HEALTHCARE AND HOUSING (H²) SYSTEMS INTEGRATION INITIATIVE MICHIGAN
Action Plan Overview

MICHIGAN H² ACTION PLAN OVERVIEW[1]

Goals and Strategies: Michigan has identified four goals, each of which focuses on a key area of activity essential to achieving their vision of improving health and housing stability for Michigan's neediest residents.

Expand Community Capacity to Empower Data-Driven Decision Making to Support the Integration of Housing and Healthcare Systems.

- Expand training and support resources—including increasing awareness of existing resources—to foster a culture of data-driven decision among community stakeholders.

- Expand access to performance evaluation data and analytics to support development of improved service delivery and/or payment models.

- Regularly review and distribute emerging research and models to inform planning and decision making (including healthcare providers).

- Create benchmarks for insurance enrollment of people experiencing homelessness and develop regular reports to track progress.

- Publish an analysis of local housing inventory and demonstrated need (including acuity assessment and evaluation tools).

- Support regional data sharing agreements to improve client care across the region.

- Encourage healthcare providers to support data sharing and coordination by demonstrating that housing falls under the umbrella of care.

- Agree upon what questions are needed/appropriate criteria for healthcare providers to use to determine whether a patient is experiencing homelessness.

- Examine ways to use Coordinated Entry to determine healthcare needs and link to both appropriate housing and tenancy support service as well as primary care and healthcare.

- Develop strategies to gather key data from non-HMIS participating agencies.

- Enable sharing of information throughout the state to reduce burden on clients of providing the same information multiple times, to improve ability to link clients to needed services, and to track clients around the state.

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[1] The Michigan H² Action Plan Draft is currently being finalized by the Leadership Team, and therefore the Goals and Strategies presented here are subject to change.

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Optimize Existing Service Delivery Systems by Improving and Increasing Communication and Coordination to Create a Seamless Approach to Providing Housing and Related Services.

- Increase case management coordination. Where people have multiple case managers, establish "Lead" or Case Management Coordinator.

- Improve discharge planning processes/protocols.

- Build relationships between CoCs and non-HUD funded agencies that serve target populations.

- Improve communication across the state to share information about resources, successful programs, and best practices.

- Ensure CoCs provide input to hospitals' 2016 Community Health Needs Assessment planning processes.

Increase Capacity and Flexibility of Care Delivery to Improve Access and Utilization of Services That Support Housing Stability.

- Create specific strategies for rural populations, including a focus on in-person outreach.

- More aggressively enforce fair housing laws and combat discrimination (including and in particular against LGBT youth population).

- Create incentives to encourage providers to target the most difficult to serve clients, and limit opportunities to select "easier" clients on entry.

- Close "side-doors" to coordinated entry.

- Improve/increase landlord outreach and engagement to increase available affordable housing stock.

- Make informed, strategic decisions about use of housing and staffing resources.

- Increase resources available to serve the following populations:
    - People with behavioral health issues that do not meet SPMI (severe and persistent mental illness) level (i.e. people with mild to moderate mental illness).
    - People with physical health issues that do not meet definition of "disability."
    - People with substance use disorders who typically don't meet standards for vouchers.
    - Youth aged 18-24 (Assess need for transitional housing).
    - Homeless individuals with pets or companion animals.
    - People with criminal sexual conduct.

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- Increase training opportunities for:
  - Harm Reduction model of engagement for providers that do not yet embrace it
  - Maximizing the use of primary health care
  - Alternatives to Opioid pain management
  - Goals and structure of CoC activities for faith-based organizations
  - Cross-training of staff from medical health, behavioral health, and housing sectors on use of terminology and programs/resources available.
  - Housing orientation training for medical/behavioral health workers

- Increase resources to address:
  - Dental/oral health care
  - Podiatry
  - Medical detox
  - Vision services
  - Medical respite and community home nursing

- Create more flexible primary care system to accommodate needs of people experiencing homelessness, especially those with behavioral health issues.

Fully Utilize Current Capacity to Bill Medicaid for Health Care and Supportive Services and Identify Alternative Funding Sources to Fill Remaining Gaps.

- Engage managed care organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs) through access to data on Special Populations, which homeless service agencies have.

- Provide input to work group currently working on eligibility criteria and service package for expansion of Health Homes.

- Increase capacity to bill Medicaid for services that support housing stability.

- Use the CABHI report that Technical Assistance Collaborative created to inform public about needed elements in State Medicaid Plan.

- Develop alternative funding models to provide those services that are not (and will not be) Medicaid billable.

- Create a more streamlined mechanism to look up whether a client is already enrolled in Medicaid.

- Improve Medicaid enrollment and redetermination process as it relates to people experiencing homelessness or others who do not have an address, to include on-line applications.

- Increase SOAR capacity to apply for SSI/SSDI and Medicaid coverage.