North Carolina H^2 Action Planning

Stable Housing as a Healthcare Intervention: Integrating Housing and Healthcare Systems to Create Stable Housing and Positive Health Outcomes for North Carolina's Most Vulnerable

*This document – the **North Carolina H^2 Leadership Team's Priority Plan** – is a portion of the Action Framework emerging from the North Carolina Housing – Healthcare (H^2) Action Planning Session held on April 28 and 29, 2015 in Durham and Kernersville. The ideas presented are a concise presentation of the recommended actions put forth by the session's participants.*

*This **Priority Plan** outlines the strategies and action steps identified as the key, urgent, and feasible work to be done at the state level and in the four pilot communities that participated in the event**: Alamance County, Durham County, Forsyth County, and Guilford County.** These strategies and action steps will be the focus of the Leadership Team's implementation efforts going forward.*

*The complete **Action Framework**, which includes the priorities that were identified to make up the Priority Plan, as well as additional strategies and action steps that the Leadership Team may return to at a later date, as time and resources allow, will be posted in its entirety when it is finalized.*

PRIORITY PLAN

Priority State Level Action

Objective: Create Partnerships and Integrate Housing and Health Care Treatment and Services To Increase Housing Stability and Health Outcomes for North Carolina's Most Vulnerable.

PSL-1. Educate, train and institute consistent, thorough use of universal billing codes (specifically, International Classification of Diseases, 9th Revision "ICD-9" codes) for homelessness and housing instability in health care system (hospitals, clinics, behavioral health providers, those who sponsor financial-hardship medications).

- Determine how to make consistent use widespread and easy. Collect and aggregate data regularly and share analysis.
- Have Primary Care Association inform their providers that they want them to pay attention to this.
- Note: Federal partners to take recommendation back to instigate change at federal level.

Objective: Maximize Use of Medicaid and Other Resources to Improve Access to Health Care and Other Services that Support Housing Stability.

PSL-2. Recommend that Department of Health and Human Services investigate Medicaid funding for tenancy supports and housing navigators using a gaps analysis on the current Medicaid service array. Determine how Medicaid can fund Tenancy Supports including navigators, or via housing providers, health clinics, or behavioral health providers.

- Outline with specificity the activity that we need done.
- Specify who would be best suited to do that work.
- Identify the conditions/characteristics of population targeted for this service.
- [These bullets will come from local communities/H² Leadership Team members]

PSL-3. Expand capacity and use of SOAR program throughout North Carolina.

- Conduct needs assessment for number of additional SOAR workers needed (including where they are most needed). Delegate responsibility to each CoC within state to conduct this assessment.
- Use motivational interview techniques to build clients' interest in moving forward and following through with appointments & treatment.
- Explore team concept, so existing SOAR workers do not have to conduct case management, leaving less time for eligibility assistance.

PSL-4. Examine/analyze existing State Medicaid Plan, including Waivers and Amendments, to determine:

- **First priority step:** Whether presumptive Medicaid eligibility for chronically homeless, persons living with HIV/AIDS, and/or homeless persons exiting hospitals or acute care is currently possible. [Note: Downtown Health Plaza in Winston-Salem currently uses presumptive eligibility for pregnant women.] If not, what needs to be added/changed to create presumptive eligibility for those that meet the definition of chronic homelessness. (See Louisiana example.)

- Which people experiencing homelessness may qualify for care under existing provisions (given age, condition, experience, health needs)
- Whether, and for what, mental health workers can bill Medicaid.
- Replacement language for payable services to cover better version of "targeted case management."

Objective: Engage With Managed Care System To Improve Health Outcomes and Housing Stability.

PSL-5. Convene a meeting with the Council on MCOs to discuss the MCO-related strategies and action steps in this section and ensure MCOs remain part of this work on a consistent basis going forward.

PSL-6. Evaluate MCO contracts to assure they are required and encouraged to use best practices around prior authorization, assessment, and patient engagement. Add housing outcomes to contracts for both behavioral health and primary care.

Objective: Improve Data Collection and Analysis Across Housing Assistance and Health Care Systems Throughout North Carolina.

PSL-7. Look to foundations to fund a state employee position to be in charge of data analysis (consider Washington, where a similar position is funded by Gates Foundation).

- Consider adding a position at DHHS similar to NCCEH's Data Analyst position (currently held by Tia Sanders-Rice). The two positions could work together on data analysis, which would add benefit of building information-sharing about homelessness/housing (NCCEH) and health (DHHS) and collaborative projects or initiatives.

[Note: This strategy is not meant to suggest individual counties would not benefit from their own data analysis position, nor that any county should not pursue adding such a position to analyze county-specific data.]

Priority County Level Common Action: To Be Undertaken By Four Pilot Counties (and ultimately all communities throughout North Carolina)

Objective: Increase and Improve Meaningful Access to Health Care and Services That Support Housing Stability Through Education and Coordination.

PCL-1. Expand and strengthen coordinated entry system for CoC, including integrating Coordinated Entry system with health care through use of VI-SPDAT by health care providers or otherwise inputting data from health care system into HMIS. (North Carolina's HMIS is becoming HIPAA compliant, which should help.)

- First step: Facilitate the development of Qualified Service Organization Business Associates Agreements (QSOBAAs) between health care systems and homeless housing provider organizations.
- Add Department of Public Health.
- Add DSS Adult Medicaid staff.
- Link to SOAR training for disability documentation.
- Link to health assessments, insurance, health care and housing.
- Check insurance status at coordinated entry. Inquire about documentation.
- Provide warm hand-off between housing and health care systems.
- Implement team approach, with housing navigators, care navigators.

- Include outreach to emergency departments.
- Screen for cognitive impairments, which may lead to disability determination, improved recordkeeping, and increased Medicaid eligibility.
- Co-locate additional non-homeless programs that clients will need to access.
- Create ability to bring services to where clients are (including telemedicine).
- Involve entire care team in decision-making.

PCL-2. Conduct "Documenting Disability" trainings for medical providers (especially nurses and other charting staff) to ensure medical records support SSI/SSDI applications and Medicaid enrollment, particularly for chronic and long term homeless.

PCL-3. Explore flexibility of enrollment locations.

PCL-4. Create "1-pager" Quick Reference Tool for eligibility determinations/referrals to appropriate agencies/resources. House on various websites in addition to hard copies at agencies/providers/hospitals:

- 2-1-1 (NC211.org)
- United Way
- Hospital websites
- County sites (Health Departments) and municipalities

Objective: Increase and Improve Data Collection, Sharing, and Analysis to Enable Data-Informed Education, Data-Driven Decision Making, and Data-Supported Funding Requests.

PCL-5. Conduct frequent user studies (EMS/ER use; Corrections; Behavioral Health services; etc.).

- Identify people experiencing homelessness that are not already touching housing system.
- Show costs associated with frequent use of EMS/ER.
- Could also use to identify "hot spots" – shelters or housing sites from which high percentage of ambulance rides occur – to determine where on-site clinics would have greatest impact.
- If large enough problem is shown, may support need for on-site clinic(s).
- Look to Durham's Medical Respite project, which has an evaluation component, and also may be engaging in some frequent-user analysis.

PCL-6. Identify existing expenditures and sources of funding that are used across state that achieve poor health outcomes for un-housed people.

PCL-7. Train health care providers (especially charting staff) on consistent ICD9 coding for homeless patients so patients are identified and tracked accurately in medical records.

- Have Primary Care Association inform their providers that they want them to pay attention to this.

Objective: Integrate Housing and Health Care Systems Interventions & Treatments Through Education, Relationship-Building, Coordination, and Innovative Collaborations.

PCL-8. Build relationships between housing, social services, and health care providers through regular in-person meetings (such as creating a coalition).

- Use opportunity to bring housing case managers and medical social workers together to build relationships. [Note: this may need to come after a concrete plan or motivational strategy is in place to ensure buy-in.]

- Share resources and information so housing providers understand what resources exist on health care side relevant to their clients and health care providers understand what resources/programs exist on the housing side that could benefit their patients
- Exchange of best practices and ideas that work on one side that could be incorporated on other side (e.g. elements of coordinated entry system that could be instituted on health care side)

PCL-9. Adopt a Health-Focused Paradigm for People Experiencing Homelessness who Have Chronic Conditions. Reconsider homeless population as public health population by replicating NC HIV patient management network model. Explore ways to involve Public health Departments into conversations. Create this "new" paradigm, describe the flow, identify the partners, and support with new ways to work together.

- Care includes medical, dental, substance abuse, mental health, emergency financial assistance, health insurance premiums, medicines
- Recertification is two times a year
- Ryan White and HOPWA funds are [for practical purposes] blended into one program
- Network of care is in constant touch with covered population; able to provide under "supportive services" the case management; provides medical, behavioral health, dental, insurance premiums, emergency financial assistance, medication assistance, housing subsidy
- Screens weekly and refers to first appointment if test positive
- Network has regular meetings and regular communication
- Funding decisions made by network members following needs assessment to determine where services are needed and who will provide them
- Designated recipients must serve rural areas [parity requirement built into program]

PCL-10. Formalize partnerships between housing programs and FQHCs and other hospitals/health providers.

- Identify achievable needs that could be translated into MOUs outlining formal responsibilities relating to, e.g., access to health care services, priority for housing, creation of collaborative teams.
- Negotiate and execute MOUs.

PCL-11. Increase number of health care clinics on-site at shelters.

- Approach Housing Authorities about funding, especially if data shows cost-savings.
- Partner with FQHCs/Community Health Clinics/Health Care for the Homeless to have staff on-site.
- Possible starting point: Develop demonstration project to target chronically homeless, coordinating permanent supportive housing with on-site health clinic.

PCL-12. Create care coordination teams (consisting of nurses, dentists, mental health providers, substance abuse service providers, housing navigators/specialists, job-skills trainer/career counselor, life skills coaches, financial counselors at hospitals, social workers), particularly for clients in emergency shelters or living on the street (i.e. people experiencing homelessness that have not yet been connected to support services via PSH or otherwise).

- Link case into full care coordination team/network.
- Establish communication system across team. Could be supported by technology. Possible to have client/patient agree to the communication, and approve someone during the application process to "represent" them so information flows smoothly.

- For example/model, look to Durham's prioritization process for openings in CoC-funded PSH, which includes development of "care coordination teams for prioritized individuals. Six "Care Reviews" take place each month, during which care coordination teams meet with individual to address challenges.
- Explore using volunteers to comprise teams:
    - Reach out to NC Dental Association, Nursing Association, Nursing Schools, retirees, AmeriCorps, Jesuit, Lutheran
    - Explore various "part-time" options such as volunteering only a few hours a week, or creating monthly clinics where clients would be able to meet with one or more members (e.g. free dental clinics)
    - Need to consider liability insurance issues. In some states, if volunteers are providing care and there is no exchange of money, there is no need for malpractice insurance. Research whether that is the case in North Carolina.
    - If volunteer program proves successful, use data to seek funding for more permanent/larger care coordination team program

Objective: Maximize Medicaid and Other Existing Resources to Fund and Support Health Care and Services that Support Housing Stability for People Experiencing Homelessness.

PCL-13. Research what services relevant to housing support are potentially Medicaid reimbursable, and what Medicaid stakeholders can provide these services through partnerships with CoC-funded agencies to free up CoC funds for other programs.

PCL-14. Conduct CoC-wide survey of eligible/enrolled people experiencing homelessness or in the housing system (i.e. determine who is eligible and enrolled and who is eligible but not yet enrolled.)

- Use HMIS and CE system (include search for elderly)
- PSH programs to survey their residents
- Seek information from health service providers that tend to serve uninsured individuals (they may have information because patients ask questions about Medicaid eligibility and/or how to enroll)

PCL-15. Review MCO prior authorization practices to evaluate their effectiveness in addressing chronic homelessness.