without parental permission. (Currently, their only option is the ER.)

- Research how FQHCs would treat an unaccompanied minor that presents.
- Research other options for unaccompanied minors. What can they access without parental permission?
- Research whether a minor can enroll in CHIP without parental signature/approval.

II. Implementing Data-Driven Solutions

Objective: Develop a robust, integrated data-driven system that uses data to understand and assess needs, evaluate program effectiveness, demonstrate cost savings and secure funding, and generate an accurate picture of homelessness in Idaho.

Priority Strategies

Strategy II-A. Determine what data is currently collected at various agencies/providers across the state. Specifically:

- Housing data collected by health care providers (including hospitals, MCOs, Indian Health Services, etc.)
- Housing data collected (or just maintained) by local health districts
- Health care data (including insurance, access, health status info) collected by housing providers/agencies
- Housing and/or health care data collected by other systems:
    - Criminal justice/jails
    - Police and fire departments
    - EMS
    - Schools
    - Faith-based organizations
    - Community-based organizations (CBOs)
    - Mental Health Centers
    - Funders (e.g. United Way)
    - CMS
    - Education
- For each, identify:
    - How data is collected (what questions are being asked)
    - By whom
    - When in client engagement process
    - Where the data is stored
    - Who can access which data
    - What privacy/sharing requirements exist
    - What, if anything, is done with the data

Strategy II-B. Develop crosswalk between terms and among programs' varying eligibility standards and cross-train staff.

- Educate health care providers on housing resources, including who is eligible, how to access, what is provided.
- Educate housing providers on health care resources, including who is eligible for what, how to access, and what is provided.
- Include education on various definitions of homelessness used across systems.
- Educate on the benefit of Coordinated Entry and the role health care providers can play in housing program referral, access, and education.

Strategy II-C. Use data collected to:

- Assess need and understand community;

- Evaluate/demonstrate cost savings resulting from successful interventions;
- Support funding requests and funding reports;
- Determine effectiveness of interventions (i.e. identify successful and unsuccessful programs and interventions) and improve processes on an ongoing basis; and
- Generate an accurate picture of homelessness that go beyond data collected during PIT count.
- Conduct Frequent User Data Matching:
    - HMIS-Medicaid: Request TA from HUD for HMIS-Medicaid data matching
    - Housing- Jails
    - Housing- EMS

Additional Strategies

Strategy II-D. Develop common data set for entry and assessment in all systems (including: Housing, Health Care (including public hospitals and FQHCs), Behavioral Health (including regional mental health centers and statewide behavioral health), Medicaid/Optum Health, Substance Abuse, Education).

- Work with State Healthcare Innovation Plan steering committee to ensure housing/homelessness related questions are included in its data collection/performance measures. Get housing advocate/representative onto Steering Committee.
- Create survey(s) or other data collection tool to gather additional needed information. May vary by system, program/program type, region.
    - Avoid duplication.
    - Evaluate how best to start a conversation/arrive at information needed. [Ex: Should question be "Where did you sleep last night?" vs. "Are you homeless?"]
    - Tie into HMIS to the extent possible.
    - Figure out how to incorporate domestic violence data.
    - Innovative example from Washington state: patient history questionnaire at health care providers includes socio-economic factors.
    - Look at Handout 2-A and appendix from H^2 session.
- Determine necessary release changes to allow for sharing of data for purposes of coordination across systems.
- Attain buy-in from providers/agencies for new/additional data collection:
    - Present details about the purposes of data collection and how its collection/analysis will benefit them (e.g. cost savings that result by identifying need and coordinating access to treatment/services for shared clients).
    - Work with funders to have them add the questions we identify to their reporting requirements for grantees.
        - Primary Care Association
        - United Way
        - HUD/other federal agencies
    - For health care providers: emphasize that properly coding V60 could result in more reimbursement. (See VA system for example.)
- Train all staff (on housing and health care side) on data quality assurance and input consistency. Make clear what the larger purpose of data entry is to ensure buy-in (i.e. ultimately to better serve clients/improve health and housing outcomes for the people they serve).
- Connect with ongoing effort to create statewide health care data repository. Effort is in its infancy. Advocate with group in charge to include questions/data relating to housing.

- Initial steps to move strategy forward:
    - Sheila Pugatch (Medicaid) will coordinate meeting between Optum staff and CoC coordinated entry lead staff (and ultimately to incorporate all managed care)
        - Ask Optum what assessment is being used for clients/patients to exchange with coordinated entry tool used by CoC
        - Goal of meeting is to reach agreement on best tools, assessment steps and allocation of roles and responsibilities for improved housing and health care outcomes.
    - Form H^2 data committee. Link to (or place within) existing Data Collection, Reporting, and Evaluation Committee within the Balance of State CoC. Boise CoC also participates in that committee, which meets monthly.
    - Develop agreements to improve access and service delivery based on convenings.

Strategy II-E. Coordinate data analysis.

- Define outcome measurements and benchmarks to justify additional investment.
- Develop local reports on trends and rates of homelessness and insurance coverage.
- Forge partnerships across local health districts and area CoC. Structure relationships to improve access to health care and housing.
- Get good numbers that can show if/when programs are having an impact.
- Convene H^2 data committee to review data on periodic basis – bi-monthly/quarterly.

Strategy II-F. Explore ways to increase real-time access to data across systems.

- Example: Ryan White providers have access to State IBES data platform to verify insurance coverage. Explore expanding that kind of access to homeless system in some way.
- Medical providers would benefit from comparable ability to look into SSI/SSDI application and coverage status.

III. Integrating Affordable Housing and Health Care

Objective: Establish mechanisms for housing and health care systems to work cooperatively, thereby reducing barriers and improving health through greater access to, and maintenance of, health care and stable housing.

Leaders needed to accomplish this objective: John Ruche in House; prominent Boise person (e.g. a physician); Richard Armstrong, State Director of Health and Welfare; unaffiliated 3rd party.

Priority Strategies

Strategy III-A. Develop Community-based Permanent Supportive Housing Solutions.

- Create a model for community-based systems.
    - Teach fundraising.
    - Look at match support through the Home Partnership Foundation, other foundations or philanthropic groups, and local communities.
- Launch demonstration program in local areas.
    - Identify top utilizers who are homeless. [See Strategy II-F.]
    - Create PSH intervention pilot program.
    - Document effort through evaluation by university. [See Albuquerque, NM study.]
    - Include faith-based interdisciplinary support.
    - Explore community agency capacity to deliver Medicaid-eligible billable services.
    - Partner with hospital as investment opportunity with targeted vulnerable populations. (Fits with population health focus.)
    - Look at project-based vouchers.
- Include consideration of Medicaid billing capacity.

Strategy III-B. Establish funding priorities at both the county and state level for the development of permanent supportive housing for chronically homeless, with an emphasis on housing the most vulnerable and those most in need.

Strategy III-C. Launch H^2 permanent supportive housing Production Pipeline process.

- Develop housing production targets for H^2 population in each region, working with health care districts.
- Identify SSI/Medicaid and other resources for tenants in project to maintain sustainability.
- Develop pilot, tools, and templates for replication.
- Possible locations:
    - Vacant lot adjacent to Allumbaugh House (detox and crisis center) owned by public housing authority.
    - Former criminal justice site in Twin Falls
    - Nampa hospital retrofit site, available in 2017
- Identify other possible sites
- Identify resources through IHFA, including new Housing Trust Fund.
- Perform financial analysis for each project, resulting in viable development budgets.
- Identify legal and ownership structure for each project.
- Establish memorandum of understanding (MOU) between housing and healthcare entities to promote cross-system collaboration and take steps towards integration.

- Develop services and operations that are linked to the units for the H^2 population

Strategy III-D. Explore discharge planning options in each Region to reduce situations where people remain in hospitals and other institutions (mental health, jails, prisons) longer than medically necessary due to lack of housing and/or services available outside of the hospital/institution.

- Research models/best practices from similar states (e.g. Nevada, New Mexico, etc.).
- "Medical hotel" or "respite shelter" for those not needing institutional level care (potentially at the regional level), with costs shared by hospitals.
- Secure funding for discharge programs:
    - Approach hospitals, highlighting cost savings that would result from reduced length of stays and recidivism
    - Hospital Associations and Hospital Foundations
    - Public Health Departments
    - Home Partnership Foundation (statewide)
    - Private funders (within Idaho and nationally), including CRA
    - Explore creation of public-private partnerships
- Develop discharge guidelines (minimum components). Note: CoCs are doing this currently.
- Rehabilitative services would be the core of this effort, perhaps as a path to enrollment.
- Explore voucher model, as well as site-based options for housing.

Additional Strategies

Strategy III-F. Strengthen connections between HIV testing sites and Ryan White-funded care coordination in communities where co-location or warm hand-offs are not available.

Strategy III-G. Facilitate positive engagement with housing and health care providers, including development of provider relationships, use of "warm hand-offs"/personal introductions, and the use of appointment reminders for continuing/follow-up care.

IV. Maximizing Resources

Objective: Minimize Homelessness by Maximizing all Funding Streams to Finance Services, Treatment, and Permanent Supportive Housing

Priority Strategies

Strategy IV-A. Maximize use of current Medicaid program.

- Focus on eligibility/enrollment.
  - Use 211 line and existing Division of Welfare eligibility work group.
  - Access SSI/SOAR to get disability and/or Medicaid.
  - Track and monitor homeless enrollment with 100% target.
- Work to enroll and keep enrolled currently-eligible members of target population.
- Identify Medicaid-reimbursable providers in state. (See provider link on website.)
- Determine what connections can be made between Medicaid providers and housing agencies to connect eligible/enrolled clients to Medicaid-billable services.
- Develop training and partnerships with MCOs and housing entities. [Resources: Medicaid website; SOAR training.]

Strategy IV-B. Conduct gap analysis of Medicaid plan to determine need for waiver, partnering with Medicaid-reimbursable providers, using existing coverage, or seeking financing elsewhere to accomplish the following:

- Provide services that support housing stability to:
  - People with:
    - Primary mental health diagnosis (not limited to those reaching level of primary severe and persistent mental illness – SPMI)
    - Primary substance abuse diagnosis
    - Chronic illness (including HIV/AIDS)
    - Complex health needs
  - People who are:
    - Chronically homeless or at risk of chronic homelessness
    - Homeless
    - Unstably housed
- Package of services to prioritize:
  - Housing search assistance
  - Advocacy and engagement (necessary types/extent may vary by region)
  - Coordination with
    - Primary care and health homes
    - Substance abuse treatment providers
    - Mental health providers
    - Hospitals/emergency departments
  - Transportation to appointments
  - Independence living skills coaching
- Approach Medicaid Division to request an analysis, using CMS's June 29, 2015 Program and Policy Alert, "Medicaid Financing for Housing-Related Services," as a launching point.

Strategy IV-C. Incorporate housing stability in health plan contracts.

- Recommend that Department of Health & Welfare Medicaid Division consider:

- Reinvestment clause on Optum contract to target housing stability supports. Add as agenda item to meeting of CoC and Optum staff.
- Add a performance measure to Idaho health care contracts on housing stability and access. Look to Washington State as best practice model.

Strategy IV-D. Support continued identification of creative funding streams of Housing Trust Fund, including acceptance of federal resources. IHFA will participate, along with representatives from health service providers and development community.

- Look to taxes/fees aimed at non-Idahoans (e.g. rental car taxes) and avoid efforts to advocate for other taxes/fees/bonds (which have not gained traction in past).
- Reach out to LDS, faith community, business community, and banks.
- Explore private companies and/or public-private partnerships.
  - Ex: Starbucks creates "Idaho blend" of coffee for Idaho locations; portion of sales for that coffee go to fund
  - Explore other like-minded corporations (based in or just operating in Idaho) who would benefit from positive branding
- Research other possible funders, within Idaho or elsewhere – either with connection to Idaho population, such as entities in Washington state, or history of philanthropic efforts. Include private foundations and corporations.
- Investigate private funding sources for public/private partnership to secure resources.

Additional Strategies

Strategy IV-E. Evaluate redundancies in housing and health care systems across core and specialty programs.

- Conduct subsidy review.
- Recommend reducing the health care costs of H^2 target populations by investigating extension of coverage of HCBS waiver for Methamphetamine mothers & NICU babies.
  - Cost benefits including saving money and delivering healthier babies.
  - Explore use of Idaho Health and Welfare sub-programs funded by SAMHSA block grants.
- Focus on subpopulations for Medicaid (e.g. pregnant moms, felons exiting prison).

Strategy IV-F. Expand SOAR program.

- Identify where SOAR-trained workers are located.
- Train additional housing and health care staff on SOAR process.
  - Use online training tools (free 16-hour training). Idaho Fundamentals calendar will be published soon.
  - Work with State Training Coordinator in Dept. of Health and Welfare. [Crystal Campbell to work on this. Follow up with her.]
  - Include information on how SSI/SSDI approval links to Medicaid eligibility; how SOAR process works in general.

Strategy IV-G. Explore non-monetary resources.

- Ex: Approach Idaho-based tech companies to pay for/supply branded internet kiosks, which could be used to apply for benefits, search for and apply for jobs

Strategy IV-H. Explore ways for City of Boise's Pay for Success Grant to bolster health care access for target populations. Monitor and duplicate successful efforts.

Appendix – Additional Ideas

The following ideas were also discussed at the planning session, and validated as useful and necessary, but are not being prioritized for action under Idaho's H^2 initiative at this time. The Leadership Council 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.

Strategy: Create Regional Housing-Health Care Advisory Councils.

- Two lead agencies will be IHFA for Balance of State CoC and City of Boise for Boise/Ada County CoC.
- Additional members from:
    - IHFA (will lead process of setting regional Balance of State housing goals)
    - Healthcare reps from each region (hospitals, Health District, regional MH centers,
    - County indigent services (also state county association)
    - Free clinics (Garden City, Pocatello, Friendship, Mustard Tree)
    - Managed care organizations
    - Indian Health Services
    - Tribal Designated Housing Entity (TDHE) (e.g. Nez Perce)
    - Primary Care Association (FQHCs)
    - CAPI, NAHRO, AHMA
    - Commercial payers (Blues, etc.)
    - Office of Rural health (state)
    - Private-practice associations (Medical, Hospital, Dental, etc.)
    - Medicaid reps from regions (Sheila Pugatch, Financial Specialist in the Medicaid Division of Dept. of Health and Welfare, attended H^2 session on May 27.)
    - USDA Rural Development
    - Elected officials – representative from associations
    - Faith communities – ministerial associations in some
    - Business leaders
    - Economic development groups
    - Real estate
- These groups will meet regularly to discuss issues identified in this Action Plan and work through implementation, including: determining what data is collected/what should be added for each program/program type in the regions; and collecting housing and homeless data and stories to share with hospital administrators and medical providers.

Strategy: Address the major gap in transportation across the state.

- Advocate for public transportation. (Wesley Pruitt of Positive Connections will work on approaching City Council, using success of Red Bluff initiative.)
- Expand use of mobile vans/clinics.
    - Increase services/schedules of existing mobile units (e.g. Heritage, Terry Reilly, St. Alphonsus).
    - Investigate implementation of mobile vans/clinics in communities without them.
- Explore option of sending providers/medical staff to clients where they live.
- Advocate for FQHCs to include transportation line item in budgets submitted to HRSA.
    - Approach Primary Care Association to help communicate with FQHCs.

    - HRSA/ORO and Bureau of Primary Care to provide TA to clinics on how to make those budget changes.
- Explore using taxis and other similar services to create programs aimed at target populations.
    - Ex: Uber $20 promotional vouchers. Explore expansion of program. (Currently, single $20 voucher per person; requires use of cell phone to use app.)
    - Explore possibility of approaching Idaho-based or national companies (e.g. Idaho Power, Goldman Sachs, tech companies, etc.) to partner with Uber/fund an expansion of the voucher program for target population. Approach could also be used with taxi companies.
- Approach Wal-Mart to become part of their bicycle donation program.
- Research what programs offer deliveries of prescriptions.
- Look into Department of Labor/Department of Transportation grants to fund rides to appointments.
- Work collaboratively with Veterans Affairs (VA) and FQHCs to create a transportation program.
- Consider volunteer program to recruit volunteer drivers.
- For people who have cars that simply do not run due to needed repairs:
    - Approach high schools to partner with shop classes to conduct needed repairs.
    - Approach mechanics or major care dealers to donate parts/labor.
    - Approach Les Schwab to fund repairs.
- Research what transportation resources and programs already exist and compile a resource guide.
    - Who is eligible to use
    - How to use
    - What is provided
    - What geographic areas are served

Idaho 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:

Brady Ellis
Homeless Program Manager
Idaho Housing and Finance Assn
bradye@ihfa.org; 208-331-4839

Sheri Cook
Special Needs Team Lead
Idaho Housing and Finance Assn
sheric@ihfa.org; 208-331-4754

Aimee Shipman
Idaho Dept. of Health and Welfare

Anna Johnson-Whitehead
Veterans Affairs

Bill Campbell
CLUB, Inc.

Billy Williams
Idaho Housing and Finance Assn

Brenda Price
Crisis Center of IF

Brian Dale
HUD

Cindy Miller
Allumbaugh House

Corey Surber
St. Alphonsus

Cynthia York
Idaho Dept. of Health and Welfare – Behavioral Health

Deanna Watson
Boise City/Ada County Housing Authority

Dennis Carlson
Portneuf Medical Center

Gina Westcott
Idaho Dept. of Health and Welfare

AnaMarie Guiles
Senior Manager
City of Boise, Housing and Community Dev.
aguiles@cityofboise.org; 208-570-6839

Stephanie Bloom
Specialized Programs Coordinator
City of Boise, Housing and Community Dev.
sbloom@cityofboise.org; 208-570-6845

Gretta Jarolimek
St. Joseph RMC

Jeff Conroy
St. Vincent de Paul Coeur d'Alene

Julie Wiliams
Idaho Housing and Finance Assn

Ken Robinette
SCCAP

Melanie Curtis
SHIP

Mike Baker
Heritage Health

Pam Thompson
Kootenai Health

Rosie Andueza
Idaho Dept. of Health and Welfare, Division of Behavioral Health

Stuart Dempster
VA - VASH

Theresa McLeod
St. Luke's

Wyatt Schroeder
CATCH, Inc.

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. Point of Contact: Gillian Morshedi, HomeBase, 415.788.7961 ex 301 gillian@homebaseccc.org.