Welcome to Healthcare and Homelessness Pilot Initiative Workshop Day 1!

Mute your audio!

Turn on your video!

Say hi in the chat box! Tell us:

What are you most looking forward to this summer?

HEALTHCARE & HOMELESSNESS PILOT INITIATIVE

WORKSHOP 2: DAY 1

HEALTHCARE & HOMELESSNESS

WORKSHOP 2: DAY 1

1

Welcome!

Introductions: Community Solutions

Beth Sandor
Principal

Andi Broffman
Portfolio Lead

Meghan Arsenault
Senior Manager

Anna Bialik
Systems Improvement Advisor

John Gauthier
Project Manager

Nadia Lugo
Systems Improvement Advisor

Tyler Harmon
Data Integrations Advisor

Introductions: IHI

Aleya Martin
Sr. Project Manager

Catherine Mather
Project Director

Ninon Lewis
Vice President

Catherine Craig
Faculty Coach

Lauran Hardin
Faculty Coach

Agenda: Day 1

Time	Agenda Item
1:45-2:15pm ET / 10:45-11:15am PT / 9:45-10:15am AKT	Welcome and Grounding
2:15-3:00pm ET / 11:15am-12:00pm PT / 10:15-11:00am AKT	Model for Improvement: Bringing Your Portfolio to Life
3:00-3:15 ET / 12:00pm-12:15pm PT / 11:00 - 11:15am AKT	Break and Transition to Breakouts
3:15-4:45pm ET / 12:15-1:45pm PT / 11:15am-12:45pm AKT	Team Time: Finalizing Pilot Site Aim and Portfolio of Projects

Agenda: Day 2

Time	Agenda Item
1:45-2:00 ET / 10:45-11:00am PT / 9:45-10:00am AKT	Welcome Back
2:00-2:45 ET / 11:00-11:45am PT / 10:00-10:45am AKT	Data Sharing for project portfolios
2:45-2:55 ET / 11:45-11:55am PT / 10:45 - 10:55am AKT	Break
2:55-4:15 PM ET / 11:55am-1:15pm PT / 10:55am-12:15pm AKT	Cross Pilot Site Aim and Project Portfolio Share Out + Q&A
4:15-4:45 PM ET / 1:15-1:45pm PT / 12:15-12:45pm AKT	Close Out

Welcome to our Pilot Teams!

Say hi in the chat box and share one thing you are proud of from the past 6 months of work on the Pilot.

Bakersfield, California

Kaiser Permanente
CommonSpirit Health

Anchorage, Alaska

Providence St. Joseph


Chattanooga, Tennessee
CommonSpirit Health

Sacramento, California

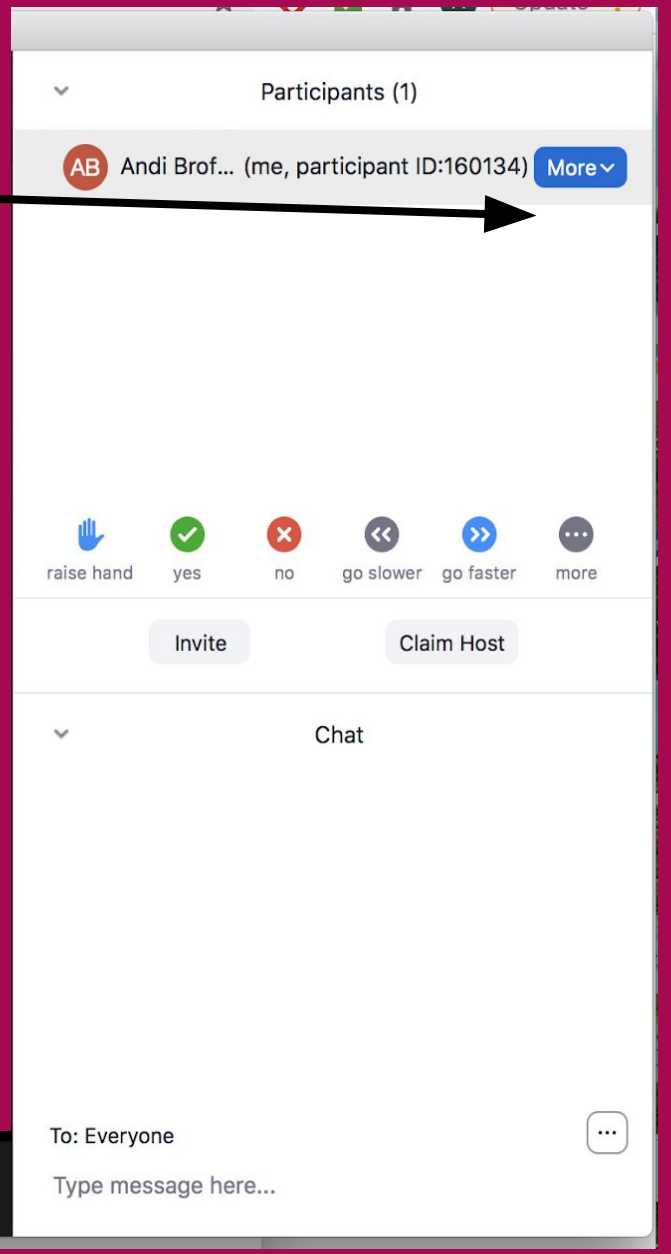
Kaiser Permanente
CommonSpirit Health
Sutter Health
UC Davis

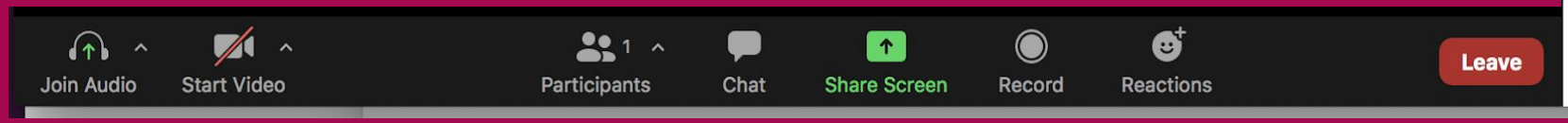
Washington County, Oregon

Kaiser Permanente

Zoom: How to Change Your Name

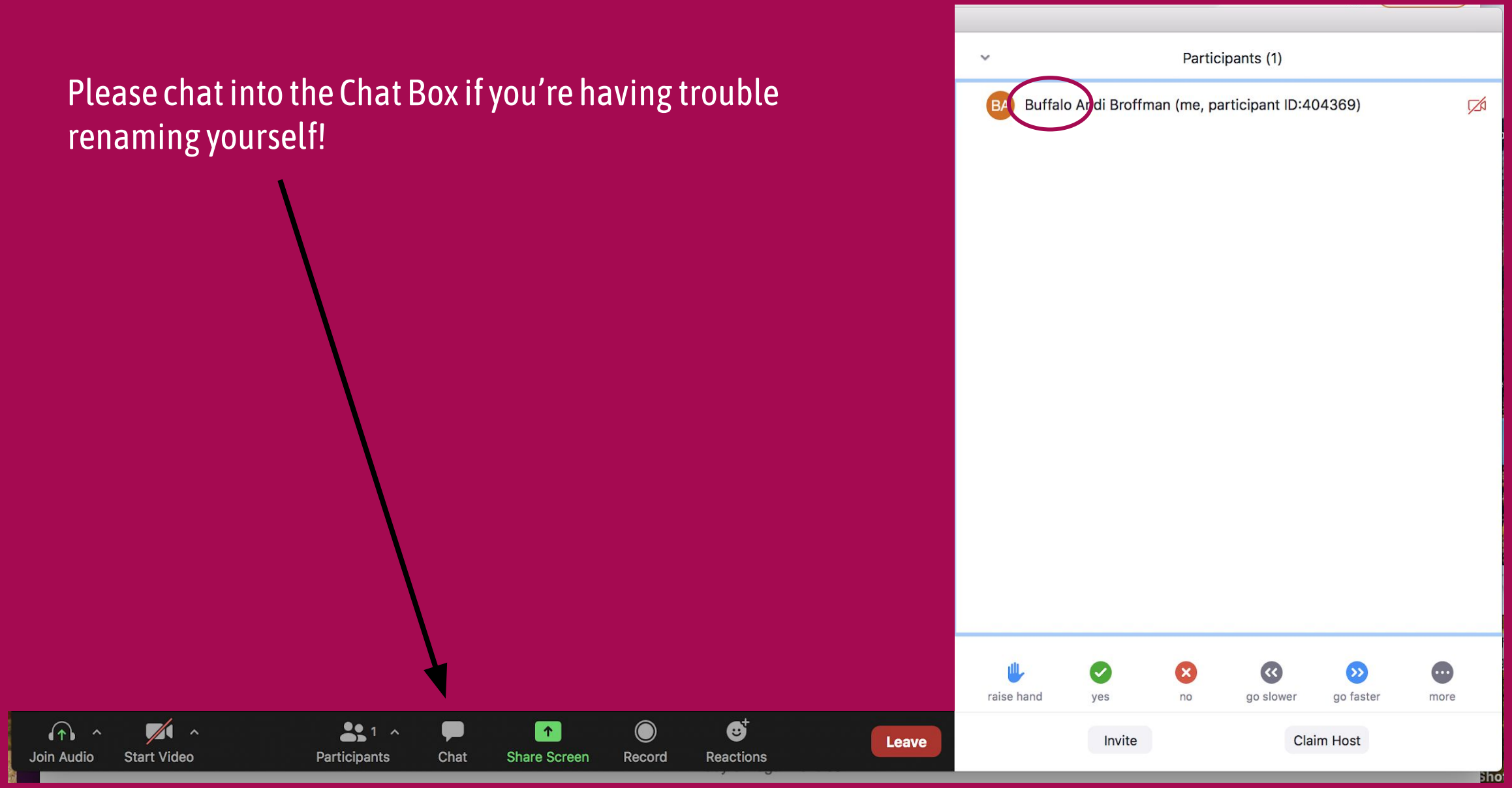
1. Click on 'Participants'
2. Hover over your name and click 'More'
3. Select 'Rename'
4. Add your Community's Name ***before*** your own name
   a. **CH** for Chattanooga
   b. **BKC** for Bakersfield/Kern County
   c. **ANCH** for Anchorage
   d. **SAC** for Sacramento
   e. **WaCo** for Washington County
   f. **NAT** for National





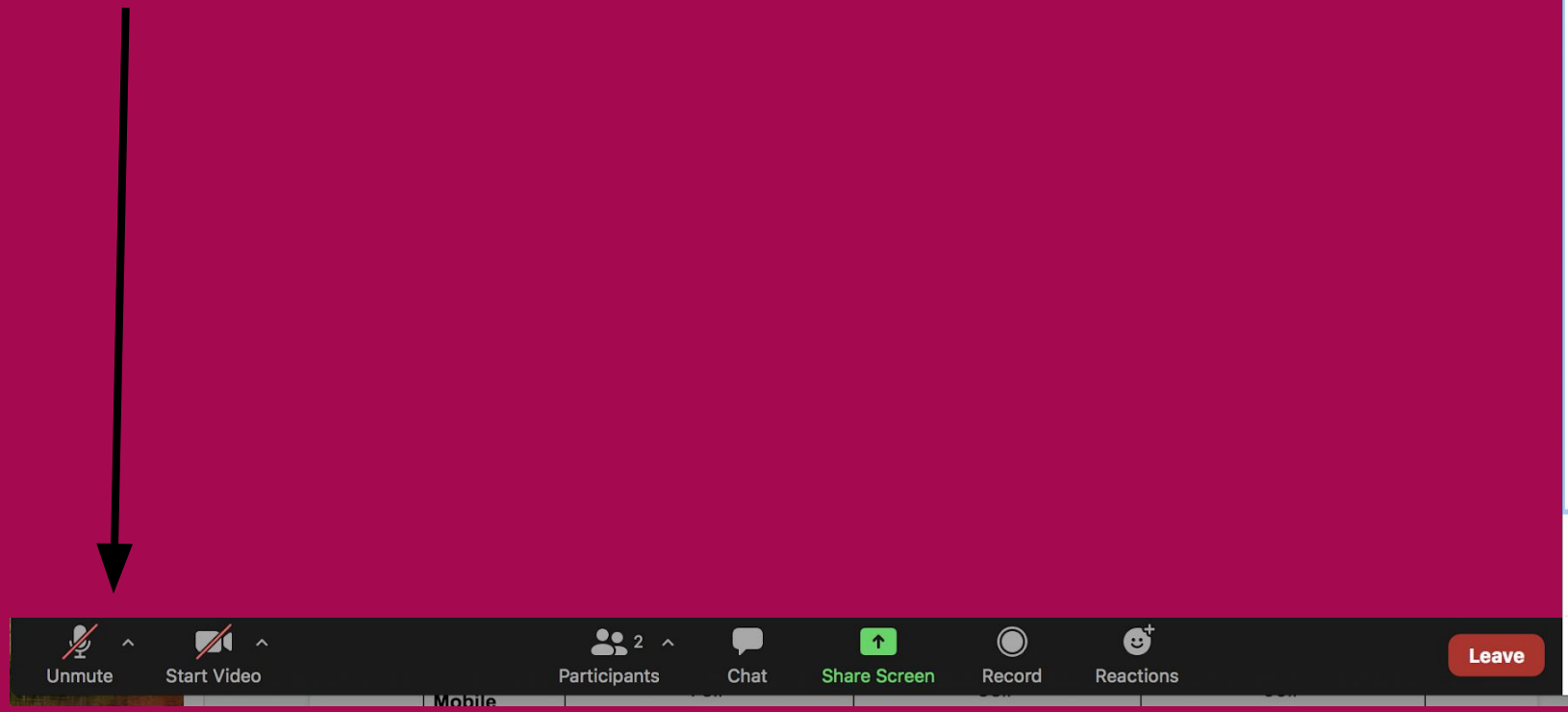
Zoom: How to Change Your Name

Please chat into the Chat Box if you're having trouble renaming yourself!



Zoom: Connect Your Name to Your Phone Number

Move your mouse over your screen to see the Mute/Unmute button and click on the small upward arrow ^



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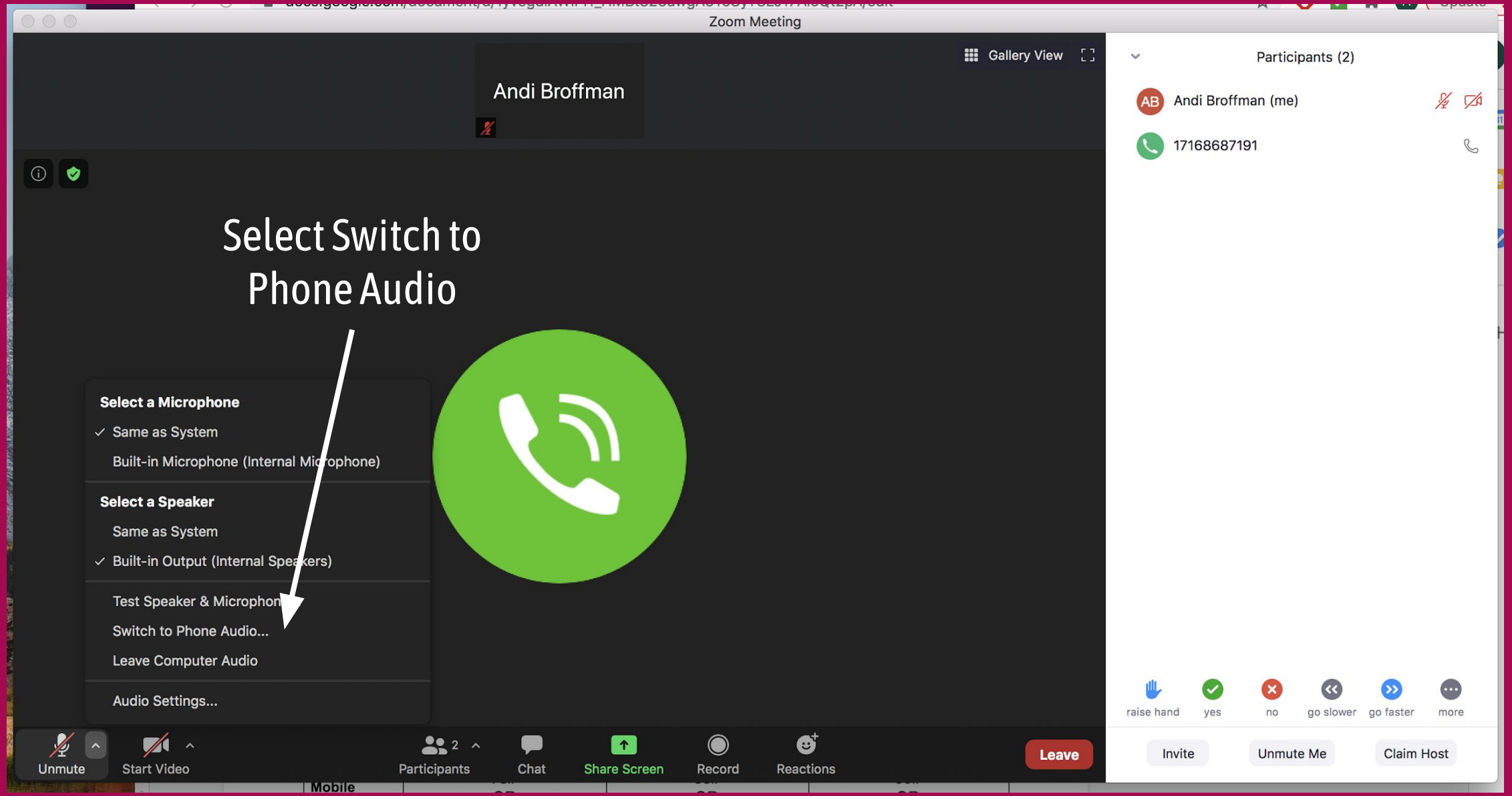

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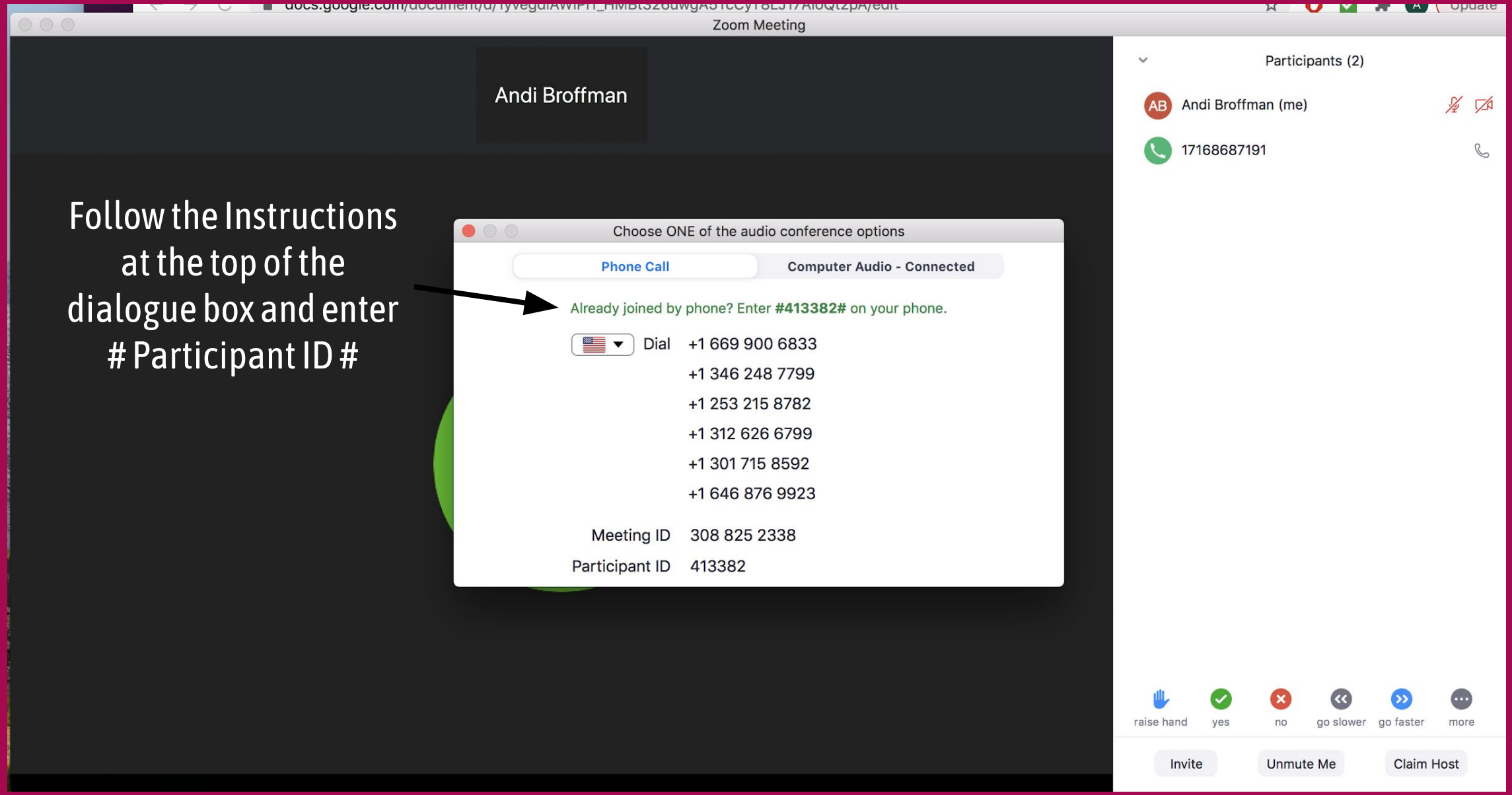


HEALTHCARE & HOMELESSNESS

WORKSHOP 2: DAY 1

2

Timeline & Progress Scale

Pilot Initiative Purpose Statement

Health Systems will make a meaningful, measurable and transformative contribution to ending chronic homelessness in a community

Pilot Initiative Aim

Over the course of the 2 year initiative, Pilot Teams will have made measurable progress toward ending chronic homelessness, with a focus on building racially equitable systems.

Where Are We Now?

Charting Our Journey Together in the Pilot

Action Period 1 is Complete!

Action Period 1 Goals

Participate in Pilot Site Coaching Calls	
Participate in All Pilot Site Monthly Calls	
Finalize a 3 Month Milestone & Identify a Portfolio of Projects	
Prepare for Workshop 2	

Pilot Initiative Aim

Over the course of the 2 year initiative, Pilot Teams will have made measurable progress toward ending chronic homelessness, with a focus on building racially equitable systems.

Measuring Our Progress Together in the Pilot

IHI and Community Solutions have created a scale that we'll all use together to track our progress through this pilot

The Progress Scale

- Coaches and Pilot Teams will use this together to understand critical next steps for progressing through the Pilot initiative
- Target dates for completing specific actions
- A charted path to measure improvement

Measuring Our Progress Together in the Pilot: 2021

February 2021

Pilot site formally enrolls in program and first point of contact is identified

Project sponsor identified

Score: 0.5

April 2021

Pilot team is identified key roles/leadership; roles and responsibilities are clear

Score: 1

Aim statement and team forming

May 2021

Pilot team has taken all singles scorecard + reported BFZ data for chronic homelessness (or completed some type of data analysis) to understand current baseline

Score: 1.5

Planning for project has begun

June 2021

Pilot team has identified a portfolio of projects (in at least three different pillars of the Theory of Change)

Score: 2

Activity, but no changes

September 2021

Pilot team is working on getting to a 28 on the scorecard and starting to report All Singles Data

Pilot team engages with Racial Equity Assessment

Score: 2.5

Changes tested, but no improvement

December 2021

Pilot team has received a 28 on the scorecard and is reporting quality chronic and all singles data

Pilot team is testing and reporting data on at least three of their projects

Score: 3

Modest improvement

Measuring Our Progress Together in the Pilot: 2021

March 2022

Pilot team is testing and reporting data on all of the projects in their portfolio

PIlot team has seen improvement in at least one process or outcome measure

Pilots team has a shared understanding of baselines against all 4 race equity indicators

Score: 3.5

Improvement

May 2022

Pilot team has shown improvement in at least three process or outcome measures

Score: 4

Significant improvement

August 2022

Pilot team is actively reducing the number of people experiencing chronic homelessness in their community and maintaining data reliability

Pilot team is making progress against the race equity indicators and is collecting data consistently for race/ethnicity and engaging People with Lived Expertise of Homelessness in a meaningful and influential way

Pilot Team has implemented changes in at least 3 pillars of the ToC.

Score: 4.5

Sustainable improvement

November 2022

Over the course of the 2-year initiative, Pilot Team has made measurable progress toward ending chronic homelessness, with a focus on building racially equitable systems.

Score: 5

Outstanding improvement

Committing to Racial Equity

INDICATORS

SYSTEM DECISION-MAKING POWER

Black, Indigenous, and People of Color (BIPOC) at all levels of the homeless response system have decision-making power to influence the design of the system.

LIVED EXPERIENCE

BIPOC receiving services from the homeless response system have experiences that preserve their dignity and have their needs met in a timely manner.

QUALITY DATA

All people experiencing homelessness have access to the system and are known by name in real-time. Communities accurately collect data around race and ethnicity.

SYSTEM OUTCOMES

Communities close all racial/ethnic disproportionality in housing placements, returns to homelessness, and the average length of time from identification to housing by improving outcomes for BIPOC who experience homelessness.

Update on Racial Equity Indicators

Community Solutions and the Center for Social Innovation are collaborating to:

1. **How will we know what good looks like:** create a way to measure if Pilot Sites are meeting all 4 indicators

2. **Where are we now:** create an assessment to measure a baseline for Pilot Sites around current state for each of the four indicators

3. **How do we build more racially equitable systems:** create materials, coaching approaches and resources to support Pilot Sites in improving against their baseline

The Work Ahead

1. **September 2021:** Pilot Teams will engage with the Racial Equity Baseline Assessment

2. **March 2022:** Pilot Teams have a shared understanding of baselines against all 4 race equity indicators

3. **August 2022:**
    a. Pilot teams are making progress against the race equity indicators and are collecting data consistently for race/ethnicity
    b. Pilot teams are engaging People with Lived Expertise of Homelessness in a meaningful and influential way

Institute for Healthcare Improvement

Model for Improvement: Bringing Your Portfolio to Life

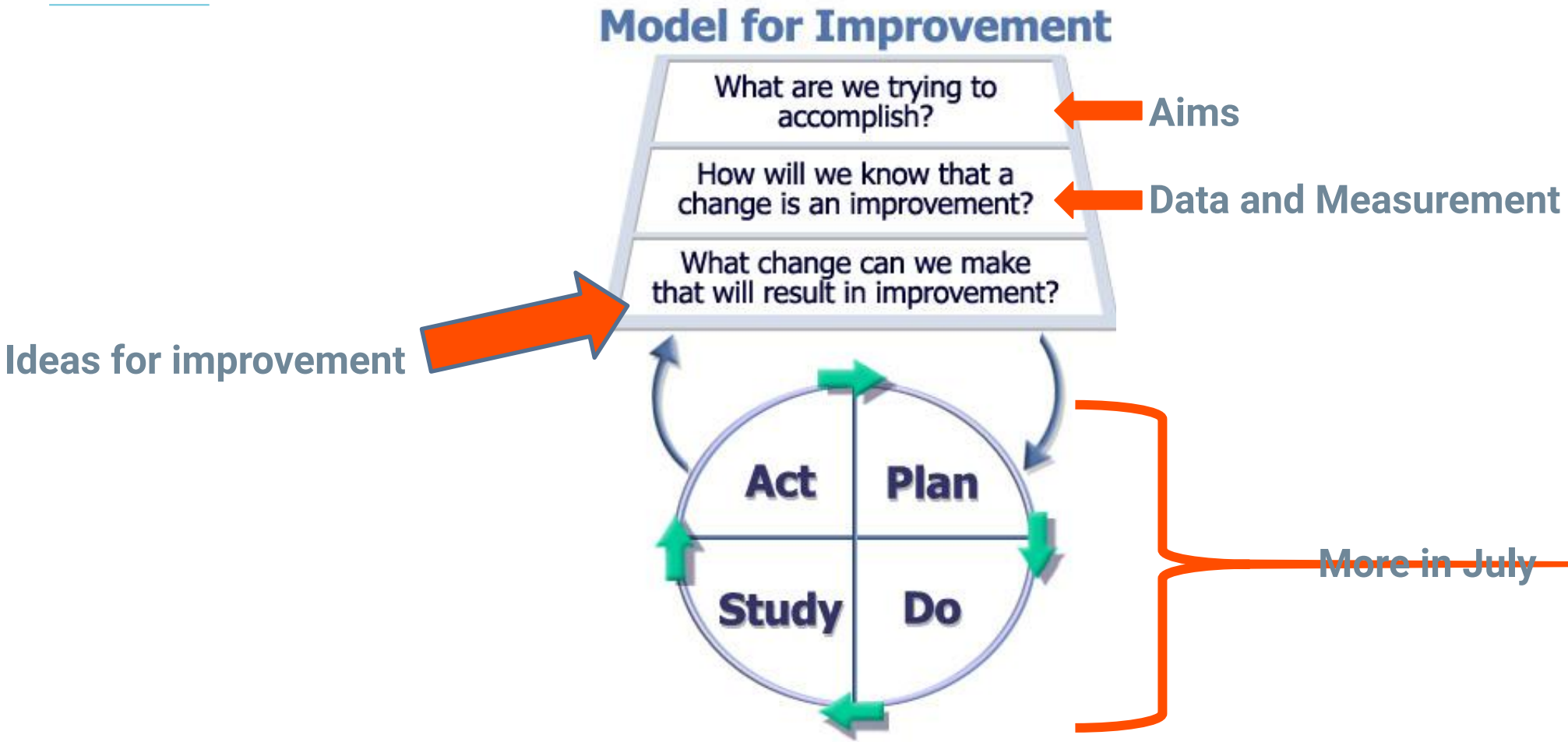
Healthcare + Homelessness Pilot Initiative

June 2021

Topics we'll cover

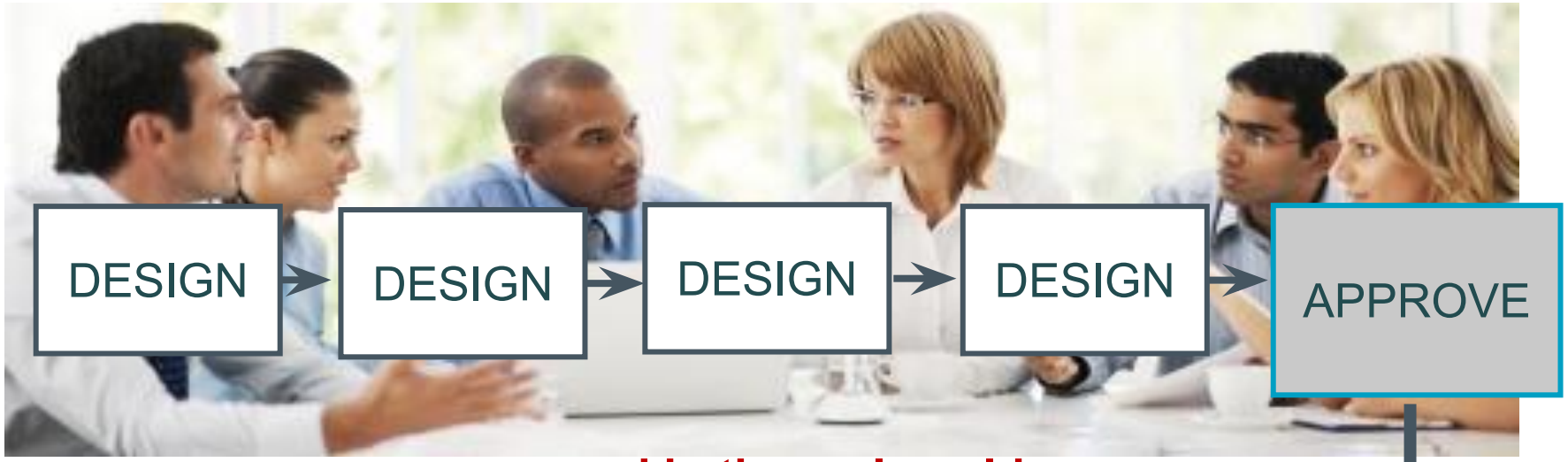
- The Model for Improvement as Quality Planning Tool
- Bringing Your Portfolio to Life
- Introduction to change ideas

A Model for Learning & Change



The Typical Approach…

In the conference room



…..and in the real world.

IMPLEMENT

Model for Improvement Approach

In the conference room

DESIGN

APPROVE
IF NECESSARY

…..and in the real world.

TEST & MODIFY

TEST & MODIFY

TEST & MODIFY

START TO IMPLEMENT

PDSA

PDSA

PDSA

What Are We Trying to Accomplish?

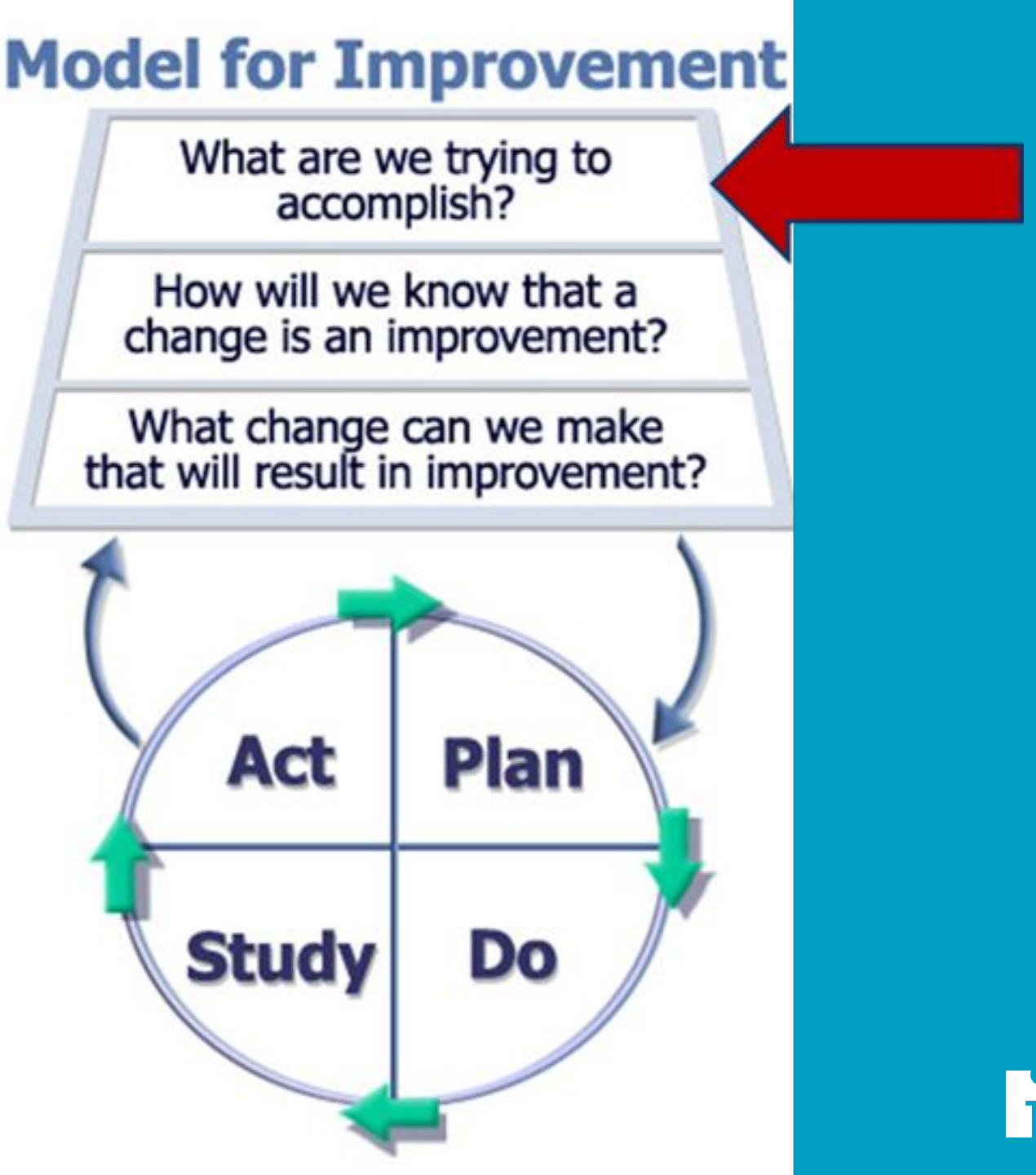
Question #1

What?

By When?

For Whom?

By How Much?



Centering Equity in an Ongoing Way

Continuous quality improvement centering equity, **first focusing on those not thriving**

How are our interventions reaching people?

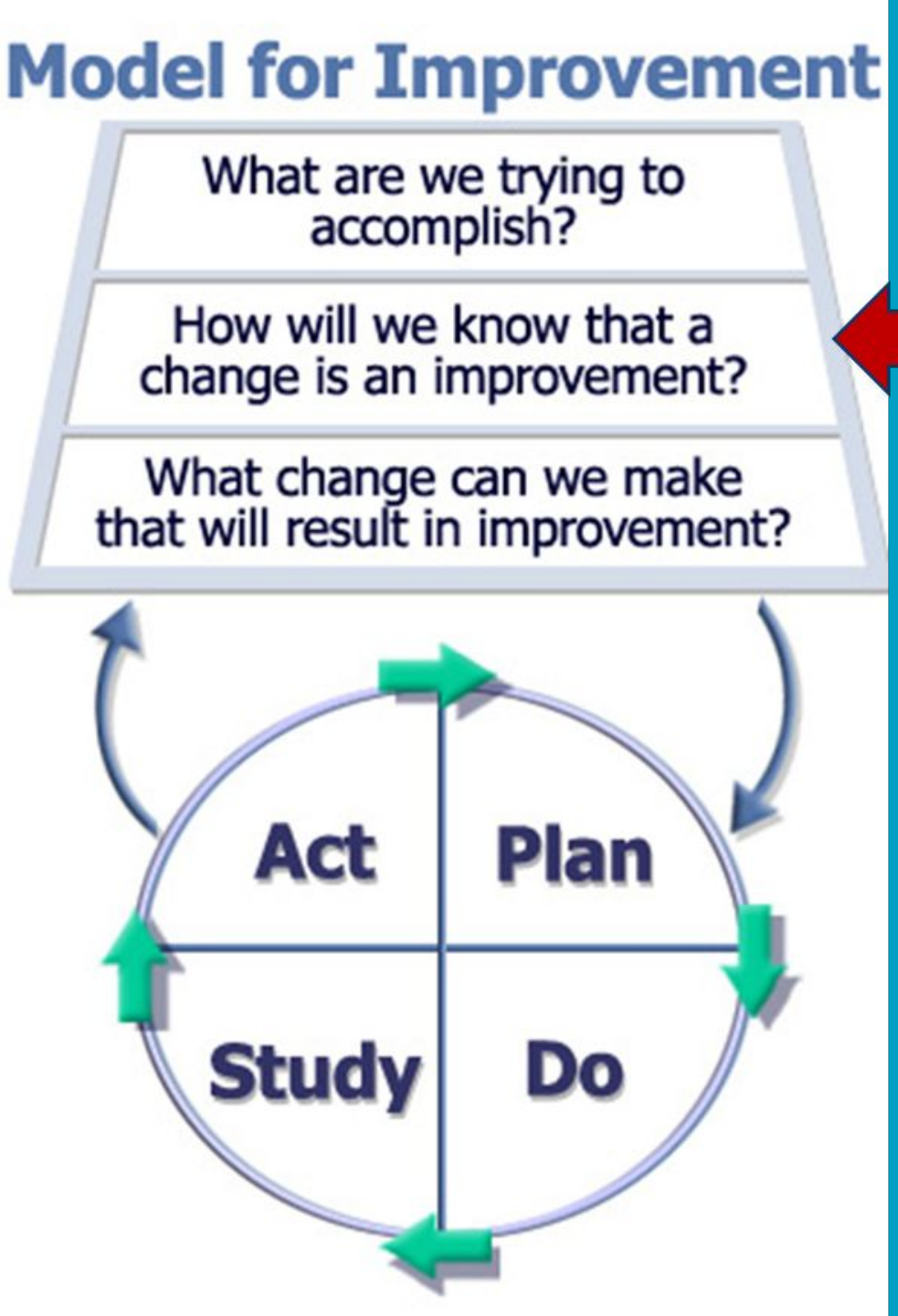
- Are you recruiting and engaging persons across your entire target population? Or are some groups under-represented?
- Does satisfaction or engagement vary by demographics?
- Do outcomes vary by demographics?
- Are evidence-based practices provided across the entire target population?

http://www.ihi.org/resources/Pages/Publications/Framework-Improving-Health-Equity.aspx

Question #2:

How will we know that a change is an improvement?

All improvement requires change, but not all changes lead to improvement



A Family of Measures

- **Outcome Measures**: Voice of the customer or patient. How is the system performing? What is the result?

- **Process Measures**: Voice of the workings of the system. Are the parts/steps in the system performing as planned?

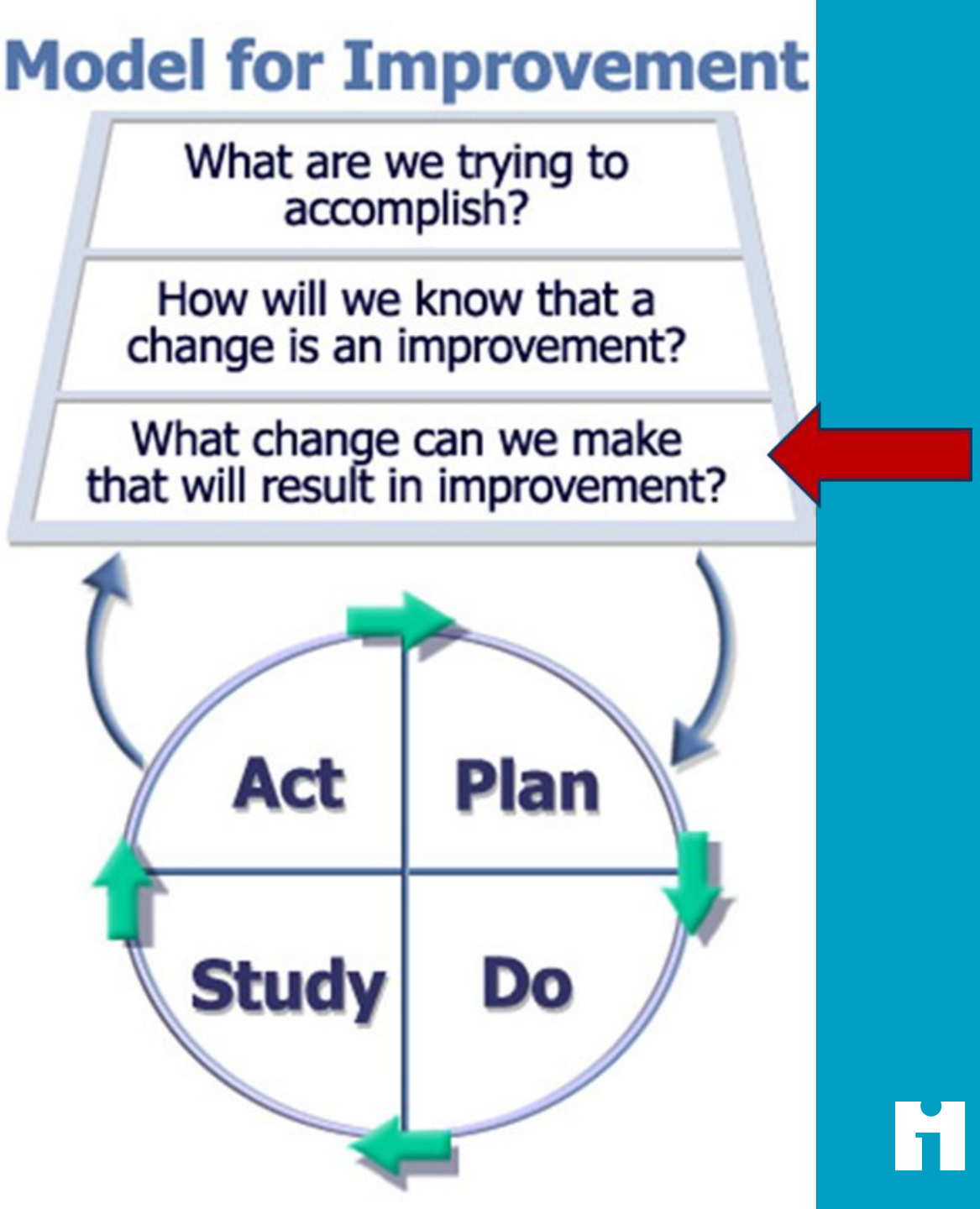
- **Balancing Measures**: Looking at a system from different directions/dimensions. What happened to the system as we improved the outcome and process measures (e.g. unanticipated consequences, other factors influencing outcome)?

Harvard Business Review

Question #3:

What change can we make that will result in improvement?

IDEAS ARE WORTHLESS UNTIL YOU GET THEM OUT OF YOUR HEAD TO SEE WHAT THEY CAN DO.



[Insert Community Name]: Aim Statement

Community Aim	
Pilot Aim	Over the course of this 2 year Pilot initiative, your teams will have made **measurable progress** toward ending **chronic homelessness**, with a focus on building **racially equitable** systems.
	By When? How Much? What? For Whom?

[Insert Community Name] - Project Portfolio

ToC Pillar	Project	Owner/Point Person	New or existing project?	Timing	Opportunity to foster equitable outcomes?	Impact/Effort (Quick Win, Major Project, Fill in Job, Thankless task)

Community Name: [Insert Community Name] Project: [Insert Project Name]	
What is the aim of this project?	
Who is the target population for this project?	
Who is the project point person (big red ball holder)?	
What will we measure to know that the project is successful? How will this project lead to a population level reduction?	
What is the next step(s) to launch this project?	

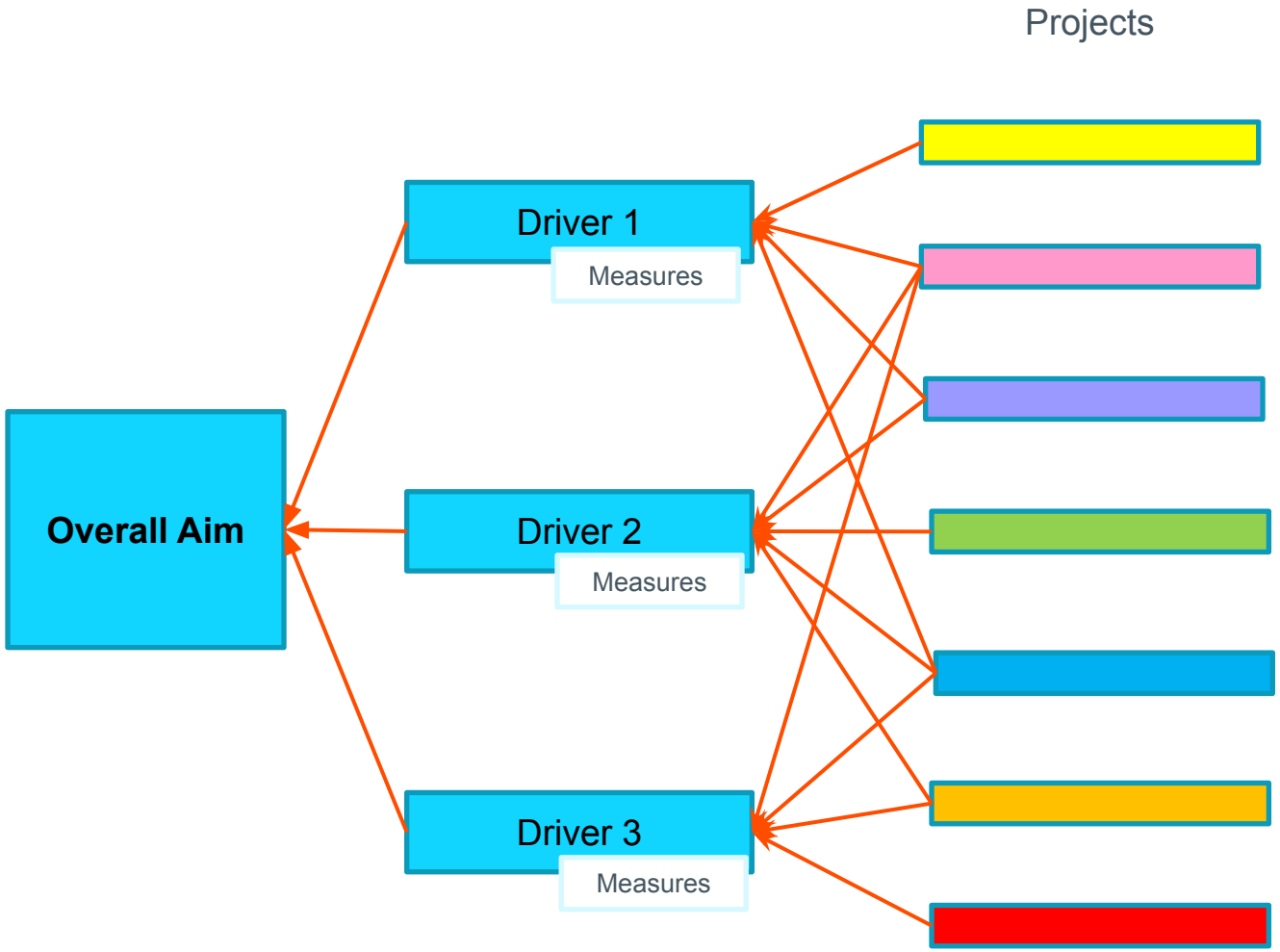
You actually use the MFI every day

DISCUSSION

What is the last test you ran, in your daily life or in your work?

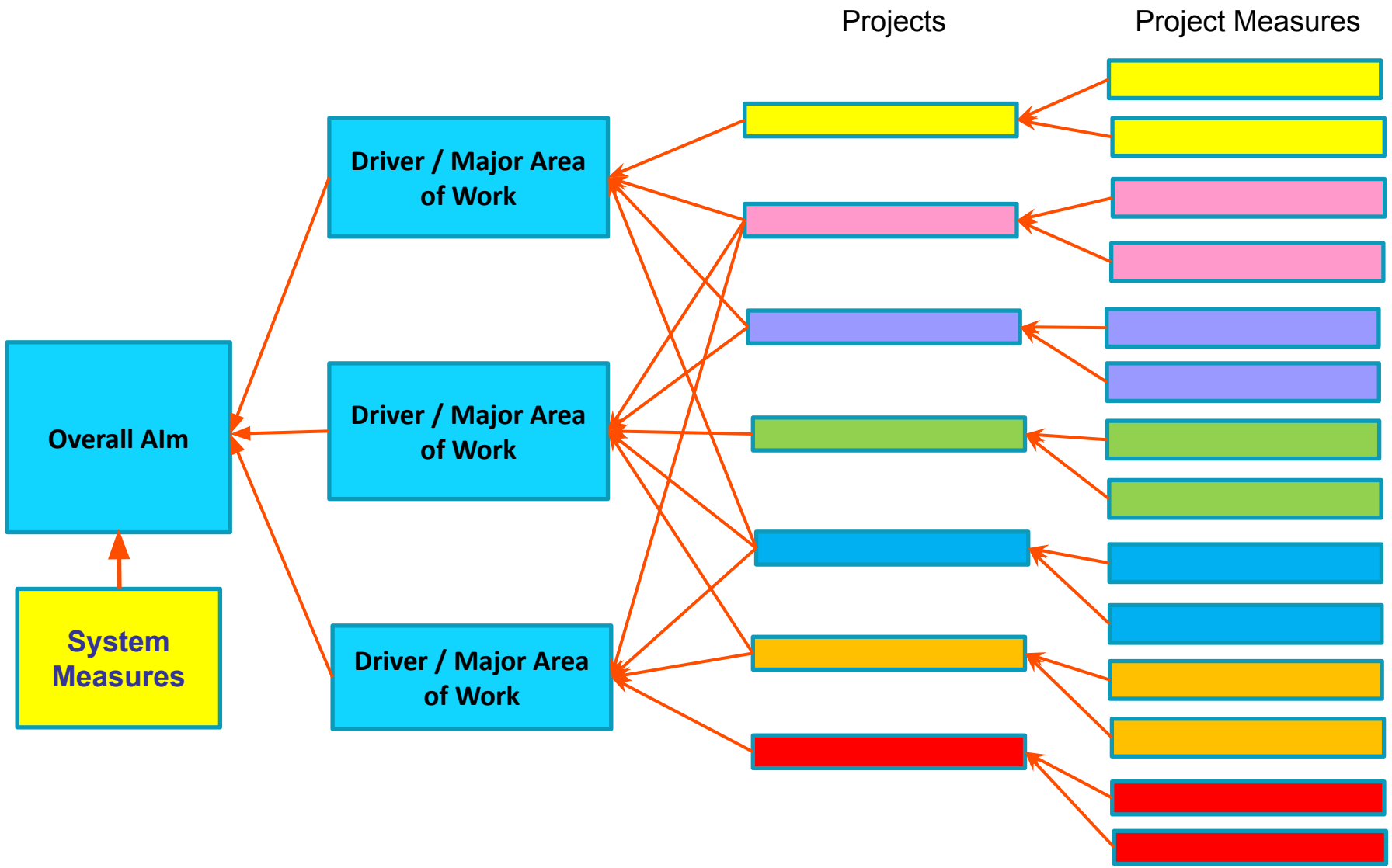
What questions do you have?

Building a Portfolio



Graphic compliments of Care Oregon

Building a Portfolio



Creating a Balanced Portfolio

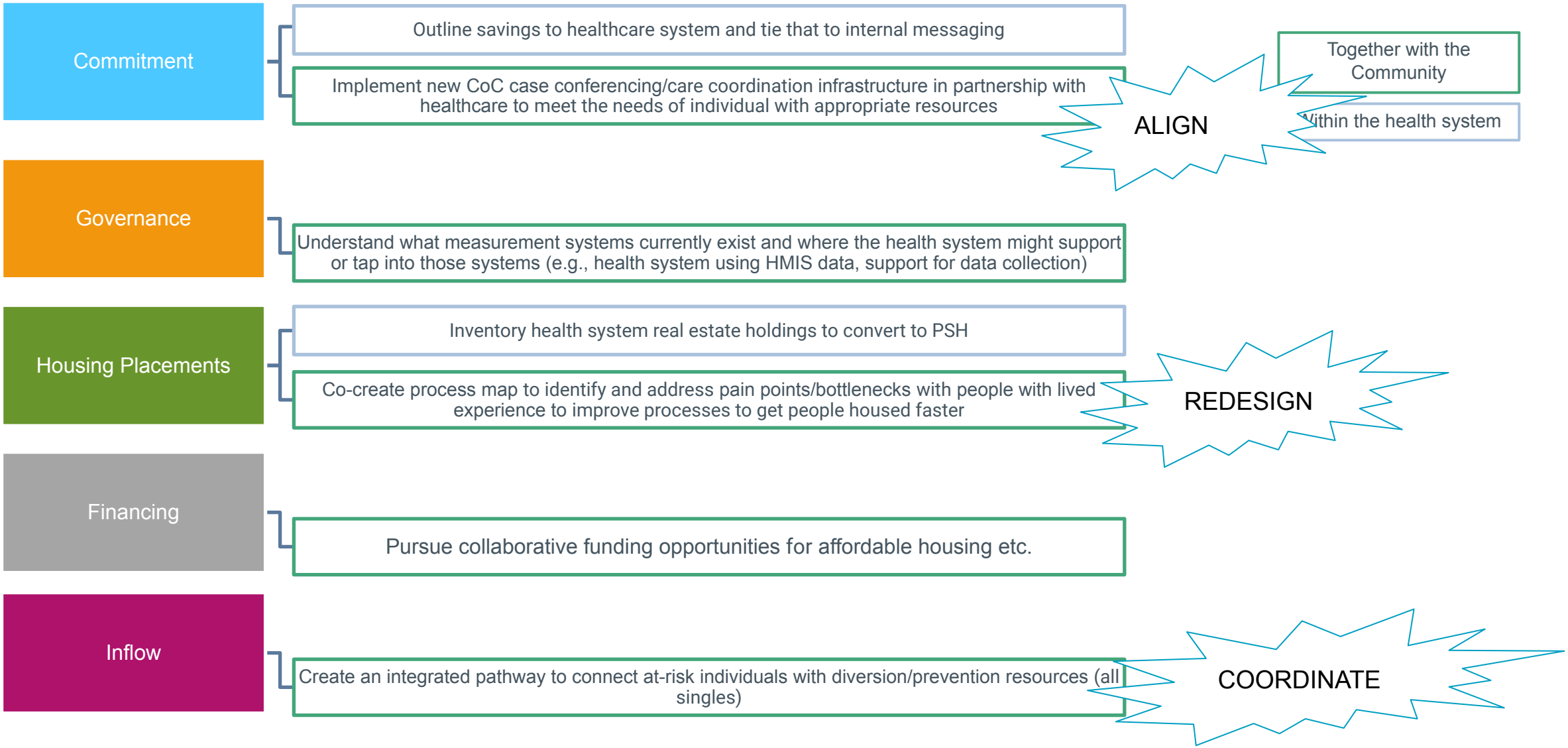
- A balanced portfolio will have a blend of:
  - Quick wins & big bets
  - Existing programs & new work
  - Projects within HC system & cross-sector work
  - Activity across at least 3 of the 5 pillars of the Healthcare + Housing Pilot Theory of Change

Different projects require different approaches

Sample Project Portfolio

Overall Pilot Team Aim:
Reduce chronic homelessness by 75% from May baseline by Dec 31, 2022, with a focus on building racially equitable systems

Outcome Measure: # of active chroniC homeless



Pueblo, Colorado: Portfolio of projects

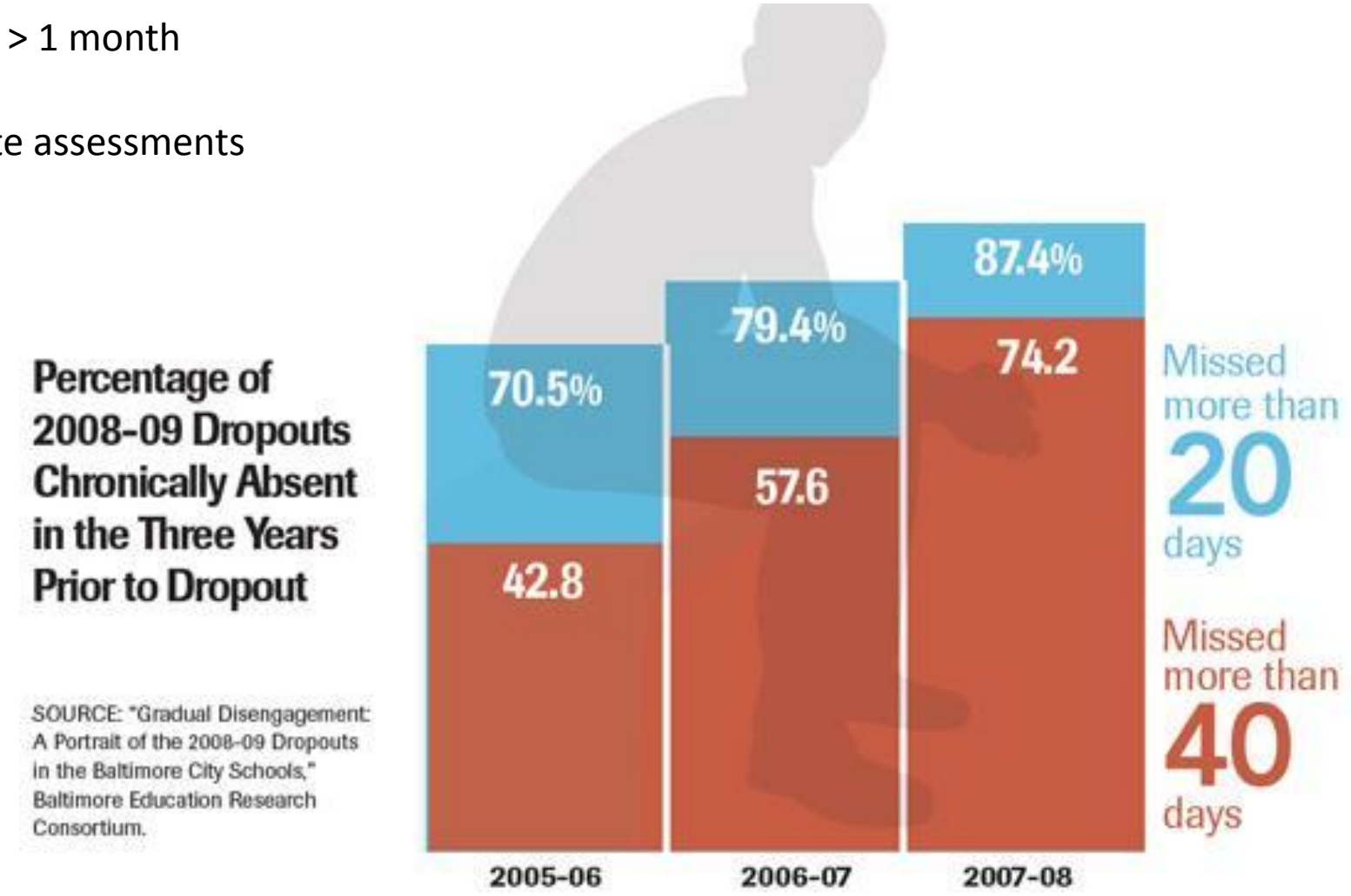
Area of Emphasis (Portfolio)	*Initiatives*
Obesity *Goal: Reduce rate of adult obesity by 2017 from 29.76 to 23.7%*	• Food Systems • Physical Activity • Built Environment
Teen/Unintended Pregnancy *Goals: Maintain reduced teen pregnancy rate from 51/1000 in 2009 to 30/1000 in 2014; reduce rate to state average of 19/1000 by 2020.*	• Mentoring • Long Acting Reversible Contraceptives
Smoking *Goal: Reduce adult smoking rate from 24% to the state average of 17% by 2020.*	• Safety Net Population • Youth (14-24) • In Person Cessation Assistance
Readmissions/ED Use *Goal: Reduce avoidable Medicare readmissions from 35/1000 enrollees to 33/1000 enrollees by 2020.*	• Frail Elders/Dual Eligibles • Heroin Addiction

Healthy Shelby County, Memphis: Portfolio of projects

Data	Initiative	Partners	Measures
High rates of chronic disease	Hypertension	Faith community, hospitals, clinics, local celebrities	•Percent of patients in the registry with controlled blood pressure •Incidence of heart attacks and strokes in the community
Very high hospital utilization & costs in last 6 months of life	Living Well/Dying Well	Hospitals, medical schools, primary care, churches, rotary club, schools	•Medicare costs in last 6 months of life •Percent of Medicare patients dying in the hospital
High rates of infant mortality	Safe Sleep	Public health, primary care, hospitals	•County infant mortality rate

Chronic absenteeism in Baltimore schools

1 in 5 middle school students missed > 1 month
40% high school students
Scored 15 to 20% points lower on state assessments



Franklin Square Elementary/Middle School

- Surrounded by boarded-up buildings
- An average of nine out of 10 of its students live in poverty;
- One in five, on average, is highly mobile
- Principal Terry Patton and her staff weave attendance strategies into every part of the school.
- Track data proactively.

- http://www.edweek.org/ew/articles/2010/10/01/06absenteeism_ep.h30.html

A portfolio of solutions

Franklin Square Elementary/Middle School, Baltimore

The Result?

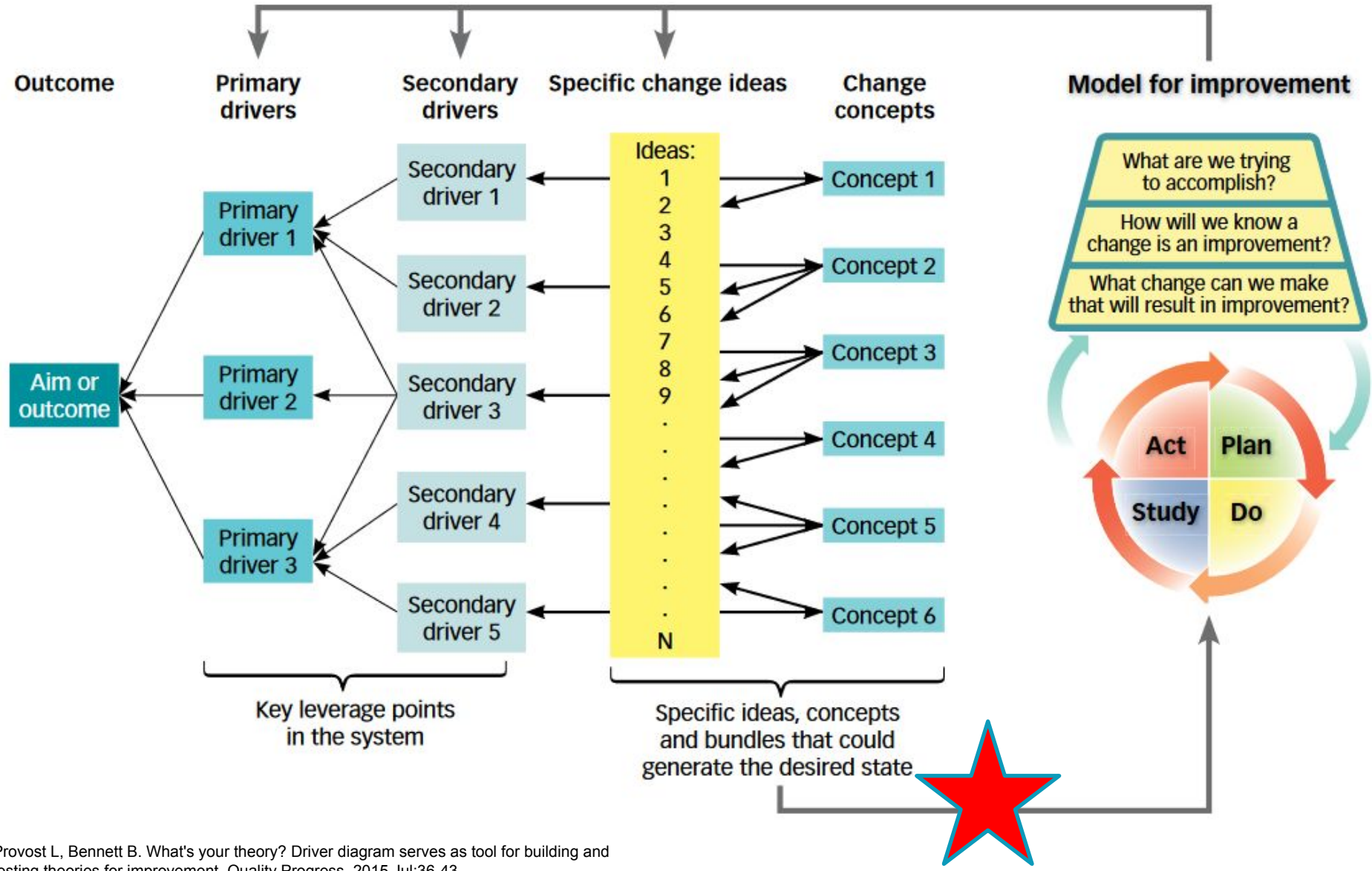
- Daily attendance above 96 percent
- Test scores above the state average

DISCUSSION

What projects are in your portfolio today?

Where can your team redesign, better align, coordinate, or build capacity?

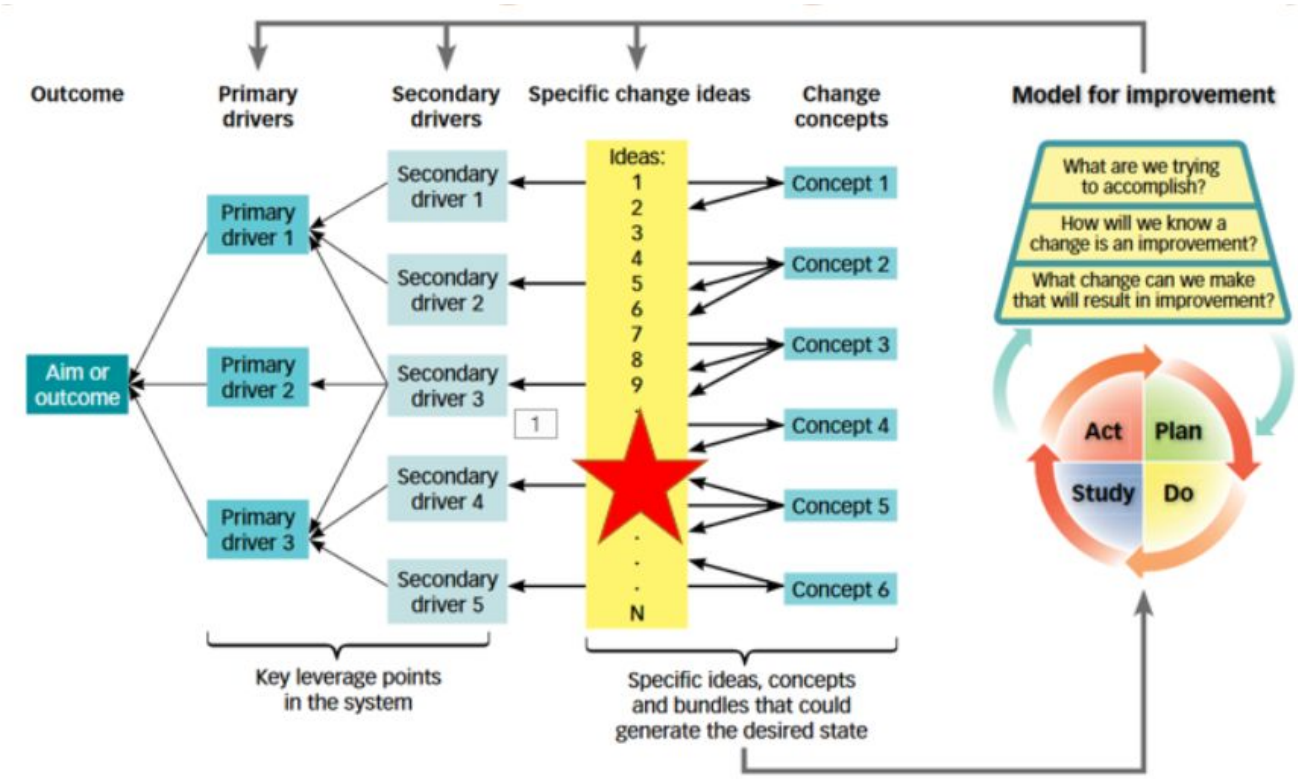
Theory informs testing, and in turn testing refines theory



Provost L, Bennett B. What's your theory? Driver diagram serves as tool for building and testing theories for improvement. Quality Progress. 2015 Jul:36-43.

Change Ideas

Change Idea: A tangible, specific idea describing how something may lead to the desired state in the system



Eliminate Waste

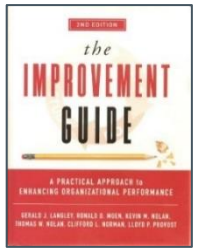
1. Eliminate things that are not used
2. Eliminate multiple entry
3. Reduce or eliminate overkill
4. Reduce controls on the system
5. Recycle or reuse
6. Use substitution
7. Reduce classifications
8. Remove intermediaries
9. Match the amount to the need
10. Use Sampling
11. Change targets or set points

Improve Work Flow

12. Synchronize
13. Schedule into multiple processes
14. Minimize handoffs
15. Move steps in the process close together
16. Find and remove bottlenecks
17. Us automation
18. Smooth workflow
19. Do tasks in parallel
20. Consider people as in the same system
21. Use multiple processing units
22. Adjust to peak demand

Optimize Inventory

23 Match inventory to predicted demand
24 Use pull systems
25 Reduce choice of features
26 Reduce multiple brands of the same item



Change the Work Environment

27. Give people access to information
28. Use Proper Measurements
29. Take Care of basics
30. Reduce de-motivating aspects of pay system
31. Conduct training
32. Implement cross-training
33. Invest more resources in improvement
34. Focus on core process and purpose
35. Share risks
36. Emphasize natural and logical consequences
37. Develop alliances/cooperative relationships

Enhance the Producer /Customer Relationship

38. Listen to customers
39. Coach customer to use product/service
40. Focus on the outcome to a customer
41. Use a coordinator
42. Reach agreement on expectations
43. Outsource for “Free”
44. Optimize level of inspection
45. Work with suppliers

Manage Time

46. Reduce setup or startup time
47. Set up timing to use discounts
48. Optimize maintenance
49. Extend specialist’s time
50. Reduce wait time

Manage Variation

51. Standardization (Create a Formal Process)
52. Stop tampering
53. Develop operational definitions
54. Improve predictions
55. Develop contingency plans
56. Sort product into grades
57. Desensitize
58. Exploit variation

Design Systems to avoid mistakes

59. Use reminders
60. Use differentiation
61. Use constraints
62. Use affordances

Focus on the product or service

63. Mass customize
64. Offer product/service anytime
65. Offer product/service anyplace
66. Emphasize intangibles
67. Influence or take advantage of fashion trends
68. Reduce the number of components
69. Disguise defects or problems
70. Differentiate product using quality dimensions
71. Change the order of process steps
72. Manage uncertainty, not tasks

Change Concepts and Related Ideas

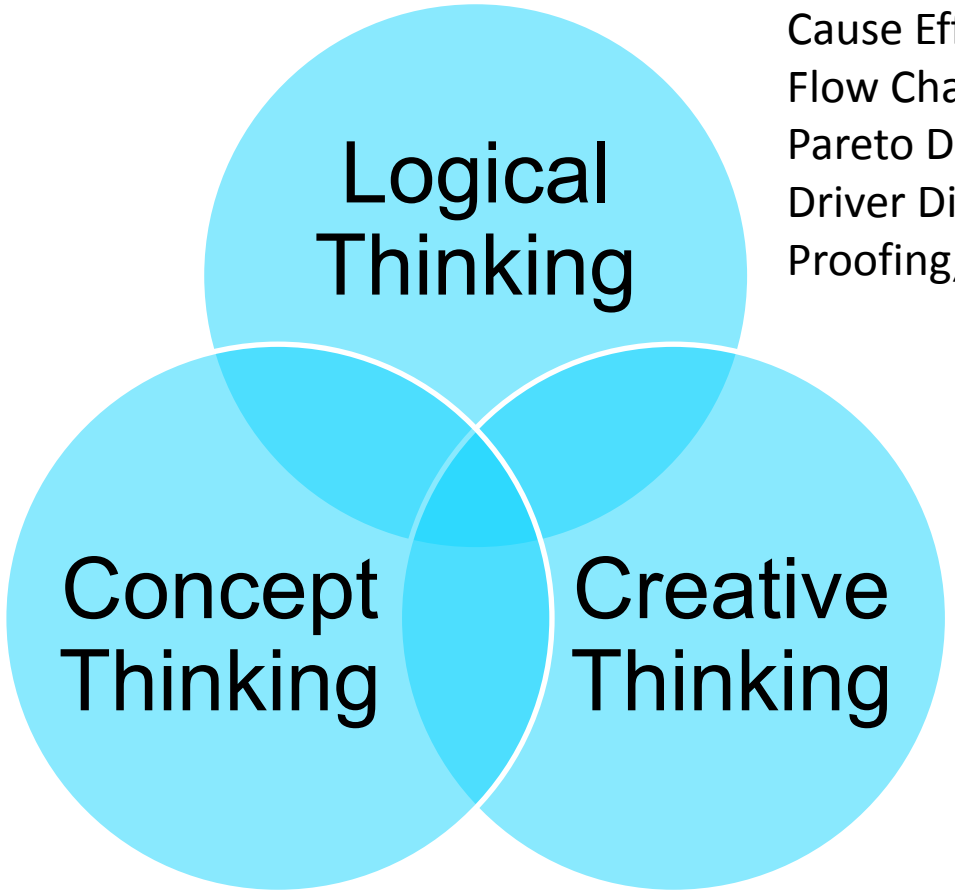
Source: *The Improvement Guide*, Langley, Nolan, Nolan, Norman and Provost, Jossey-Bass,2009, p.357.

Seven Go-to Change Concepts for Communities

Change concepts that might be helpful to eliminate waste, improve workflow, and improve the relationship with the customer or client:

1. Eliminate things that don’t add value for the customer/client
2. Minimize handoffs
3. Find and remove bottlenecks
4. Do tasks in parallel
5. Coach clients to use the service
6. Create a formal process (standardization)
7. Implement cross-training

Three sources of change ideas



Cause Effect Diagrams, Flow Charts, 5 Why, Pareto Diagram, Driver Diagrams, Error Proofing,…

Change Concepts, Lean 8 Wastes, Benchmarking, Best Practices, Change Packages,…

Brainstorming, Nominal Group, Reversal, Distortion Exaggeration, Wishful Thinking Random Word,…

DISCUSSION

What can you do by next Tuesday?

HEALTHCARE & HOMELESSNESS

WORKSHOP 2: DAY 1

3

Break & Team Time

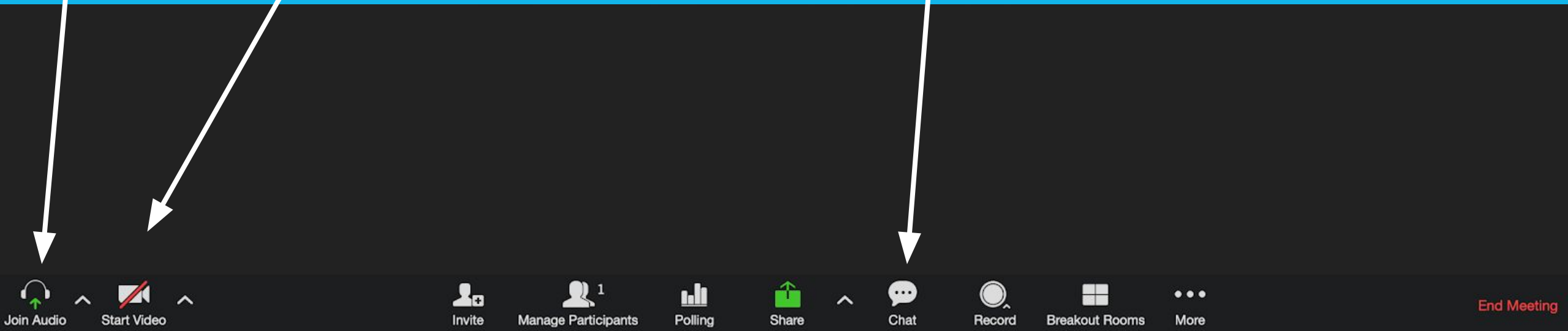
Welcome to Healthcare and Homelessness Pilot Initiative Workshop Day 2!

Mute your audio!

Turn on your video!

Say hi in the chat box! Tell us:

What song is playing on repeat for you this summer?



HEALTHCARE & HOMELESSNESS PILOT INITIATIVE

WORKSHOP 2: DAY 2

HEALTHCARE & HOMELESSNESS

WORKSHOP 1: DAY 2

1

Welcome Back!

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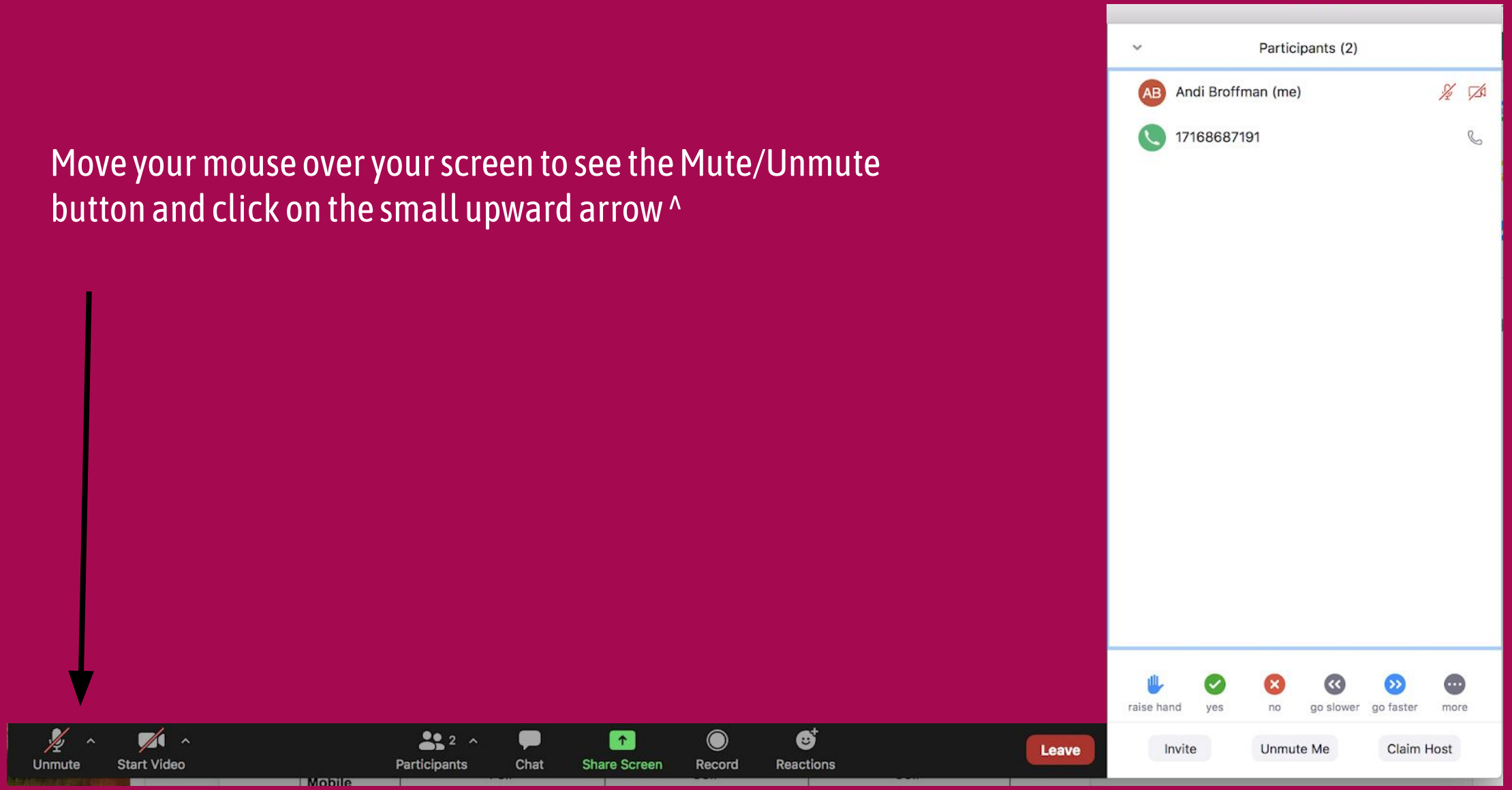

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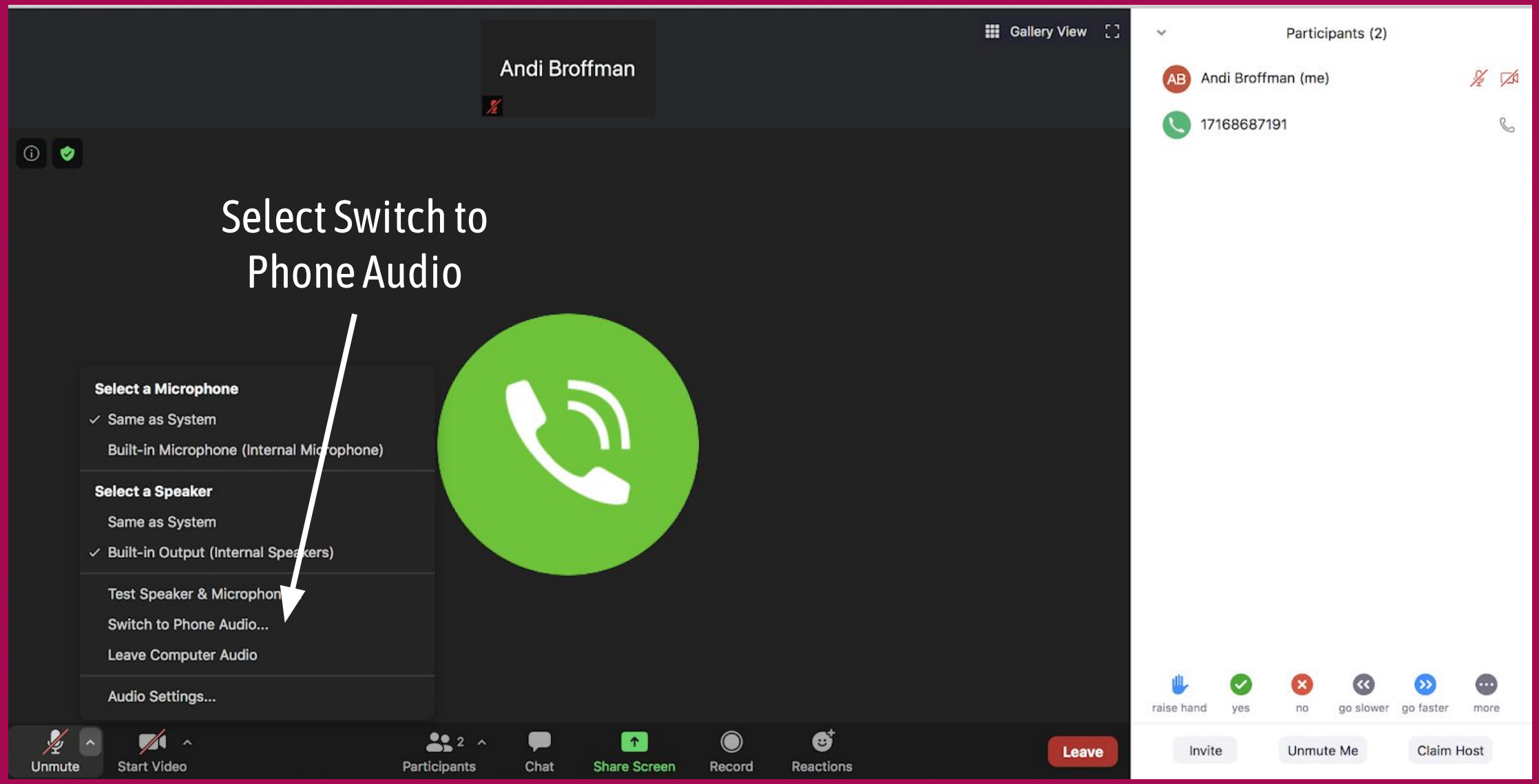

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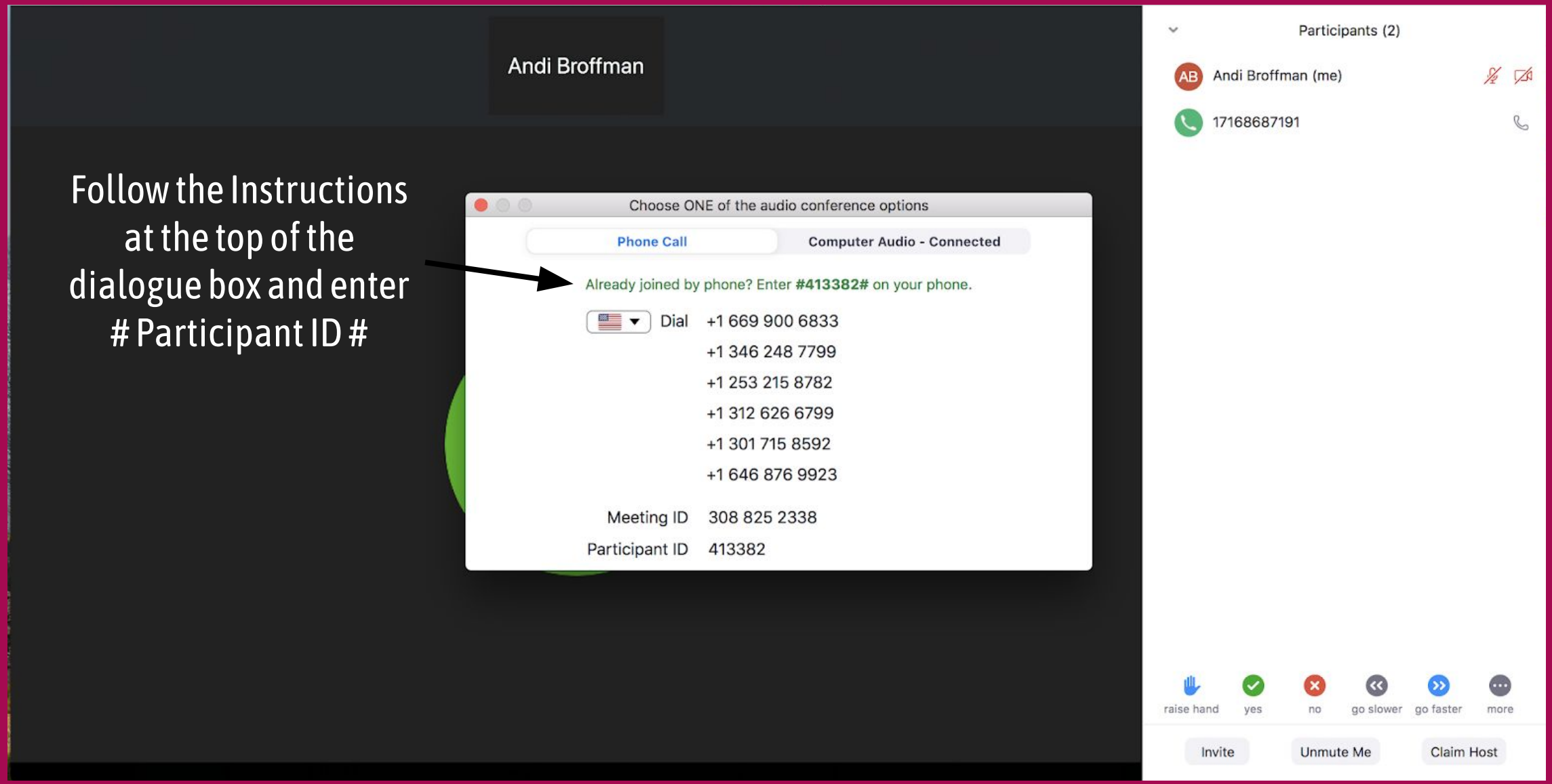

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1:45-2:15pm ET / 10:45-11:15am PT / 9:45-10:15am AKT	Welcome and Grounding
2:15-3:00pm ET / 11:15am-12:00pm PT / 10:15-11:00am AKT	Model for Improvement: Bringing Your Portfolio to Life
3:00-3:15 ET / 12:00pm-12:15pm PT / 11:00 - 11:15am AKT	Break and Transition to Breakouts
3:15-4:45pm ET / 12:15-1:45pm PT / 11:15am-12:45pm AKT	Team Time: Finalizing Pilot Site Aim and Portfolio of Projects

Quick Debrief

What's squared away?

What do you really understand?

What's still going around in your head?

Where do you need more clarity?

Agenda: Day 2

Time	Agenda Item
1:45-2:00 ET / 10:45-11:00am PT / 9:45-10:00am AKT	Welcome Back
2:00-2:45 ET / 11:00-11:45am PT / 10:00-10:45am AKT	Data Sharing for project portfolios
2:45-2:55 ET / 11:45-11:55am PT / 10:45 - 10:55am AKT	Break
2:55-4:15 PM ET / 11:55am-1:15pm PT / 10:55am-12:15pm AKT	Cross Pilot Site Aim and Project Portfolio Share Out + Q&A
4:15-4:45 PM ET / 1:15-1:45pm PT / 12:15-12:45pm AKT	Close Out

Institute *for* Healthcare Improvement

Data Sharing: What, when and how to begin

Healthcare + Homelessness Pilot Initiative

June 2021

So many opportunities!

- **Data for improvement:** Identify people in the population, track work processes, capture real-time impact
- **Data to coordinate care:** Around specific people & across different organizations
- **Outcome data:** Tell the story of the results of our work at the aggregate level
- **Value Case data**: Show the impact of the change process in measures that matter to stakeholders and result in permanent, sustainable financing

Data As a Critical Lens on Equity

Step 1: Learn demographics

Step 2: Review your target population data:

- Does your population of focus have disproportionate numbers by:
  - race or ethnicity
  - socioeconomic status
  - gender
  - disability status
  - sexual orientation
  - age
  - location (sub-region of community)
  - Primary language / country of origin
  - Other relevant factors? (ie Health literacy, lack of insurance)

Step 3: Filter the data to look for differential impacts among sub-populations.

- Is length of homelessness distributed evenly among groups in proportion to local demographics?
- Who is not thriving?

Equity as an Ongoing Question

How are our interventions reaching people?

- Are you recruiting and engaging patients across your entire target population? Or are some groups under-represented?
- Does patient satisfaction vary by demographics?
- Do health outcomes vary by demographics?
- Are Evidence-Based Practices provided across the entire target population?

Continuous quality improvement toward equity

Data for improvement

Identify people in the population: Share with data agreements

- 1 organization identifies individual people to focus their improvement efforts
- *Option A:* BfZ team shares by-name list with health system, then health system runs that list for patient identification
- *Option B:* BfZ team shares by-name list with payer, then payer runs that list for patient identification of healthcare system involved in care delivery
- Start by sharing required fields in each system (HMIS, health system)

Data to track processes and outcomes

Process data: Share aggregate data

Count work processes that come from Theory of Change, such as

- # of people connected to transitional housing within 15 days of intake

Outcome data: Share aggregate data

Count specific indicators of the results of our work, such as

- # of people reporting good health
- # of hospital visits (Emergency department, inpatient admissions, inpatient days)

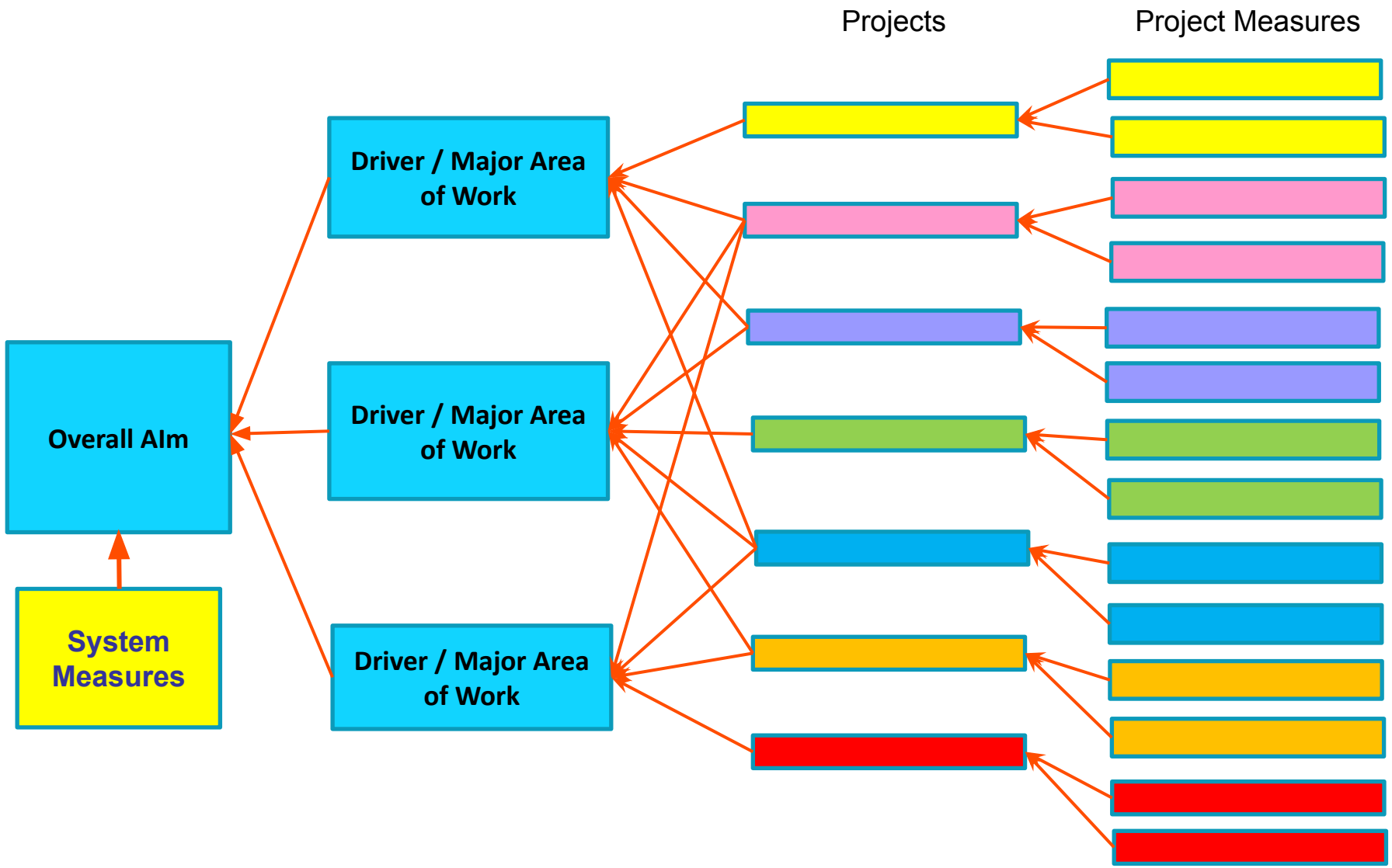
DISCUSSION

What questions about equity will your data help answer?

How will you identify people in your target population?

Questions?

Building a Portfolio



Sample Project Portfolio

Overall Pilot Team Aim:
Reduce chronic homelessness by 75% from May baseline by Dec 31, 2022, with a focus on building racially equitable systems

Outcome Measure: # of active chronic homeless

Commitment	Outline savings to healthcare system and tie that to internal messaging	Together with the Community
	Implement new CoC case conferencing/care coordination infrastructure in partnership with healthcare to meet the needs of individual with appropriate resources	Within the health system
Governance	Understand what measurement systems currently exist and where the health system might support or tap into those systems (e.g., health system using HMIS data, support for data collection)	
Housing Placements	Inventory health system real estate holdings to convert to PSH	
	Co-create process map to identify and address pain points/bottlenecks with people with lived experience to improve processes to get people housed faster	**Process Measures:** Length of time homeless Patient experience within hospital # referrals from hospital to homeless response system
Financing	Pursue collaborative funding opportunities for affordable housing etc.	
Inflow	Create an integrated pathway to connect at-risk individuals with diversion/prevention resources (all singles)	**Process Measure:** # at risk individuals

Chinle Service Unit, IHS: Portfolio of Projects

Projects	*Type*	*TA Dimensions*	*Project Measures*
Improving Patient Care Medical Home	Existing Project	Population Health Experience of Care Per Capita Cost	Outcome: ED/UC visits; Child Immunizations; Outcome Bundle; Primary care access Process: Continuity Rates; Supply/Demand Ratio
Diabetes Health Coach Model of Care	Existing Project	Population Health Experience of Care Per Capita Cost	Outcome: A1c, LDL, BP under control; rate of hospitalization Process: Active diabetics current on comprehensive care measure; Percent of patients with a health coach visit
Chinle Hospital Engagement Network	Existing Project	Experience of Care Per Capita Cost	Outcome: Inpatient satisfaction; Inpatient Safety Index Process: Measures of team function
Community Health Improvement Councils	New Project	Population Health	Outcome: Coalition Development Score Process: Attendance at Council Meetings by Sector

Chinle Service Unit
Project and Outcome Measures tracking the theory of change

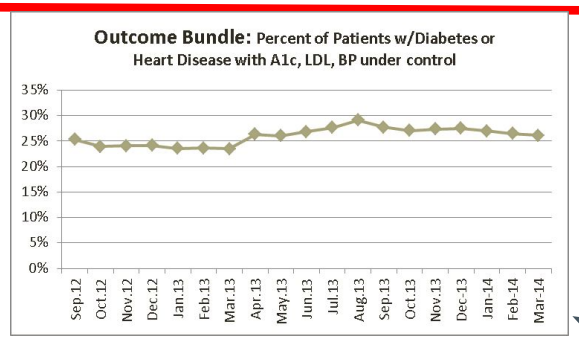
Outcome Bundle

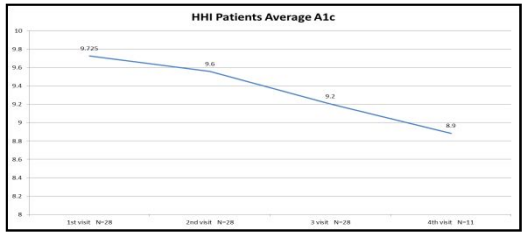
Self-Reported Health Status

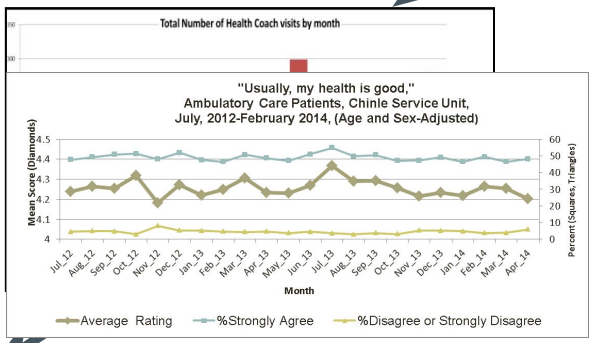
Patient Confidence

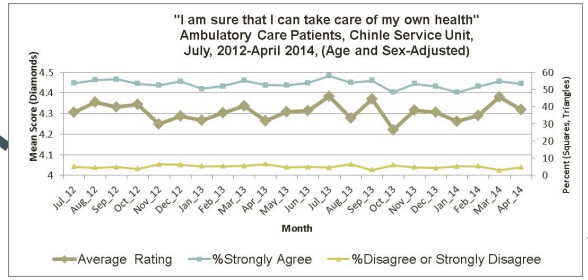
Reach/ Scale-Up: Number of Health Coach Visits

Effectiveness Of Change Concept: Average A1c









DISCUSSION

What process or outcome measures are you considering?

Questions?

Data for care coordination

HIPAA allows data sharing for care coordination.

If still hesitant:

- Use an integrated consent form for patients that allows data sharing between partners

Coordinate care around specific people: Share de-identified data

- Case conferencing with partner organizations
- Discuss cases using initials or aliases to allow team to problem-solve specific challenges and uphold confidentiality if agreements are forthcoming

Data to track the Value Case

Cost data:

- Impact on total cost of care
- Impact on direct or variable costs

Utilization data:

- Admissions and visits
- Impact on Length of Stay Days inpatient

Equity data:

- Improvement in housing status
- Improvement in access to benefits
- Improvement in access to care

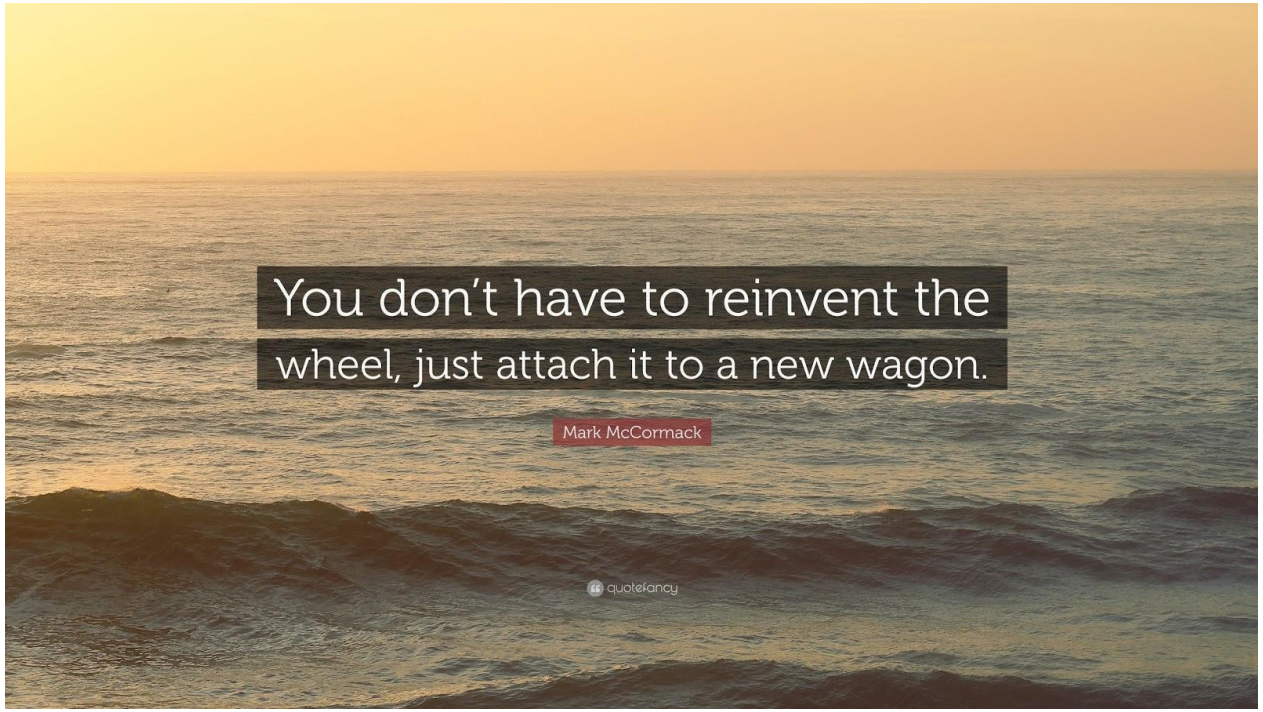
Quality data:

- Impact on disease management
- Impact on quality indicators tied to VBP

Satisfaction data:

- Client satisfaction or Story
- Provider satisfaction or Story
- Partner satisfaction or Story

Where can you start to understand the opportunity?



- Care Management/Social Work reports
- ACO or Value Based Payment reports
- 30 day readmit evaluation committee or long length of stay committee reports
- Existing complex care management programs that intersect with the homeless
- Community based data/CHNA on homeless
- 911 call/transport evaluation reports
- Police call reports
- Payer reports on the population
- Existing SDOH screening initiatives/AHCs

Adventist Health Clear Lake

Lake County, California

- Ranked last in health outcomes
- 75% of county burned in wildfires of the past 5 years
- High rates of poverty and substance misuse

Project Restoration

- County-wide cross-sector collaborative (Police, Fire, EMS, Criminal Justice, Mayor, Health, Social Services, Education)
- Shared data
- Process improvements to change root cause

Adventist Health

How did they begin?

- Completed a BAA with each cross sector collaborative organization
- Created an integrated patient consent form that allowed data sharing between organizations
- Each identified highest utilizers in their own databases
- Identified shared high utilizers
- Identified a set of metrics that mattered to all the stakeholders
- Captured these metrics by hand in an excel spreadsheet


The team worked with **28 patients** over the first **12 months** and saw reduced utilization and strengthened community partnerships.
AdventistHealth

Utilization

Hospital Reduction (ED & IP)

44% ↓

Community Services

Police, EMS, Jail

83% ↓

Cost Reduction

71% ↓

Hardin, et al. Cross-Sector Collaboration for Vulnerable Populations Reduces Utilization and Strengthens Community Partnerships. Manuscript submitted to JIEP *(copy on file with author)*

AdventistHealth

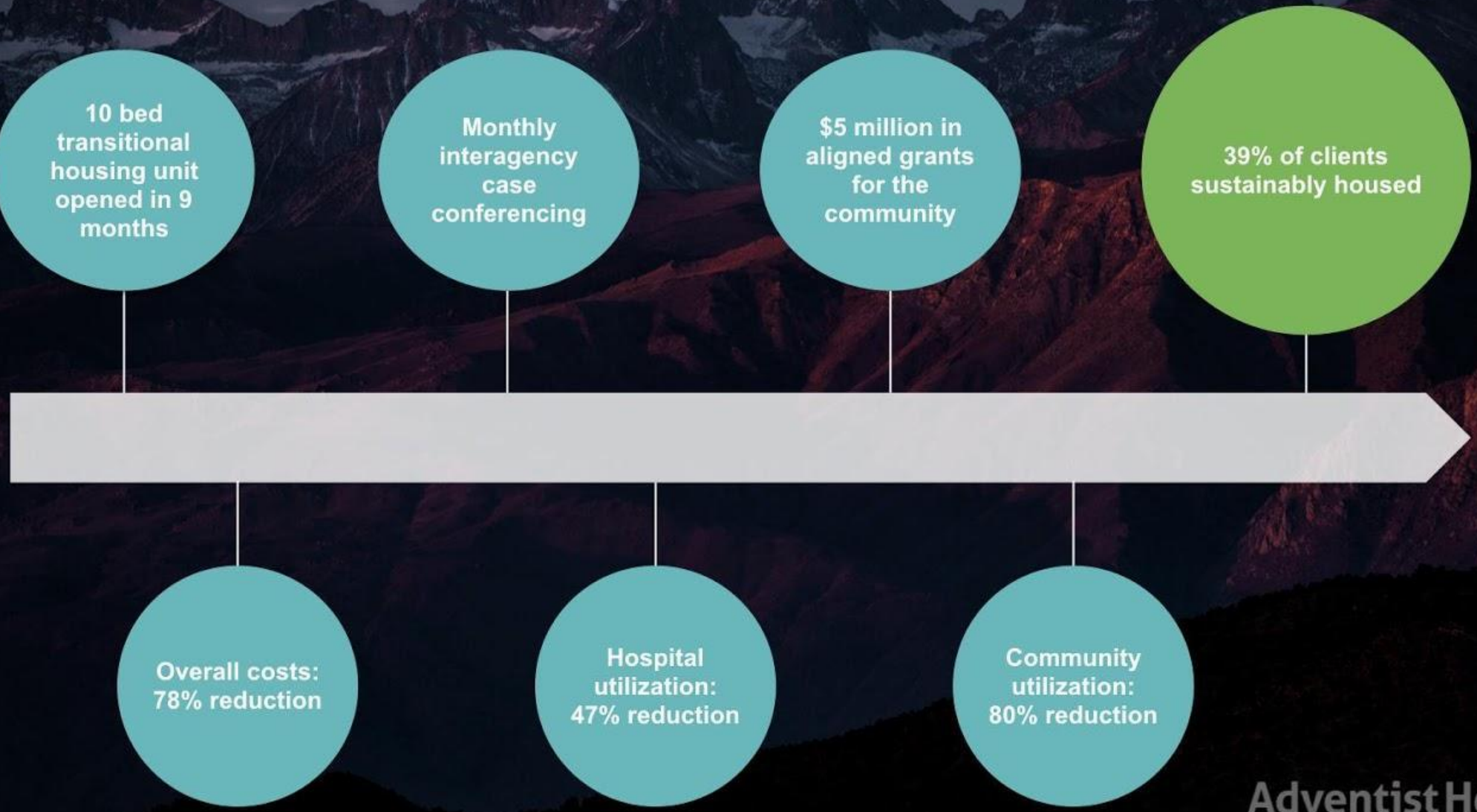
Patient Experience

Access to Care and Safety

Hardin, et al. Cross-Sector Collaboration for Vulnerable Populations Reduces Utilization and Strengthens Community Partnerships. Manuscript submitted to JIEP *(copy on file with author)*

AdventistHealth

Outcomes



AdventistHealth

DISCUSSION

What steps can your team take in the next month toward collecting and sharing needed data?

What data do you currently share with partner organizations?

Questions?

HEALTHCARE & HOMELESSNESS

WORKSHOP 2: DAY 1

2

Break

HEALTHCARE & HOMELESSNESS

WORKSHOP 2: DAY 1

3

Pilot Team Report Outs

Bakersfield, California

Kaiser Permanente
CommonSpirit Health

Bakersfield, Kern County Health &Homelessness Portfolio

Overall Pilot Team Aim:

We will develop and implement strategies to reduce the number of homeless individuals in Bakersfield, CA by 5% and stem the tide of growth in the homeless population by addressing respite care, hospital discharge processes, and case management infrastructure during the two year pilot project period.

Outcome Measure:
Number of single adults experiencing homelessness in Bakersfield/Kern County. (Goal is to reduce by 5%, baseline still needed)

Commitment	Create case conference infrastructure in partnership with local hospitals & resource groups to ensure proper placement & resources for individuals.	**Process Measures**: # of completed case conferences # of identified needs # of secured resources
Governance Structure	Determine available data in each health system and align parameters for data sharing.	**Process Measure**: # of readmissions for single adults experiencing homelessness (Goal is to decrease)
Housing Placements	Create Respite housing resource.	**Process Measure**: % of single adults housed post-hospitalization requiring medical care (Goal is 90% housed)
Financing		**Process Measure**:
Inflow	Create standardized discharge process for all Kern County hospitals.	**Process Measure**: # of hospital discharges indicating discharge housing (Goal is to increase, baseline needed)

KEY

Together in the Community

Within Health System

Bakersfield, California

Kaiser Permanente
CommonSpirit Health

Questions + Discussion

- Clarifying questions
- Do you have any asks for the other pilot sites that would would help move your work forward?
- What offers/ideas do you have for Bakersfield?
- Recommendations for next steps?


Chattanooga, Tennessee
CommonSpirit Health

Chattanooga: Aim Statement

Community Aim	Recognizing the impact housing has on health, we come together to prioritize housing as an integral component of health services. Our coordinated response will improve the health of 300 of our community's most vulnerable citizens by January 2023. We will accomplish this by partnering with caregiving agencies in our community, analyzing data and identifying the barriers that prohibit compassionate care.
Pilot Aim	Over the course of this 2 year Pilot initiative, your teams will have made **measurable progress** toward ending **chronic homelessness**, with a focus on building **racially equitable** systems.
	By When? How Much? What? For Whom?

Chattanooga - Project Portfolio

ToC Pillar	Project	Owner/Point Person	New or existing project?	Timing	Opportunity to foster equitable outcomes?	Impact/Effort (Quick Win, Major Project, Fill in Job, Thankless task)
	Care Coordination: ID homeless individuals who are in both systems	CHI Memorial - Angela and CRHC staff?				
	Data Sharing across healthcare and homeless services	CHI Memorial and CRHC Staff				
	Engage Public will (other projects will feed into this: respite care, data sharing, care coordination)	CHI Memorial?				
	Serving the Long Stayers on the BNL (Engaging more partners; addressing the fact that the longer you are homeless, the more your health needs increase) - Case conferencing as the process for this - evolve this to include healthcare partners/behavioral health.	Jaime Angela		Can bring up in ESG mtgs		
	Respite Care: CH focus, but not exclusive. Already ID'd 3 partners interested in the work (20-30 beds, Community Kitchen, Catholic Charities, Welcome Home,) - and connect to PH at exit.	Community Partner Welcome Home Director?		By end of 2021		

Chattanooga, Tennessee

CommonSpirit Health

Questions + Discussion

- Clarifying questions
- Do you have any asks for the other pilot sites that would would help move your work forward?
- What offers/ideas do you have for Chattanooga?
- Recommendations for next steps?

Sacramento, California

Kaiser Permanente
CommonSpirit Health
Sutter Health
UC Davis

Sacramento Health System Aim Statement

Aim: Sacramento will reduce the number of individuals experiencing chronic homelessness with regular encounters with health systems by 15%, from A to B, by July 31, 2022.

Scope: *Pending data matching with BNL*

- *Regular Encounters:* Individuals with >X ED visits or >Y hospital days per year?
- *Medically Vulnerable:* Individuals with a chronic condition or of a certain age?
  - *Placeholder: Equity/BIPOC - RR to add later*
  - Current BNL (6/17) 905 individuals are on chronic homelessness list aged 50+

Measurement:

- Number of individuals on "chronic homelessness" BNL list

Sacramento Project Portfolio Draft

Overall Pilot Team Aim:

Outcome Measure:

Commitment	Outline savings to healthcare system and tie that to internal messaging
	Implement new CoC case conferencing/care coordination infrastructure in partnership with healthcare to meet the needs of individual with appropriate resources
Governance	Understand what measurement systems currently exist and where the health system might support or tap into those systems (e.g., health system using HMIS data, support for data collection)
Housing Placements	Co-create process map to identify and address pain points/bottlenecks with people with lived experience to improve processes to get people housed faster
Financing	Evaluate impact of community benefit and operations funded investments
	Pursue collaborative funding opportunities such as grants, affordable housing, etc.
Inflow	Create an integrated pathway to connect at-risk individuals with diversion/prevention resources (all singles)

Together with the Community

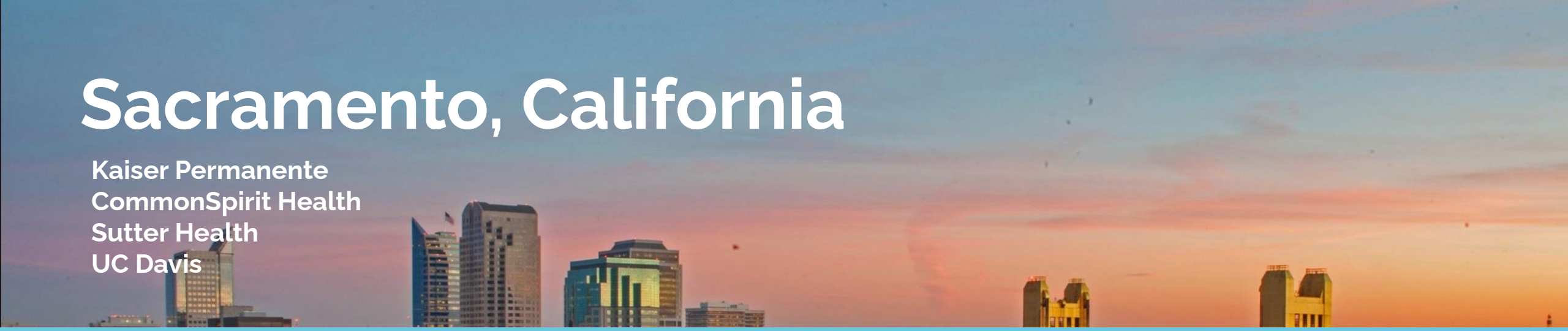
Within the health system

Sacramento - Project Portfolio

ToC Pillar	Project	Owner/Point Person	New or existing project?	Timing	Opportunity to foster equitable outcomes?	Impact/Effort (Quick Win, Major Project, Fill in Job, Thankless task)
Commitment	Implement new CoC case conferencing/care coordination infrastructure in partnership with healthcare to meet the needs of individual with appropriate resources		New			
Governance	Understand what measurement systems currently exist and where the health system might support or tap into those systems (e.g., health system using HMIS data, support for data collection)					
Housing Placements	Co-create process map to identify and address pain points/bottlenecks with people with lived experience to improve processes to get people housed faster					
Financing	Evaluate impact of community benefit and operations funded investments					
Financing	Pursue collaborative funding opportunities such as grants, affordable housing, etc.					

Sacramento - Project Portfolio

ToC Pillar	Project	Owner/Point Person	New or existing project?	Timing	Opportunity to foster equitable outcomes?	Impact/Effort (Quick Win, Major Project, Fill in Job, Thankless task)
	*Mapping people experiencing chronic homelessness on By-Name List with health system clients.		New			
	*Test what it would look like to improve care for 5-20 people from this list, who have been identified by COC as top of list for housing placement *Learn from test and scale up					

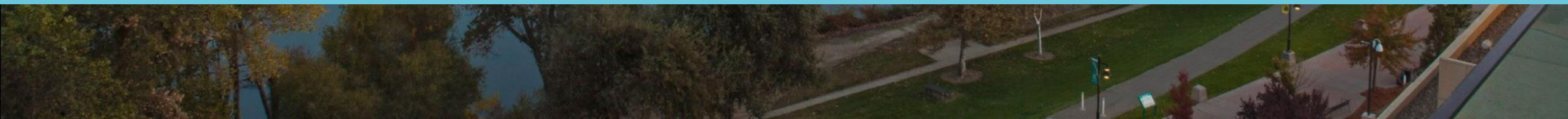


Sacramento, California

Kaiser Permanente
CommonSpirit Health
Sutter Health
UC Davis

Questions + Discussion

- Clarifying questions
- Do you have any asks for the other pilot sites that would would help move your work forward?
- What offers/ideas do you have for Sacramento?
- Recommendations for next steps?



Washington County, Oregon

Kaiser Permanente

Washington County: Aim Statement

Community Aim	Collaboration between the County and health systems (KPNW, Health Share and potentially others) including data sharing and coordination of resources/supports, to achieve a measurable reduction in chronic homelessness through coordinated interventions for people exiting or involved in health care settings who are chronically homeless or at risk of becoming homeless.
Pilot Aim	Over the course of this 2 year Pilot initiative, your teams will have made **measurable progress** toward ending **chronic homelessness**, with a focus on building **racially equitable** systems.
	By When? How Much? What? For Whom?

Washington County - Project Portfolio

ToC Pillar	Project	Owner/Point Person	New or existing project?	Timing	Opportunity to foster equitable outcomes?	Impact/Effort (Quick Win, Major Project, Fill in Job, Thankless task)
Commitment	Build relationships and shared understanding between systems	All	New	Ongoing	Yes	Slow and steady
Governance	Conduct initial data analysis - aggregate data that we have and can share now	Data leads: Angela-County Jesse - KP Katie -HSO	New	July 2021	Yes - need to disaggregate by race	Quick win (find out what we do & don't know)
Governance	Establish data sharing agreements to enable us to coordinate care + housing interventions for homeless and/or housing insecure patients	Data leads + all	New	2021	Yes	Major project (but try to start small and build)
Governance	Improve/standardize KP screening and tracking for housing insecurity and homelessness - as part of larger effort on SDOH screening	KPNW - Social Health Strategy Team	Existing	2021-2022	Yes	Major project

Washington County - Project Portfolio cont'd

ToC Pillar	Project	Owner/Point Person	New or existing project?	Timing	Opportunity to foster equitable outcomes?	Impact/Effort (Quick Win, Major Project, Fill in Job, Thankless task)
Housing placements	Explore/pilot collaborative case conferencing and care coordination across systems	TBD	New	Ongoing	Yes	Try for a quick win to start - what can we do right now
Financing	Align with Health Share's demonstration pilot to support Medicaid members who are transitioning from institutional and inpatient settings to community-based permanent or permanent supportive housing	Health Share	Existing	Launch Sept 2021; 18-mo demo project	Yes	Major project but already has significant momentum

Questions + Discussion

- Clarifying questions
- Do you have any asks for the other pilot sites that would would help move your work forward?
- What offers/ideas do you have for Washington County?
- Recommendations for next steps?

Washington County, Oregon

Kaiser Permanente

HEALTHCARE & HOMELESSNESS

WORKSHOP 2: DAY 1

3

Reflections on the Past 6 Months

Next Steps

- Scheduling set coaching call times for this Action Period
  - Pilot site calls 1 x month
  - Homeless + Healthcare coaching outside of those
- Finalizing your portfolio of projects and beginning to test
  - Continue to work on project details slides for each project in template deck
- Attending monthly All Pilot Site call
  - Wednesday, July 28th at 2PM ET / 11AM PT / 10AM AKT
  - Topic TBD

Thank you!

Share an appreciation in the chat for *someone on your team* or *someone from another pilot site*!