Healthcare and Homelessness

All Pilot Sites - Call #9

Institute for Healthcare Improvement

COMMUNITY SOLUTIONS

Introductions: In the chat

Please chat in:
- Name
- Community
- Organization
- What song do you listen to when you need to hype yourself up?

Welcome

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Our Agenda

1. Welcome and Intro [10 minutes]
2. All Team check in on case conferencing and 5X Scale up: [25 minutes]
3. Impossible cases & complex dynamics: Strategies to consider [20 minutes]
4. Next Steps and Closing [5 minutes]

Introductions

Catherine Mather
Project Director

Laura Baker
Project Manager

Lauran Hardin
Faculty Coach

Catherine Craig
Faculty Coach

Anna Bialik
Improvement Advisor

Meg Arsenault
Senior Manager
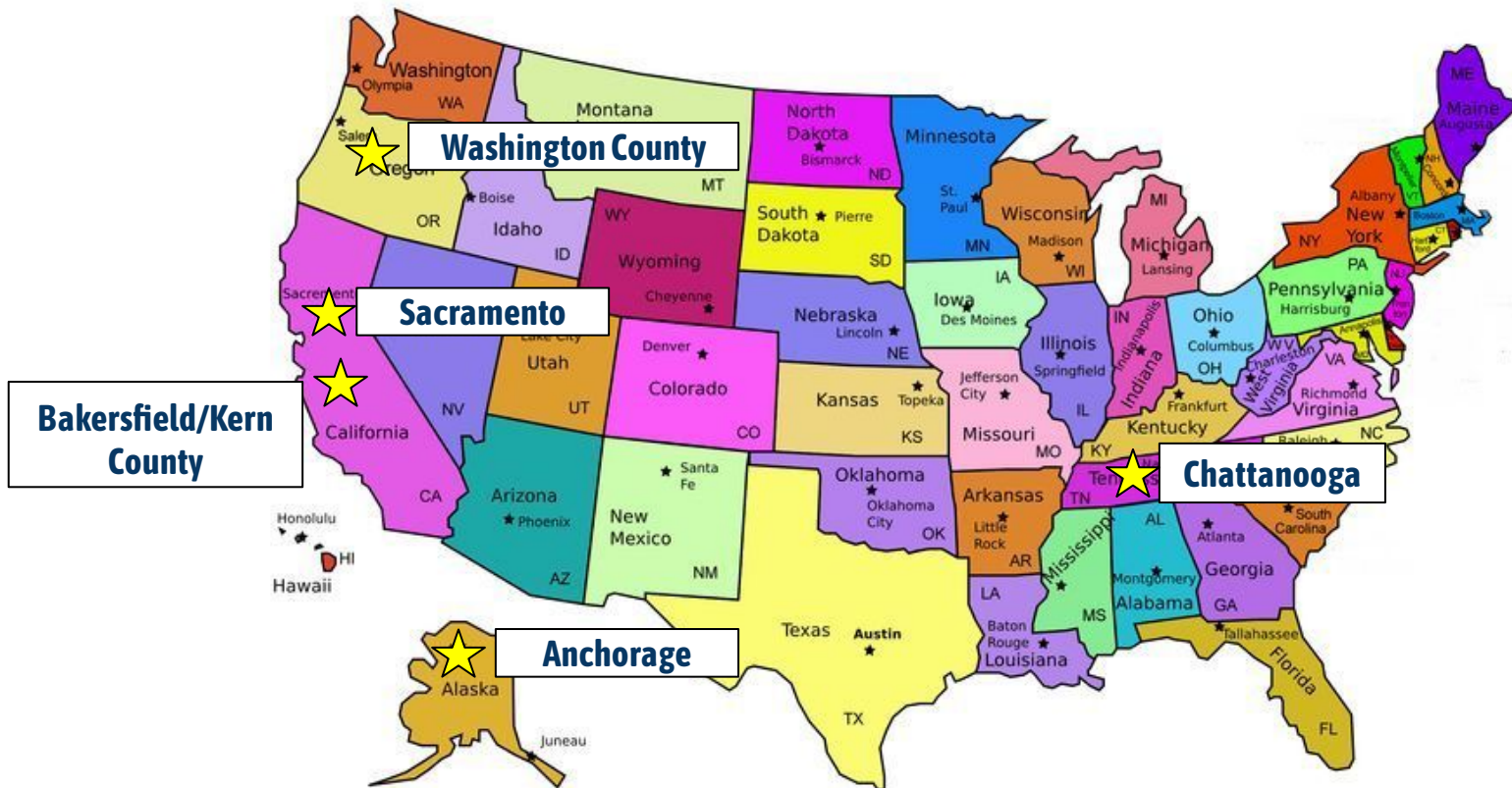
Andi Broffman
Project Advisor

Danielle Augustine
Project Manager

Ben Bradley
Improvement Advisor

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Participating Pilot Teams

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

Important Dates

- **Anchorage** March Coaching Coaching Call
  - Thurs 3/24 - 2-3:30pm ET / 10-11:30am AKT
- **Chattanooga** March Coaching Call
  - Mon 3/28 - 12-1:30pm ET
- **Bakersfield** March Coaching Call
  - Mon 3/28 - 1:30-3pm ET / 10:30am-12pm PT
- **Sacramento** April Coaching Call
  - Wed 4/27 - 12-1:30pm ET / 9-10:30 am PT
- **April All-Team Call**
  - Wed 4/27 2 - 3 pm ET/11-12 pm PT/10-11 am AKT
- **Washington County** April Coaching Call
  - Mon 4/18 - 2-3:30pm ET / 11am-12:30pm PT

Team check-in

March 18, 2022

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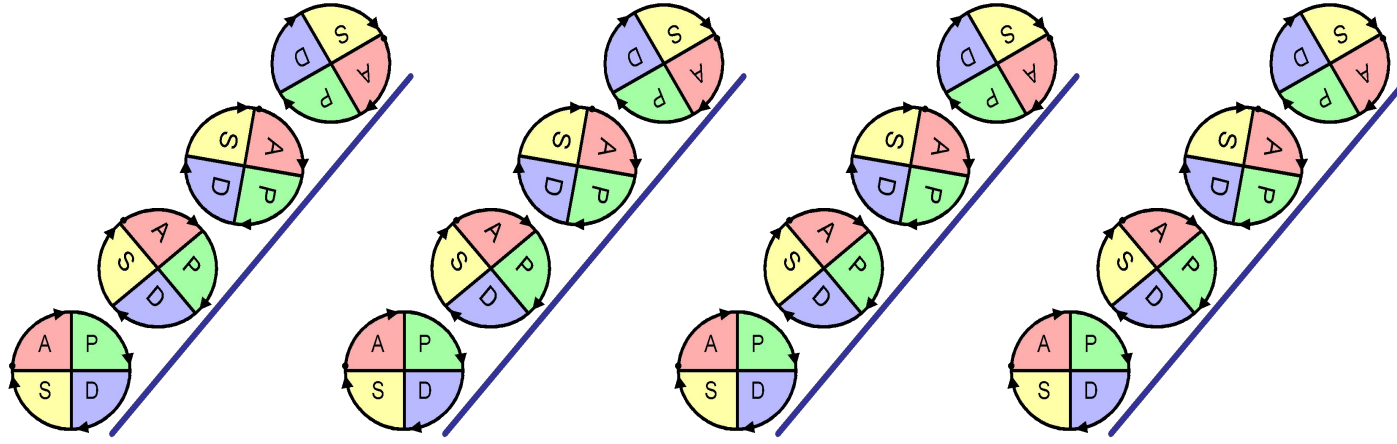
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Open discussion on case conferencing and 5X scale up

Have you made a plan and/or started using 5X scale-up in your community?

- What have you learned so far?
- What do your next steps look like?
- What challenges have emerged?

Multiple PDSA Cycle Ramps

Commitment: New CoC/Health Care Case Conferencing Infrastructure

Housing Placements: Identify & develop process to address bottlenecks in housing placements

Inflow: Connect at-risk individuals with diversion/prevention resources

Governance: Explore how health systems & CoCs can connect measurement systems

Adapted from: IHI Improvement Coach Professional Development Program
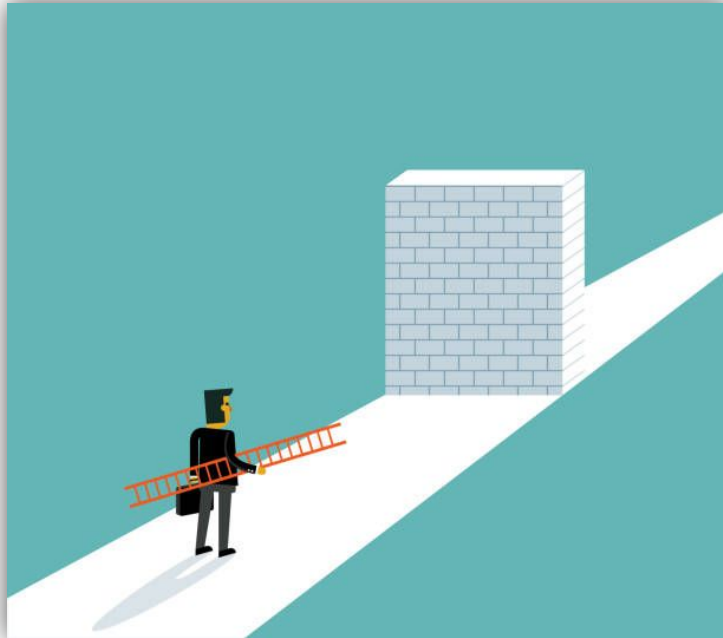
Integrated Case Conferencing

Lauran Hardin, MSN, CNL, FNAP, FAAN
National Healthcare and Housing Advisors
Illumination Foundation

Structures for Success

Expect obstacles to partnership

- ☐ Time needed to build relationships

- ☐ Culture clash

- ☐ Missions are not aligned

- ☐ Lack of shared incentives

- ☐ Funding models are different

- ☐ **Why won't anyone call me back or answer my emails?**

What is authentic collaboration?

✔ **Trust between partners**
"We have each others back"
✔ **Responsiveness**
"They get back to you quickly to help resolve issues"
✔ **Sharing resources & success**
"We all benefit when things run smoothly"
✔ **Joint accountability**
"If something isn't working we sit down and figure it out"
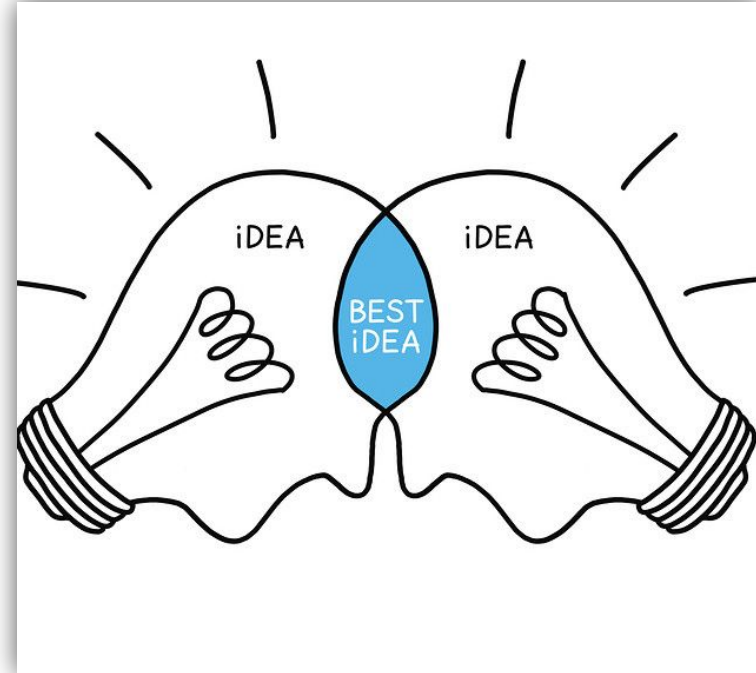
Setting the Stage

Introducing the Conference:

Why are we here?

Engaging the Group:

Every person's voice and perspective matters

Purpose of Meeting:

Improve outcomes and collaboration – save time

Practices to Model Respect

Modeling Respect:

We're here to bring the important expertise of each person to the table to improve the life of a young man experiencing trauma and complex medical conditions

Promising Efficiency:

I will capture our findings in a shared plan of action and care and send to you by x date. We meet today for 15 minutes with a follow up by email/phone if needed. We'll re-engage the conference by x date if problems don't resolve.

Quick Root Cause Report:

Present the cross continuum team and root cause story

Including Each Member:

Quick introduction and have them each add to the story

Modeling Respect:

Go around the room and engage each person

Redirect if talk gets negative to team or patient

Ask if there's anything we've missed after everyone has spoken

A Targeted Report

MS is a 26 yo male with diagnoses of Bipolar, SUD and skin and blood infections r/t IV drug use. He's had 15 ED visits and 6 IP admissions in the last year. His cross continuum team includes PCP x, BH provider x, Payer CM x. He is homeless with minimal social support and recently lost visitation privileges. Medical root cause of admissions is infection, BH root cause SUD and no medications for Bipolar, Social root cause includes homelessness and grief/trauma. System root cause includes inability to admit to LTC for 6 week course of IV treatment. Our purpose is to collaborate and share resources to improve his outcomes, connect the care team and save time for all in delivery.

Challenges

Do you have an example of a worst case scenario where it didn't go well?

(or I can share some)

Lets explore strategies for how to mitigate the challenge

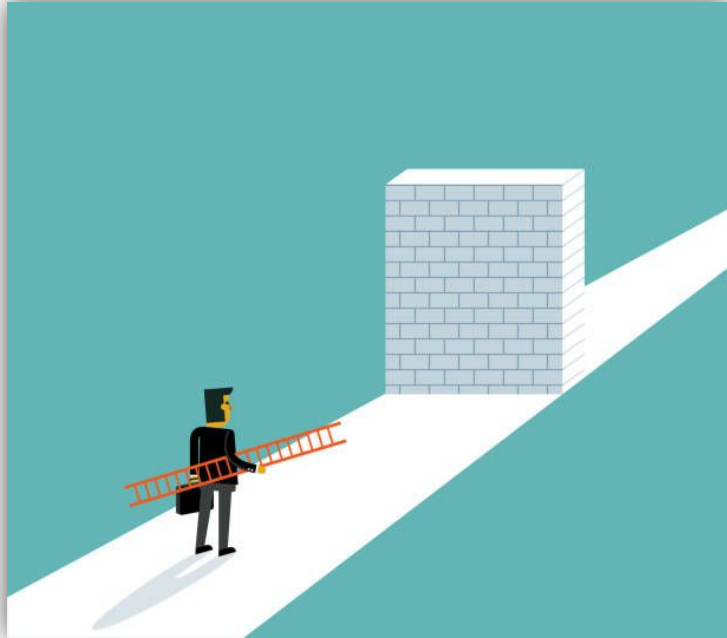# Challenging Dynamics

Challenging Dynamics

Challenging Dynamics

Challenging Cases

Expect obstacles to quick resolution

- ☐ You may receive referrals for the most complex situations occurring in the community
- ☐ Things may have been unresolved for many years
- ☐ It hasn't been anyone's role to solve this
- ☐ Examples from your community?

Challenges

Do you have an example of your most challenging or unsolvable case?

(or I can share some)

Lets explore strategies for how to mitigate the challenge

Creating a safe table for collaboration

✔ **Each of us have a piece of the story**
"All perspectives matter"

✔ **Respect**
"We seek to understand"

✔ **Shrink the change**
"What can we impact today"

✔ **Broaden the shoulders of the team**
"Who else has wisdom on this"

✔ **Celebrate incremental success**
"Small change matters"
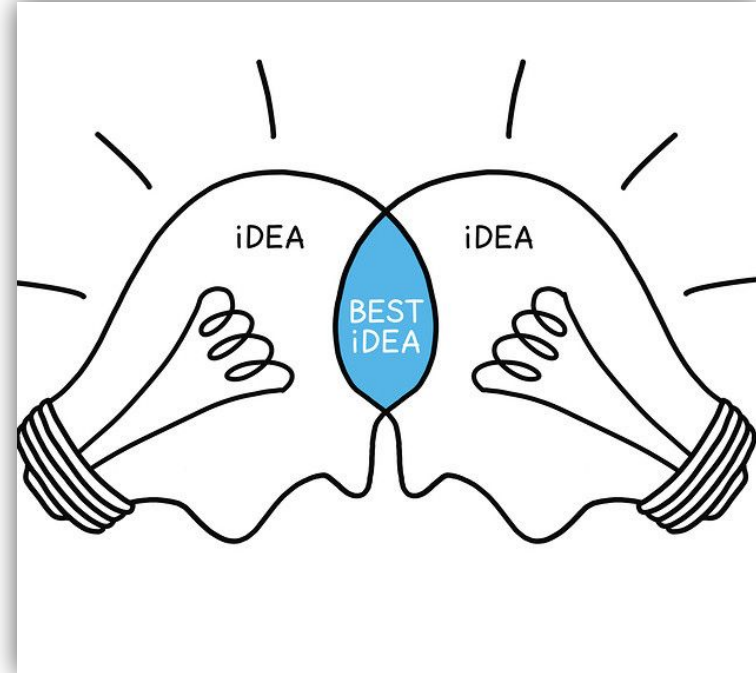
Core Elements

✔ **Root Cause Patient Story**

✔ **Cross Continuum Team identification**

✔ **Person centered solutions**

✔ **Community solutions**

✔ **System solutions**

Complex Behavioral Health
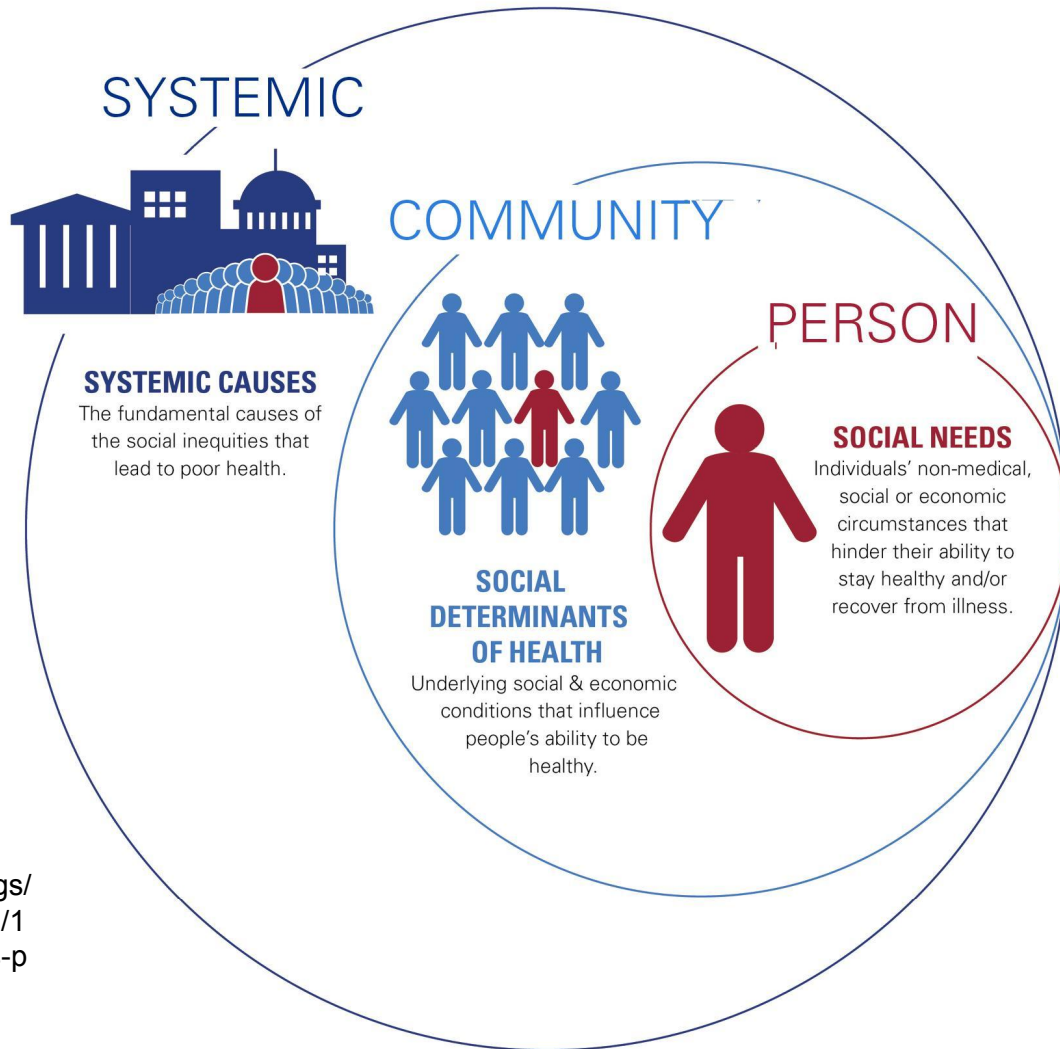
Complex Older Adult

Complex Trauma & SUD

SYSTEMIC

COMMUNITY

PERSON

SYSTEMIC CAUSES
The fundamental causes of the social inequities that lead to poor health.

SOCIAL DETERMINANTS OF HEALTH
Underlying social & economic conditions that influence people's ability to be healthy.

SOCIAL NEEDS
Individuals' non-medical, social or economic circumstances that hinder their ability to stay healthy and/or recover from illness.

Close Out
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March Coaching Calls

Washington County	☑ March 9, 2022 (rescheduled Feb call) 12-1pm ET/9-10am PT ☑ March 21, 2022 2-3:30pm ET 11am-12:30pm PT
Sacramento	☑ March 23, 2022 12-1:30pm ET / 9-10:30am PT
Anchorage	• March 24, 2022 2-3:30pm ET / 10am-11:30am AKST
Chattanooga	• March 28, 2022 12-1:30pm ET
Bakersfield	• March 28, 2022 1:30-3pm ET / 10:30am-12pm PT

Action Period: March through Summer

As a Pilot Team....

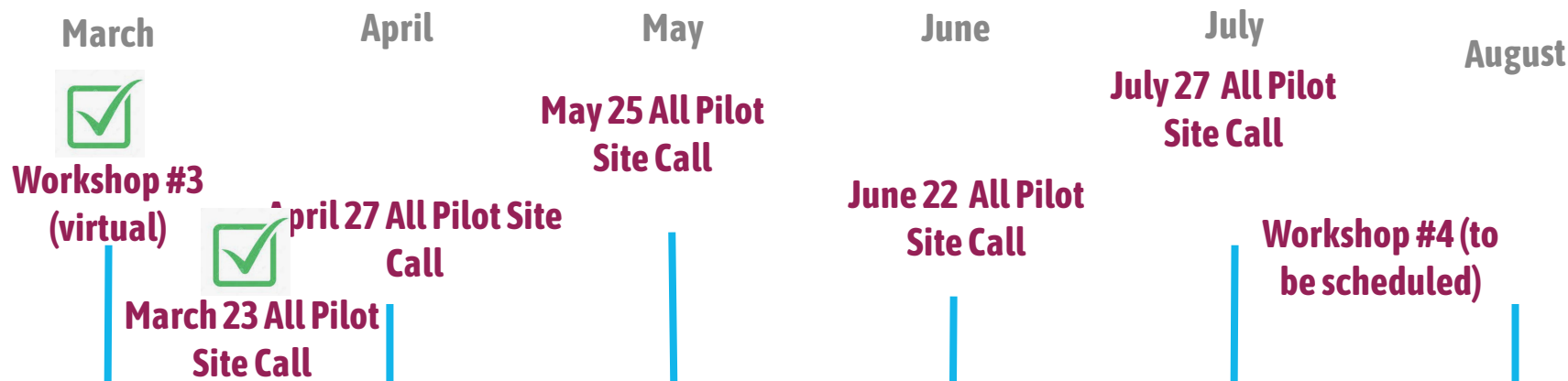| |
|---|
| Participate in Pilot Site Coaching Calls |
| Participate in All Pilot Site Monthly Calls |
| Revisit community level aim and project portfolio - do your projects get you to your aim? Does your aim account for a population level reduction in homelessness? |
| Continue testing projects in your portfolio |
| Take next steps on community communication plan |
| Prepare for Workshop 4 |

Schedule of Events Ahead

Schedule

March

April

May

June

July

August

Workshop #3 (virtual)

March 23 All Pilot Site Call

April 27 All Pilot Site Call

May 25 All Pilot Site Call

June 22 All Pilot Site Call

July 27 All Pilot Site Call

Workshop #4 (to be scheduled)

All Pilot Site Call Upcoming Content

☑ March 23: going to 5x, case conferencing of impossible cases/dynamics

- April 27: PLE engagement on care coordination, ways to move forward with meaningful engagement

- May 25: Increasing Housing Supply (housing placements)

Thank You

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