Collaborating with Health System Partners: Why, Who, and How?

Fall 2024

Homebase

Why?

Homelessness and Poor Health

- People experiencing homelessness are at greater risk for poor health.
  - Exposure to communicable diseases and infections; extreme weather; malnutrition, and stress
  - Lack of access to running water, hygiene tools and refrigeration for medication storage
- High rates of infectious and acute illnesses, chronic diseases, mental and/or substance use disorders
  - Living conditions can aggravate medical conditions, exacerbate co-occurring illnesses and disorders, and prevent adequate treatment
- Mortality rate is 3-4 times higher than for the general population plus significantly lower life expectancies (by 20-30 years).

Lack of Access to Health Care

- People experiencing homelessness are often unable to access health care, even when they have insurance.
  - Insufficient information about available resources and how to access them
  - Inaccessible behavioral health services (e.g., long wait times for appointments, lack of walk-in options)
  - Difficulty getting to appointments
  - No easy way to communicate with health care providers

Disconnected Systems

- Homelessness response and health care providers do not often coordinate, which means:
  - Missing knowledge about people's history and needs
  - Duplication of efforts
  - Failure to connect people to available resources
- People experiencing homelessness are not consistently enrolled in health benefits or engaged with health care resources.

Without adequate health care, it is challenging to achieve housing stability and well-being – and vice versa!

Benefits of Collaboration

- Helps homeless assistance and health systems AND the people those systems aim to help
- Housing contributes to better health, but health systems aren't designed or equipped to address housing needs
- Housing linked with health care and services results in:
  - reductions in emergency room visits and hospital readmissions
  - lower costs for hospitalization, crisis services, jail, and detox
  - higher rates of housing stability and retention
  - improved health and recovery

Who?

Key Health System Collaborators

- Federally Qualified Health Centers (FQHCs), especially Health Care for the Homeless (HCH) programs
- Medicaid Managed Care Plans
- Hospitals
- Street Medicine providers

Health Centers

- Serve high need communities designated as Medically Underserved Area (MUAs) or Population (MUPs)
- Provide all required primary, preventive, and additional health services to meet the needs of the populations they serve
- Key Opportunities:
  - Facilitate access to primary and specialty care and ensure adequate follow up care
  - Explore on-site health care services at shelters or housing programs

Medicaid Managed Care Plans

- Managed Care = health care delivery system organized to manage quality, utilization, and costs.
  - In Medicaid managed care, managed care plans (MCPs, MCOs, CCOs) receive a set per member per month (PMPM) payment for all covered services.
  - Incentivizes efficient improvements in member health outcomes
- Key Opportunities:
  - Ensure enrollment of CoC participants in Medicaid and referral to benefits and services for which they're eligible
  - Leverage housing and supportive services to improve members' health outcomes

Hospitals

- Emergency departments (EDs) are often the only health care provider for people experiencing homelessness + complex health conditions mean some people are frequently admitted to the hospital
  - No safe places to recover = longer lengths of stay & re-admissions
  - Hospitals may not be reimbursed
  - Providing care to people who repeatedly return for preventable or treatable condition impacts hospital staff morale
- Key Opportunities:
  - Identify and track patients experiencing homelessness
  - Connect hospital discharge planning process to CoC/Coordinated Entry access points (via protocols, co-located staff, etc.)
  - Explore recuperative care/medical respite programs

Street Medicine & Similar Programs

- Delivery of medical care to people experiencing unsheltered homelessness in or near where they reside.
  - Street/Backpack Medicine: providers go directly to person (e.g., at their tent, in their car)
  - Mobile clinics/Mobile medicine: Mini-clinics that can park nearby
  - May be connected to a hospital, university/medical school, or FQHC/HCH program
- Most common services: wound care, basic medicine administration
  - May also connect people to primary and specialty care + housing resources
- Key Opportunities:
  - Support outreach, engagement, and trust-building
  - Facilitate referrals and connections to CoC/Coordinated Entry

How?

Collaboration Strategies

Better Understanding	Access to Health Resources	Connections to Housing Resources
• Cross-system education (e.g., on available resources, partners, areas of expertise, goals, strategies, etc.) • Data matches to identify shared clients and target services to those with highest needs	• Health care referrals through Coordinated Entry (CE) • Outreach and street medicine coordination (e.g., include medical providers in outreach, expand telehealth options) • Health providers with set aside days / blocks of time for walk-ins	• Housing connections via discharge planning (e.g., updated forms, connections to CE, on-site housing navigators) • Medical respite/ recuperative care and/or co-location of health services • Expanded or better leveraged housing-related Medicaid benefits and services

Opportunities for Health Partner Participation in Coordinated Entry

Entry & Assessment

- Serve as or connect patients to CE entry points
- Help review and/or develop assessment tool(s) to more accurately capture health-related vulnerability
- Provide space for assessments to take place and/or perform assessments

Prioritization & Matching

- Help CoC factor health considerations into prioritization schemes
- Participate in case conferences to explain impacts of specific health conditions on vulnerability & inform successful matches
- Help participants understand options and potential impacts on health care access and outcomes

Referral & Placement

- Offer health care on-site for vulnerable participants to support successful placements
- Help participants procure eligibility documentation (e.g., disability verification)
- Follow up with housed participants to ensure continuity of health care to support long-term housing stability

Getting Started

- Talk to your participants about their specific health needs and challenges, if and where they access care, and providers they like
- Make sure participants are enrolled in Medicaid and that you understand resources available through your state's Medicaid benefits and waivers
- Find your local health care partners and reach out with an invitation
- Think about how to pitch your CoC or agency
- Don't just be ready with asks, but also with ideas and offers

Finding Your Local Health System Partners

Health Centers

Community Health Centers / Federally Qualified Health Centers (FQHC)	Community health centers are health facilities that deliver comprehensive, high-quality preventative and primary health care to patients regardless of their ability to pay.	Find a Health Center: https://findahealthcenter.hrsa.gov/
Health Care for the Homeless (HCH)	HCH programs are a "special populations" category of community health centers that are required to serve predominantly people experiencing homelessness. In addition to the services provided by all community health centers, HCH programs must also provide substance abuse services.	Health Care for the Homeless Grantee Directory: https://nhchc.org/grantee-directory/
Rural Health Clinics	A Rural Health Clinic is a federally qualified health clinic (but not a part of the FQHC Program) that is certified to receive special Medicare and Medicaid reimbursement.	National Association of Rural Health Clinics: https://www.narhc.org/
Free Health Clinics	Free health and medical clinics offer services free of cost or for a nominal fee to persons who have limited income, no health insurance, or do not qualify for Medicaid or Medicare.	Find a Clinic: https://nafcclinics.org/find-clinic/

Population-specific Providers

Behavioral Health Providers	Behavioral health and mental health providers are physicians and counselors who treat behaviors that arise from substance use, mental health, and/or serious emotional disturbances.	FindTreatment.Gov (U.S. Substance Abuse and Mental Health Services Administration): https://findtreatment.gov/
Indian Health Services	The Indian Health Service agency is responsible for providing federal health services to American Indians and Alaska Natives.	Find Health Care (Indian Health Service): https://www.ihs.gov/findhealthcare/
Veterans' Health	The Veterans Health Administration is the largest integrated health care system in the United States, providing care at 1,233 health care facilities, including 168 VA Medical Centers and 1,053 outpatient sites of care of varying complexity (VHA outpatient clinics).	Find VA Locations (U.S. Department of Veterans Affairs): https://www.va.gov/find-locations
HIV/AIDS Care Providers	HIV/AIDS Care Providers have experience and expertise in providing care for people living with HIV/AIDS. They will help patients determine which HIV medicine is best for them, prescribe HIV medicine, and monitor and manage patient health.	Locate and HIV Care Provider: https://www.hiv.gov/hiv-basics/starting-hiv-care/find-a-provider/locate-a-hiv-care-provider/ Find HIV Services Near You: https://locator.hiv.gov/

Local Government Partners

State and Local Medicaid Agencies/Administrators

Medicaid is the federal public health insurance program that provides coverage for people with low incomes; eligibility and scope of services vary by state. Find yours: https://www.medicaid.gov/state-overviews/state-profiles/index.html

Public Health Department/Local Health Offices

Public health departments work with health care and community partners to prevent illness and to promote and protect community health.

County Mental or Behavioral Health Department or Agency or Authority

Behavioral health agencies or authorities are the local point of contact for assisting individuals with access to behavioral health services (mental health and substance use prevention, treatment, and recovery).

Resources

- **Basics of Cross-System Collaboration**
  - Fundamentals of Homelessness Response for Managed Care Plans (for sharing basic, initial information with health system partners)
  - Opportunities for Homeless Systems of Care under HHIP (note: this tool was developed in the context of a California program, but includes many ideas for CoC-MCP collaborations that can be more broadly considered)
  - Homebase webinars on Health Care-Homeless Response System Collaboration
- **Medicaid**
  - Medicaid State Profiles (learn the basics of your state's Medicaid program)
  - State Waivers List (review waivers in your state and what's included in them)
  - Medicaid RenewalToolkit (info to get and keep people enrolled in Medicaid)
- **Data-Sharing Resources**
  - Breaking Down Silos: How to Share Data to Improve the Health of People Experiencing Homelessness
  - How to Share Data: A Practical Guide for Health and Homeless Systems of Care
- **For additional resources and tools**
  - National Health Care for the Homeless Council
  - National Institute for Medical Respite Care