Healthcare and Homelessness Workshop #4 - Day 1

September 14, 2022

Institute for Healthcare Improvement

COMMUNITY SOLUTIONS

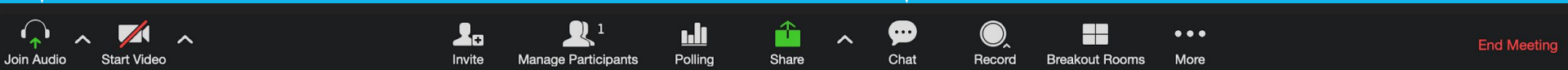
Welcome!

Mute your audio!

Turn on your video!

Say hi in the chat box! Tell us:

- Name
- Community
- Agency/Role



Introductions

Catherine Mather
Project Director

Lauran Hardin
Faculty Coach

Catherine Craig
Faculty Coach

Meg Arsenault
Senior Manager

Andi Broffman
Project Advisor

Laura Baker
Project Manager

Danielle Augustine
Project Manager

Ben Bradley
Improvement Advisor

Institute for Healthcare Improvement

COMMUNITY SOLUTIONS

Pilot Teams


Washington County
Sacramento
Bakersfield/Kern County
Chattanooga
Anchorage
Washington
Olympia
WA
Montana
North Dakota
Bismarck
ND
Minnesota
St. Paul
MN
Wisconsin
Madison
WI
Michigan
Lansing
MI
ME
Maine
Augusta
Albany
New York
NY
PA
Pennsylvania
Harrisburg
Ohio
Columbus
OH
Boise
Idaho
ID
OR
WY
Wyoming
Cheyenne
South Dakota
Pierre
SD
Nebraska
Lincoln
NE
Iowa
Des Moines
IA
Illinois
Springfield
IL
IN
Indiana
Indianapolis
WV
West Virginia
Charleston
VA
Richmond
Virginia
NC
Kentucky
Frankfurt
KY
Tennessee
TN
Utah
UT
Colorado
Denver
CO
Kansas
Topeka
KS
Missouri
Jefferson City
MO
Oklahoma
Oklahoma City
OK
Arkansas
Little Rock
AR
Mississippi
MS
Alabama
Montgomery
AL
Georgia
Atlanta
GA
South Carolina
Florida
Tallahassee
FL
Louisiana
Baton Rouge
LA
Texas
Austin
TX
Arizona
Phoenix
AZ
New Mexico
Santa Fe
NM
California
CA
NV
Honolulu
HI
Hawaii
Alaska
Juneau

Agenda - Day 1: September 14, 2022

Time	Agenda Item
2:00 - 2:10 pm ET 11 - 11:10 am PT 10 - 10:10 am AKT	**Welcome and Icebreaker**
2:10 - 2:25 pm ET 11:10 - 11:25 am PT 10:10 - 10:25 am AKT	**Overview of workshop**
2:25 - 3:15 pm ET 11:25 am - 12:15 pm PT 10:25 - 11:15 am AKT	**Telling your Pilot Sites' Story - Part I**
3:15 - 3:50 pm ET 12:15 - 12:50 pm PT 11:15 -11:50 am AKT	**Breakouts: Cal Aim or Data Sharing**
3:50 - 4:00 pm ET 12:50 - 1:00 pm PT 11:50 am - 12:00 pm AKT	**Wrap-up and prep for day two**

Agenda - Day 2: September 15, 2022

Time	Agenda Item
2:00 - 2:10 pm ET 11 - 11:10 am PT 10 - 10:10 am AKT	**Welcome Back**
2:10-2:45pm ET 11:10 am - 11:45 pm PT 10:10 am - 10:45 am AKT	**Telling your Pilot Sites' Story Part II**
2:45-3:25 pm ET 11:45 - 12:25 pm PT 10:45 - 11:25 am AKT	**UFO/Capsule Sessions**
3:25 - 3:55 pm ET 12:25 - 12:55 pm PT 11:25- 11: 55 am AKT	**Keynote: Don Berwick**
3:55 - 4:00 pm ET 12:55 - 1:00 pm PT 11:55 am - 12:00 pm AKT	**Wrap-up and next steps**

Workshop Objectives

At the end of Workshop 3, participants will:

- Feel that learning and cross pollination of ideas are a central focus for the workshop
- Feel connected to the pilot, to each other and the Pilot's goal

- Learn about CalAim (if applicable); build on August All Pilot Sites call to continue learning around data sharing work in service of care coordination/scaling case conferencing
- Understand how the work of each pilot site maps to the pilot's Theory of Change

Our Aim

Over the course of this 3 year Pilot initiative, pilot teams will have made measurable progress toward ending chronic homelessness, with a focus on building racially equitable systems.

Our Journey Together in the Pilot

Kick-Off Call
December 2020

Foundations Phase
December & January 2020

Virtual Workshop 1
Jan 28 & 29, 2021

Action Period 1
Feb - June 2021

Virtual Workshop 2
June 23 & 24 2021

Action Period 2
June - December 2021

Celebration Call
December 2021

Continued Action Period
Jan + Feb 2022

Virtual Workshop 3
March 1 & 2 2022

Action Period 3
March - Summer 2022

Virtual Worksh... 4
September 2022

Action Period 4
September 2022-Jan 2023

In person Workshop 5
February 2023

Action Period 5
Summer 2023

Workshop 6 and Site Harvesting/Dissemination
Oct 2023-Dec 2023

Telling your Pilot Sites' Story - Part I

Institute for Healthcare Improvement

COMMUNITY SOLUTIONS

PURPOSE: Health care organizations will make a meaningful, measurable, and transformative contribution to end chronic homelessness across a community with a focus on building racially equitable systems.

COMMITMENT: Build Sustained Belief in and Commitment to Ending Chronic Homelessness at the Population Level

WITHIN THE HEALTH SYSTEM

- Establish this work as a strategic priority that aligns to a broader journey towards population health and well-being and an "anchor mission" for the health system in the community
- Identify and engage key internal leaders to champion the effort and sustain their belief in the goal and the path to achieving it
- Identify and articulate the levers and roles for the health system to address homelessness, from physical and mental health services to community benefit and relations in order to believe in the opportunity and obligation
- Build a case using relevant data that resonates with health system leaders and links ending chronic homelessness to health, cost, and quality outcomes

TOGETHER WITH THE COMMUNITY

- **Create and sustain buy in for shared population level aim, timeline and measurement framework**
- Build trust and partnership with housing/homeless system partners, relevant government actors as well as key mainstream agencies
- Develop, tap into and/or refine existing ongoing community-wide communications strategy and infrastructure
- Build a case using relevant data that resonates with health system leaders and links ending chronic homelessness to health, cost, and quality outcomes

GOVERNANCE: Establish shared language and mechanisms for collaboration, measurement and governance

WITHIN THE HEALTH SYSTEM

- **Establish clear internal oversight, project management, measurement, and reporting structure from line staff to leadership that includes internal measures to align and integrate efforts**
- Identify leaders at different levels of the health system who will engage in internal and external efforts
- Reframe how people experiencing homelessness are perceived, treated and talked about within the health system at all levels
- Develop and implement a longitudinal internal communications strategy and infrastructure that builds and sustains will for local, regional and national health system staff

TOGETHER WITH THE COMMUNITY

- Build capacity and capability to partner with people with lived experience as key stakeholders in the improvement process
- Work with cross-sector stakeholders (including public health) to map assets and levers for the most appropriate role for health care
- Use population needs and community assets data to create and pursue a common policy platform on the local/regional level
- Commit to the shared goal of ending chronic homelessness and create a path toward achieving it
- Create clear and simple language and shared definitions for key terms and concepts across sectors
- Tap into and add to governance and decision-making mechanisms that align with existing coordinated efforts to end homelessness

HOUSING PLACEMENTS: Increase housing placements and retention rates for those experiencing chronic homelessness

WITHIN THE HEALTH SYSTEM

- **Understand and optimize the health system's role in the identification to housing placement process so that people don't fall through the cracks between steps in the process**
- Invest organizational funds in housing unit and subsidy gaps for high utilizers of the health system
- Focus organizational assets (funds, people, infrastructure, policies etc) to fill community-wide service and provider gaps

TOGETHER WITH THE COMMUNITY

- Engage in improvement of the identification to housing placement process
- Develop data-sharing mechanisms to target and prioritize high utilizers of the health care system that are on the By-Name list
- Identify and close community-wide housing unit and subsidy gaps
- Identify and close community-wide service and provider capacity gaps

FINANCING: Establish and build upon financial mechanisms aligned to reducing and ending chronic homelessness

WITHIN THE HEALTH SYSTEM

- **Map current funding mechanisms for care delivery within the health system to identify ways to fund coordinated service delivery and fill provider gaps (e.g., 1115 Medicaid Waiver; MSSP participation)**
- Develop internal policy and practice to align allocation of Community Benefit, foundation, and/or Corporate Social Responsibility funds
- Track organizational investments against monthly metrics for reducing, ending or sustaining an end to chronic homelessness
- Quantify and project financial value to the institution associated with savings (productivity, utilization, resources) for achieving the aim

TOGETHER WITH THE COMMUNITY

- **Build, tap into, refine and/or add to the community-wide mechanism for multi-stakeholder flexible funding to incentivize achieving and sustaining an end to chronic homelessness**
- Quantify the economic and social value of getting to and sustaining an end to homelessness across the community
- Develop and implement strategies/tools to support reinvestment/reallocation of cost savings into upstream solutions

INFLOW: Prevent the inflow of individuals into chronic homelessness

WITHIN THE HEALTH SYSTEM

- **Invest organizational funds in housing, services and/or navigation gaps for patients at risk of experiencing homelessness**
- Improve early identification and support of patients at risk of homelessness to reduce their inflow into homelessness

TOGETHER WITH THE COMMUNITY

- Understand and overcome barriers (e.g. privacy barriers) to data-sharing across housing & homelessness and health care systems
- Work with key community partners in building an "At Risk" list and data/measurement infrastructure
- Identify and close community-wide service, provider capacity, housing units and subsidy gaps
- Create an integrated pathway to connect at-risk individuals with diversion/prevention resources
- Identify, understand and work to eliminate institutional and systems barriers (including structural racism)

COMMUNITY SOLUTIONS

Your work and the Theory of Change

COMMITMENT:
Build Sustained Belief in and Commitment to Ending Chronic Homelessness at the Population Level

Pilot Sites Have:

- Buy in and interest in working in this pillar
- Anecdotal evidence that this pillar is supporting goals
- Evidence that work in this pillar is supporting reductions in homelessness

GOVERNANCE:
Establish shared language and mechanisms for collaboration, measurement and governance

Pilot Sites Have:

- Buy in and interest in working in this pillar
- Active work in this pillar
- Anecdotal evidence that this pillar is supporting goals

HOUSING PLACEMENTS:
Increase housing placements and retention rates for those experiencing chronic homelessness

Pilot Sites Have:

- Buy in and interest in working in this pillar
- Active work in this pillar
- Anecdotal evidence that this pillar is supporting goals

FINANCING:
Establish and build upon financial mechanisms aligned to reducing and ending chronic homelessness

Pilot Sites Have:

- Buy in and interest in working in this pillar
- Active work in this pillar
- Anecdotal evidence that this pillar is supporting goals

INFLOW:
Prevent the inflow of individuals into chronic homelessness

Pilot Sites Have:

- Buy in and interest in working in this pillar
- Anecdotal evidence that this pillar is supporting goals

Bakersfield, California

AGENDA

- 5 minutes - Pilot Team, Aim and Project Portfolio
- 5 minutes - Telling Our Story
- 5 minutes - Q&A

Collaborative Core Team

Dignity Health
Mercy & Memorial Hospitals

The Mission
AT KERN COUNTY

KAISER PERMANENTE®

CVAF
CALIFORNIA VETERANS ASSISTANCE FOUNDATION

Bakersfield - Kern
BKRHC
REGIONAL HOMELESS COLLABORATIVE

Community Partners

KernMedical | Health for Life.

Adventist Health

Kern Family Health Care™

BAKERSFIELD

ambetter. FROM | health net

BAKERSFIELD HOMELESS CENTER
A WAY UP

HOUSING AUTHORITY
OF THE COUNTY OF KERN
Creating brighter futures...one home, one family at a time

MERCY HOUSE

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

Flood Ministries
Reducing Homelessness ... Transforming Lives

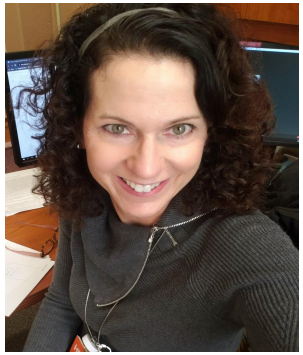
Our Community

New tagline - NYC, LA is “almost as sexy as Bakersfield”

- 60th Largest Metro Area: Growing faster than most communities in the country.
- 9th Largest City in California: Population 379,879 and counting!
- While a large community, feels like a small town: Everyone knows everyone
- Eager to collaborate across industries: Commercial, Governmental and More
- Home to:
  - Country Music Genre: Bakersfield Sound
  - KORN Rock Band
  - Edwards Air Force Base
- Big Industries:
  - Oil
  - Energy
  - Agriculture: 40-50% of all produce sold across the country
- Becoming More Progressive: Navigation Centers - Low Barrier and Community Focused
- Family Friendly
- Varied Geography - We’ve got just about everything!
- Very Philanthropic Community - Money & Time 😊

Our Team

- Donna Sharp - Healthcare Project Co-Lead
  - Dignity Health Hospitals - Regional Director of Special Needs & Community Outreach
  - Fun Fact - First century ride completed in Palm Springs on 2/22
- Anna Laven - Homelessness Project Co-Lead
  - Executive Director of BKRHC
  - Fun Fact - Born in Lima, Peru
- Kristin Weber - Healthcare Project Co-Lead
  - Kaiser Permanente - Director of Public Affairs
  - Fun Fact - Owns a Small Woodworking Business & Teaches Women Woodworking Skills
- Sydney Medina - Project Support
  - Kaiser Permanente - Project Manager II
  - Fun Fact - Recently rescued a beagle named Pickles
- Deborah Johnson - Project Co-Lead
  - President of California Veterans Assistance Foundation
  - Chair of BKRHC
- Ken Keller - Project Sponsor
  - President/CEO, Bakersfield Memorial Hospital
  - Fun Fact - Former Crawfish Farmer






Pilot Initiative Aim for Bakersfield/Kern County

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.

Project Portfolio

How We Will Know We're Making an Impact

Project	Project Status	**Outcomes:** How do we know the work is having an impact?	**Processes:** How do we know the work is progressing as planned?
Medical Respite Care (MRC)	• Expansion of Brundage Lane Navigation Center underway - will include 20-24 beds for MRC. • Open Door Network to break ground on new campus 1/23. Will include MRC. • Working to determine other site possibilities. TA w/ NIMRC	• Infrastructure to coordinate and meet the needs of PEH and MRC placement. • Transitional housing post MRC. • Placement of complex/high needs (seniors, cancer, hospice, disabled, addiction/behavioral health)	• Affordable housing placement on the backend - biggest bottleneck.
Create Standardized Discharge Planning Process for Kern County Hospitals	• Bakersfield Regional Homeless Collaborative finalizing a discharge planning process. • Hospital care coordination/social services to provide discharge planning process review.	• Creating a continuum of care.	• Documenting gaps in coordination of resources.
Data Sharing: Determine Available Data in Each Health System and Align Parameters for Data Sharing	• Data Analytic review with local hospitals • Lacking data sharing agreements • Process of connecting/scheduling various care coordinators from hospital systems.		• Building relationships between health systems and homelessness systems.

Telling Our Story

“What does living in crescendo mean? It means that the most important work you will ever do is always ahead of you. It is never behind you. You should always be expanding and deepening your commitment to that work.” - Stephen Covey

A Story From Our Work

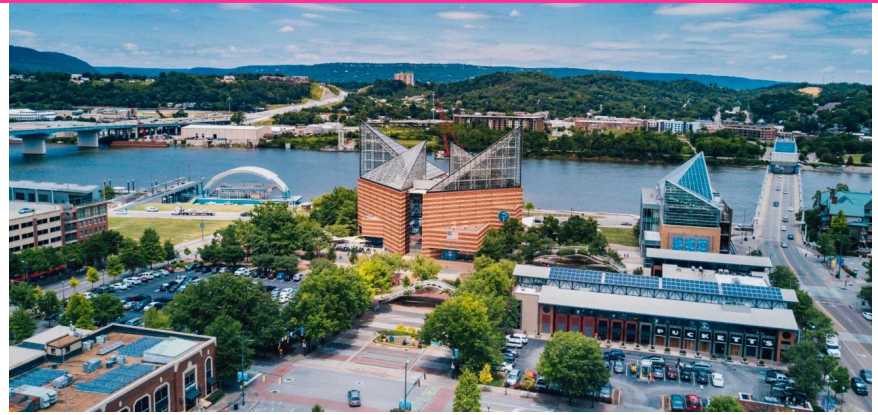
A Turning Point: Site Visit to The Illumination Foundation

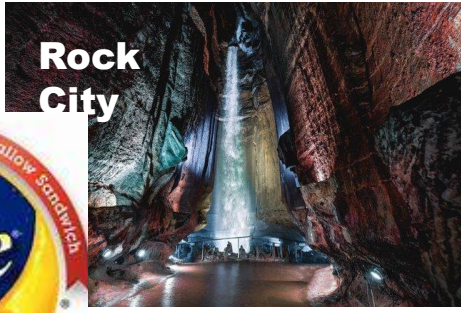
- Team was able to meet in person for the first time
- Site visit prompted discussion for NIMRC partnership
- **AHA Moment:** Following this visit, our team realized we are going to need to expand our scope to include planning for a regional approach to ensure Bakersfield city does not carry the full impact.

Q&A


Chattanooga, Tennessee

Welcome to Chattanooga

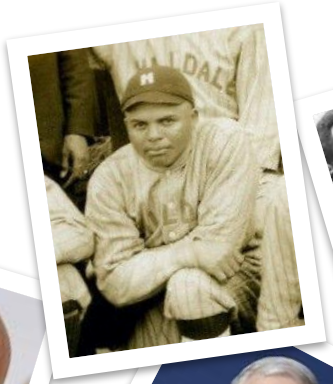




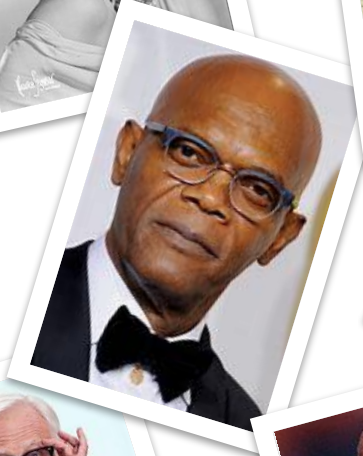
About Chattanooga

Chattanooga's Impact



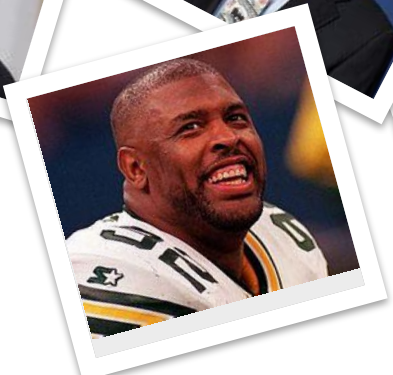












Partnering for health in Chattanooga

CHI Memorial

CRHC
Chattanooga Regional Homeless Coalition

WelcomeHome of Chattanooga

City of Chattanooga Corporation Seal Tennessee

Chattanooga Community Kitchen
Help from the Heart of the City

Catholic Charities of East Tennessee

erlanger Medical Group

Cempa Community Care

Hamilton County Official Seal Tennessee

Tennessee CHI Creating Homes Initiative

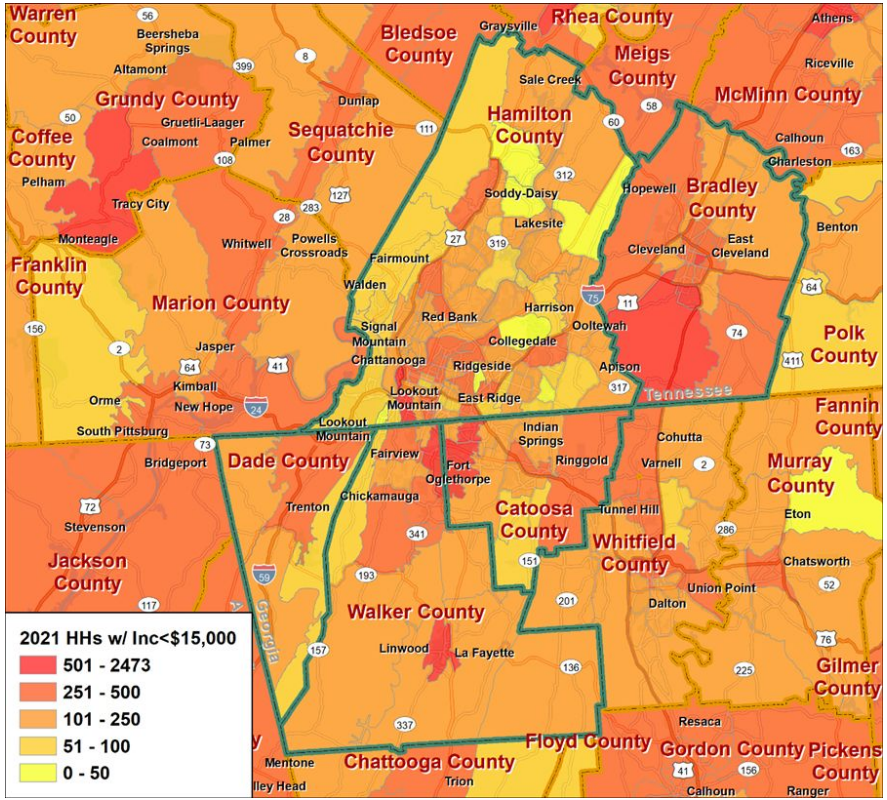
Chattanooga Housing Authority 1938

Population

	5-Counties	Tennessee	Georgia	USA
Population	**645,783**	7,025,037	10,815,378	333,934,112
Median Age	**41.3**	40	37.2	38.8
Median Household Income	**$55,259**	$55,276	$60,605	$64,730
Annual Pop. Growth (2021-2026)	**0.86%**	0.89%	1.05%	0.71%
Household Population	**256,110**	2,765,537	4,013,721	126,470,675
Dominant Tapestry	**Southern Satellites (10A)**	Rooted Rural (10B)	Southern Satellites (10A)	Green Acres (6A)
Businesses	**20,294**	217,448	353,744	12,013,469
Employees	**312,080**	3,129,625	4,675,136	150,287,786
Health Care Index*	**88**	91	97	100
Average Health Expenditures	**$5,496**	$5,663	$6,026	$6,237
Total Health Expenditures	**$1.4 B**	$15.7 B	$24.2 B	$788.8 B
Racial and Ethnic Make-up				
White	**80%**	75%	56%	69%
Black	**13%**	17%	32%	13%
American Indian	**0%**	0%	0%	1%
Asian/Pacific Islander	**2%**	2%	5%	6%
Other	**3%**	3%	5%	7%
Mixed Race	**2%**	2%	3%	4%
Hispanic Origin	**6%**	6%	10%	19%

Source: ESRI

Income <$15,000



Assets

- Scenic views
- Great places to walk
- Museums
- “Gig City”
- Free electric shuttles
- Bike share program
- Interstate connections
- Strong inter-agency collaboration and partnerships
- Strong partnership with City govt.

Challenges

- Agency capacity
- Limited beds in long term care facilities
- Lack of behavioral health providers
- Historic level of homelessness
- Data Sharing
- Hospital capacity to support
- Communication [Business/Community]
- Economy
- Equity and Social Justice
- Lack of available housing
- Very limited public transportation

Our Team

Betsy Kammerdiener
Market Director of Mission Integration CHI Memorial

Fun Fact: I lived and worked in South America for ten years.

Role: Executive Lead

Nicole Brown
Manager, Community Benefits and Diversity
CHI Memorial

Fun Fact: I did a TEDxChattanooga interview with Rock and Roll Hall of Famers The Impressions.

Role: Project Manager

Mike Smith, Executive Director, Chattanooga Regional Homeless Coalition.

Fun Fact: I once met the actor Sinbad on Beale Street in Memphis, TN. Sadly, I did not recognize him. He said I was cool!

Role: Built for Zero Team Lead

Jaime Ascarate, Coordinated Entry Outreach, Chattanooga Regional Homeless Coalition.

Fun Fact: New mom!

Role: Built for Zero Team Lead Data and Measurement Lead

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 & housing outcomes of 300 of our community's most vulnerable citizens experiencing homelessness by January 2024. We will accomplish this by partnering with caregiving agencies in our community, analyzing data and identifying the barriers that prohibit compassionate care.

Our project portfolio & how we will know we're make an impact

Project	**Project status**	**Outcomes:** How do we know the work is having an impact?	**Processes:** How do we know the work is progressing as planned?
Care Coordination	In progress	Identification, prioritization and placement across all systems	Regular case conferences with all of the stakeholders.
Data Sharing	Not yet started	Identification of individuals experiencing homelessness across all systems	Every stakeholder can/does access the data
Serving Long Stayer on the BNL	Not yet started	Reduction of length of time homeless across all systems	Identify and communicating the long stayers
Respite Care	In progress	Identify 30 respite beds around the community; Creating referral pathways for participants; Safe discharge options	Having standards of care for the program; Reducing LOS/readmits
Engaging the Public Will	In progress	Community is aware of the impact of chronic homelessness on health and is supportive of ending chronic homelessness	Using media to engage in conversations with community

Community Name: Chattanooga Project: Care Coordination	
What is the aim of this project?	Recognizing the impact housing has on health, the Chattanooga team has come together to prioritize housing as an integral component of health services. The coordinated response will improve the health & housing outcomes of 300 of the Chattanooga community's most vulnerable citizens experiencing homelessness. Chattanooga will accomplish this by partnering with caregiving agencies in the community, analyzing data and identifying the barriers that prohibit compassionate care.
Who is the target population for this project?	Individuals who are receiving care in both systems: hospitals and homeless agencies
Who is the project point person (big red ball holder)?	TBD
What will we measure to know that the project is successful? How will this project lead to a population level reduction?	Measure the number of people served
What is the next step(s) to launch this project?	Find the funding to increase capacity of CoC lead agency

Community Name: Chattanooga Project: Data Sharing	
What is the aim of this project?	Strategic sharing of data across systems to facilitate effective care coordination
Who is the target population for this project?	Healthcare and Homeless data systems
Who is the project point person (big red ball holder)?	TBD
What will we measure to know that the project is successful? How will this project lead to a population level reduction?	Progress in data sharing agreement
What is the next step(s) to launch this project?	Determine point person

Community Name: Chattanooga Project: Data Sharing

What do we have going for us for this project?	Interest and recognition of the need throughout the community
What do we need to work through to make this project a success?	Connect with legal and additional community resources
What do we think we will learn?	Effective data sharing is the key to reducing homelessness and readmits to the hospital

Community Name: Chattanooga Project: Engage Public Will	
What is the aim of this project?	Build public will around homelessness issues which will help in bolstering regional efforts and public sentiment.
Who is the target population for this project?	Residents who need assistance and ambassadors or residents who transition between hospitals and homelessness systems.
Who is the project point person (big red ball holder)?	Nicole Brown
What will we measure to know that the project is successful? How will this project lead to a population level reduction?	The expected results include increased awareness and community support on the issue of homelessness in the Chattanooga community.
What is the next step(s) to launch this project?	We are working on a media campaign with CHI Memorial on how to share stories and build awareness.

Community Name: Chattanooga Project: Engage Public Will

What do we have going for us for this project?	❏ Utilize CHRC's dashboard which has real data. This will assist in building awareness for our community. ❏ We are finalizing the messaging document for Engaging Public Will.
What do we need to work through to make this project a success?	❏ Plan the media campaign schedule as it relates to other healthcare and homelessness awareness months. ❏ Consider a campaign hashtag to share via social media. ❏ Identify a social agency contact for residents who desire more information on how to get help. ❏ Review the analytics of the campaign and explore the gaps in outreach.
What do we think we will learn?	❏ Our Engagement of Public Will could lead as a benchmark to build racially equitable systems in our community. ❏ The awareness campaign will demonstrate the need for additional full time staff to assist residents with social service needs.

Community Name: Chattanooga Project: Serving the Long Stayers on the BNL

What is the aim of this project?	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. Need to clean and maintain BNL
Who is the target population for this project?	Long stayers on BNL (defined as over a year - a little over 300)
Who is the project point person (big red ball holder)?	Jamie
What will we measure to know that the project is successful? How will this project lead to a population level reduction?	Long stayers are placed in permanent housing
What is the next step(s) to launch this project?	Recruitment of staff for the BNL

Community Name: Chattanooga	Project: Serving the Long Stayers on the BNL
What do we have going for us for this project?	Partnerships between the healthcare systems and the CoC
What do we need to work through to make this project a success?	Data sharing Additional staff
What do we think we will learn?	The scope of the need for the population being targeted.

Community Name: Chattanooga Project: Respite Care

What is the aim of this project?	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. **By the end of 2022: Have 20 respite care beds operational in Chattanooga (Welcome Home and Community Kitchen) and 4 more identified (Home Place).**
Who is the target population for this project?	Individuals experiencing chronic homelessness (vulnerable patients who are experiencing homelessness)
Who is the project point person (big red ball holder)?	Welcome Home Director -- Sherri Campbell (hospice care for homeless, expanding to respite care) Homeless Healthcare Executive Director–Karen Guinn Catholic Charities of East Tennessee Director of Programs (for The Home Place)–Paul Ritter Partners: National Institute for Medical Respite + Healthcare for the Homeless
What will we measure to know that the project is successful? How will this project lead to a population level reduction?	Decrease of discharges to homlessness by hospital and 100% of individuals in respite care are captured on coordinated entry BNL. [connected to homeless response system (coordinated entry)] How can we ensure people aren't having to experience homelessness again after leaving hospital or respite care?
What is the next step(s) to launch this project?	Learn alongside Healthcare for the Homeless Regular check-ins with Sherri, see if there are supports/structures that may help her lead this work Work with Community Kitchen to staff and open 16 respite beds (Karen) Shift focus from HIV/AIDS to homeless - Catholic Charities will write their proposal and homelessness will do the same Person identified by hospital to coordinate with Home Place to get them into respite care, and that case manager needs to coordinate with coordinated entry Develop a triage plan if there are not enough beds for everyone who needs it, or hospital could increase staff for individuals Point of transfer to respite care information is shared with coordinated entry

Community Name: Chattanooga Project: Respite Care

What do we have going for us for this project?	Variety of partners and settings Sustained energy around project Resources in the community Partnership with National Institute for Medical Respite + Healthcare for the Homeless
What do we need to work through to make this project a success?	Identified sources of financial support Clear understanding of agreements among partners Access to some permanent housing
What do we think we will learn?	How to triage cases Impact of behavioral health on overall health and medical respite How to sustain program for long-term viability

Telling Our Story

Q&A

Washington County, Oregon

Washington County, Oregon

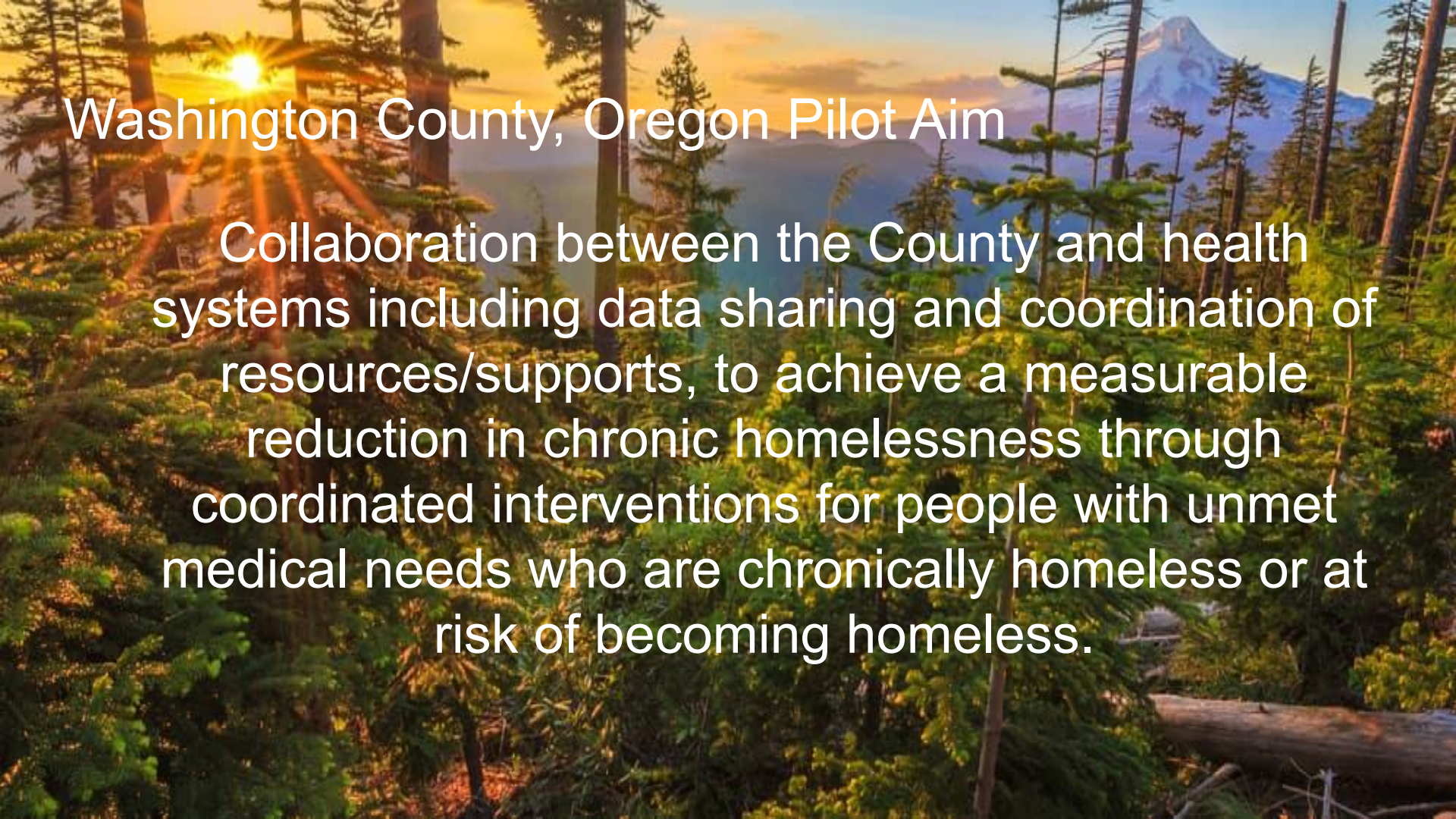
Kaiser Permanente Northwest

Health Share of Oregon

Washington County Department of Health and Human Services, Department of Housing Services, and Continuum of Care

Our Community

- Oregon's second most populous county (600K) and the most racially & ethnically diverse
- One of 3 counties in Portland metro area
- Assets include new Supportive Housing Services funding and capacity ($80+ million/year for 10 years)
- Challenges include disparities in access to housing and economic opportunity



Washington County, Oregon Pilot Aim

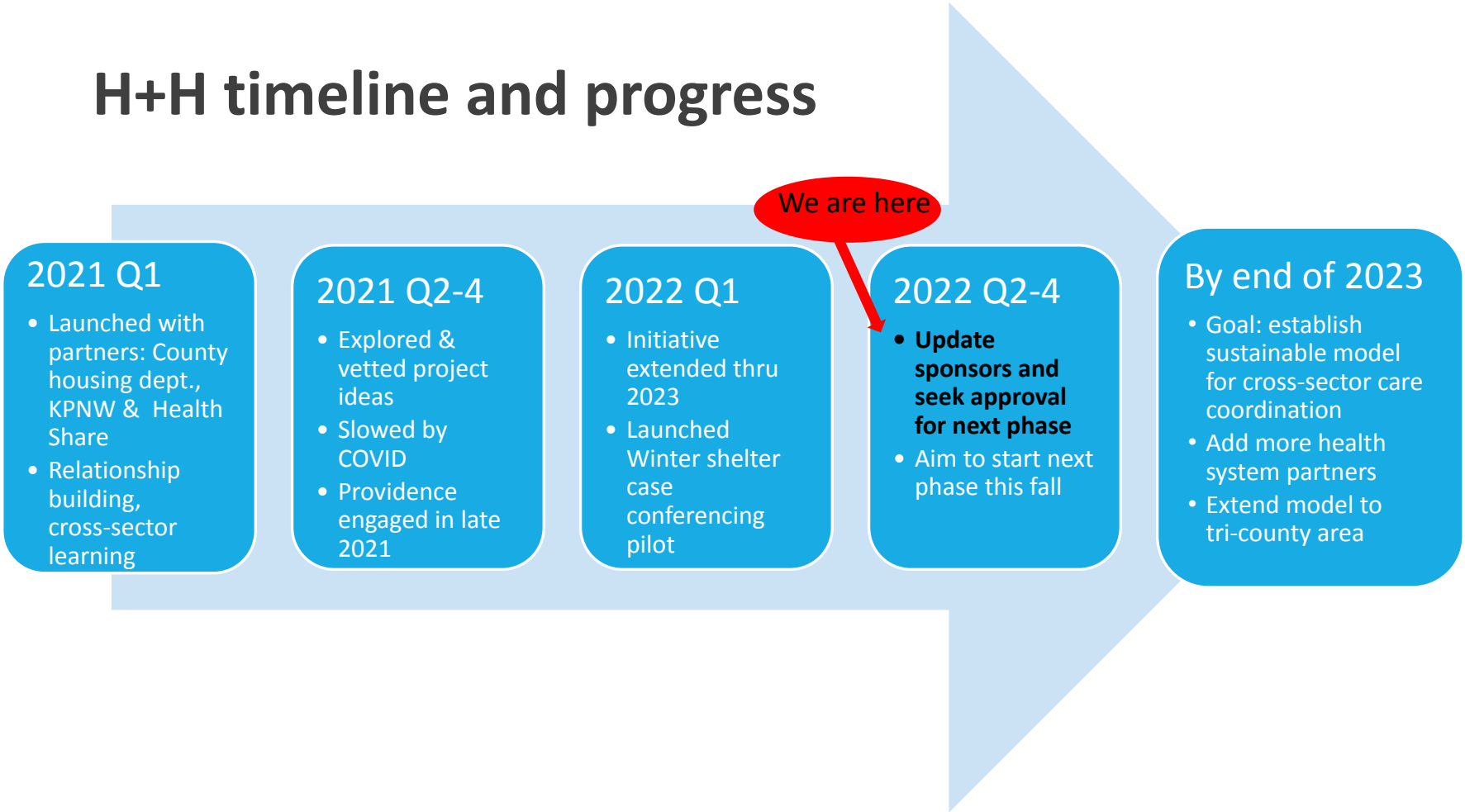
Collaboration between the County and health systems including data sharing and coordination of resources/supports, to achieve a measurable reduction in chronic homelessness through coordinated interventions for people with unmet medical needs who are chronically homeless or at risk of becoming homeless.

Our focus has narrowed to one project:

Improve care coordination for our patients experiencing houselessness and housing insecurity by joining Washington County's HMIS partner table.

- Sign the County's HMIS Participation Agreement with a customized "health care addendum"
- Launch bimonthly case conferencing
- If successful, expand to additional care teams, health systems and/or counties

H+H timeline and progress



Winter Shelter Case Conferencing Pilot

Short-term pilot to test out model during winter shelter season, January-April 2022

Participants: County shelter and housing staff + health systems

Rapid (1-hour) case conferencing; quickly problem-solve issues and find points of connection

Feedback sessions: midway + end of pilot

KP Patient Navigator time: pre-meeting chart review + updating chart afterward with notes, escalating if needed (estimated 30-50 minutes total per meeting)

Met 7 times; 13 individuals served, including 2 KP members

Winter Shelter Case Conferencing – Patient stories

Member lacked seizure medication, was unable to access virtual care. Eunice connected shelter staff with Medicaid team who set up in-person care and delivery of Rx. Shelter staff report “she now has what she needs.”

Member just had a baby. She told shelter staff she was unable to get care. Eunice saw that she had missed multiple appointments, helped shelter staff get her to appointments and reconnect with her OB/GYN.

The case conferencing pilot has been so valuable to help us understand the actual situation of patients when they are going through severe challenges. It’s about right care at the right time.” - Eunice Dunkoh, Patient Navigator

Key learnings from Winter Shelter Case Conferencing

Many unhoused people do not know who their health provider is or what services are available to them

Shelter/housing staff are unfamiliar with healthcare systems, unsure how to access care for their clients

Our care teams lack a consistent pathway to connect with unhoused patients and the homeless response system

Case conferencing worked well to close care gaps – enabled referrals, info sharing, communication and rapid problem solving

In-home care, SUD and mental health services and support are critical needs

County-required individual release of information listing specific health system participants was time-consuming and inefficient

Proposed next phase:
Case Conferencing at the Built for Zero table

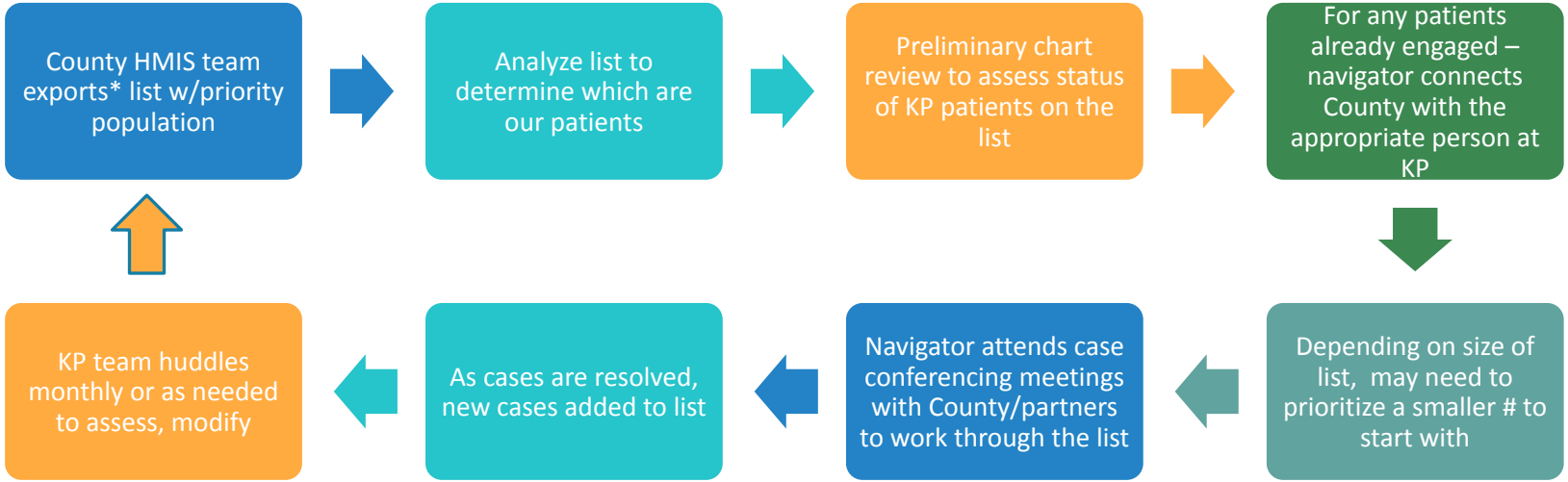
- Build on success of winter shelter pilot
  - Close care gaps
  - Build care coordination pathways
  - Provide trauma-informed care
- Enable KP and Providence care teams to communicate and collaborate flexibly with County and housing providers via Built for Zero model
- Strengthen trust and build relationships between the housing and health care sectors

Launching next phase of conferencing

To enter this next stage of collaboration, KPNW and Providence will sign the County's Homeless Management Information System (HMIS) Partner Agreement

- Custom addendum to clarify limited role in HMIS
- Will allow health systems to review HMIS lists and collaborate on case review for purposes of care coordination
- Enables flexible participation by health systems without securing individual consent
- Start small with limited patient list, establish regular cadence and expand over time

Case conferencing workflow*

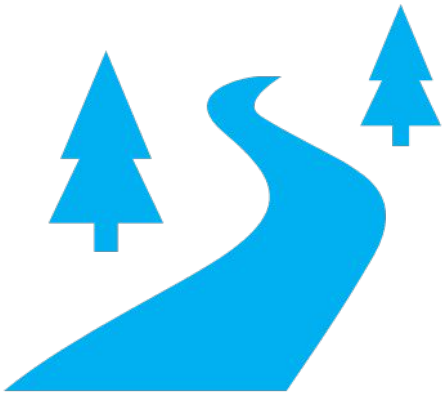


*Dependent on KPNW having signed an HMIS Participation Agreement, which enables data-sharing

Opportunities for future expansion

If this next phase of case conferencing is successful, we can consider expanding scope/scale over time:

- Expand from primary care to hospital teams
- Leverage Connect Oregon (Unite Us) for referrals (one-way and/or bidirectional)
- Work toward a “homeless flag” in Epic shared from HMIS to alert health systems on housing status
- Continue discussion with Multnomah/Portland Joint Office, Clackamas to explore tri-county regional approach



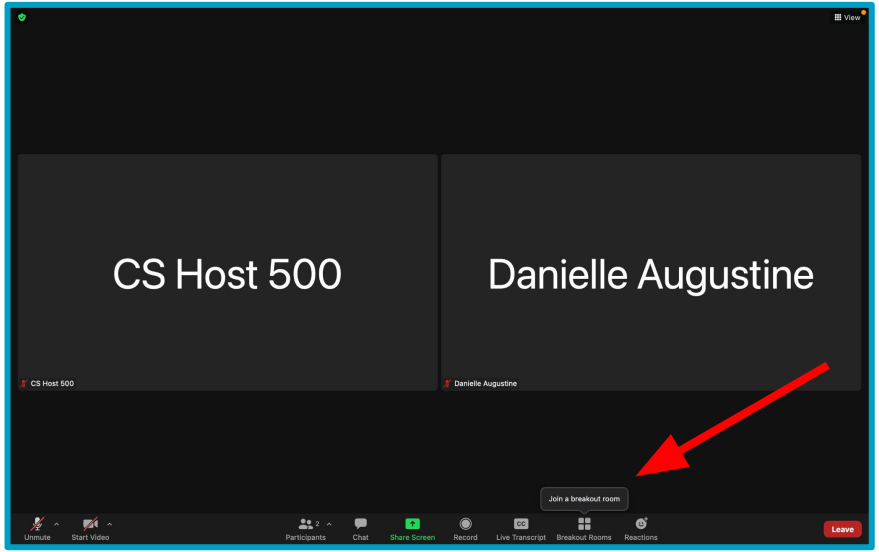
Q&A

Breakout Session

Institute for Healthcare Improvement

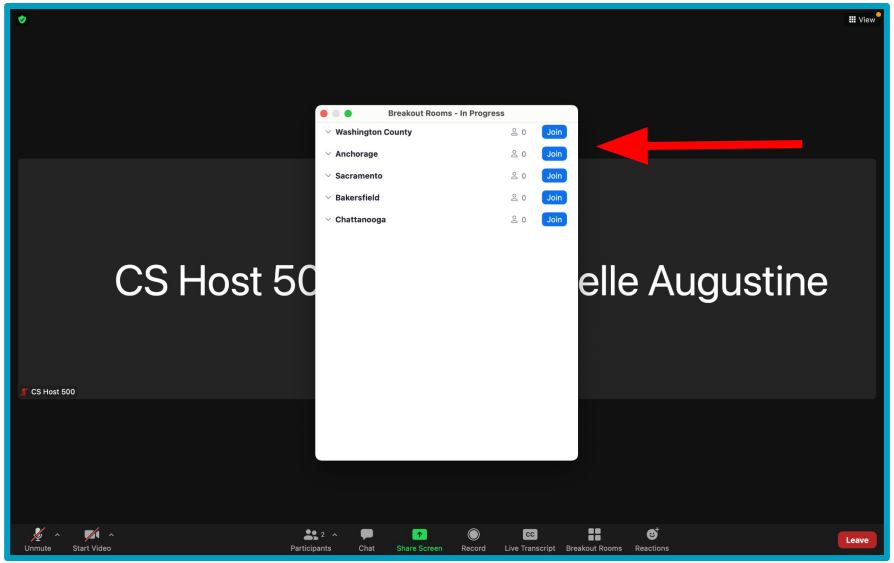
How to join breakout rooms

STEP 1



Click the **“Breakout Room”** button at the bottom

STEP 2



Click **“Join”** next to the breakout room of your choice

Cal Aim

Institute for Healthcare Improvement

Understanding CalAIM

Lauran Hardin MSN, CNL, FNAP, FAAN
National Healthcare & Housing Advisors

Anchoring the Session

What are your most burning questions about CalAIM?

What are you most confused about?

What do you wish you knew?

California Advancing and Innovating Medi-Cal (CalAIM)

CalAIM is a long-term commitment to transform and strengthen Medi-Cal, offering Californians a more equitable, coordinated, and person-centered approach to maximizing their health and life trajectory. The goals of CalAIM include:

Implement a whole-person care approach and address social drivers of health.

Improve quality outcomes, reduce health disparities, and drive delivery system transformation.

Create a consistent, efficient, and seamless Medi-Cal system.

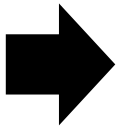
Legacy Programs to CalAIM

Health Homes Program (HHP)

- Benefit (State Plan service) in select counties
- Medi-Cal Managed Care members only
- MCP administered with care management contracted out to providers

Whole Person Care Pilots (WPC)

- Limited pilot program supported by Section 1115
- Coverage and delivery system agnostic (Medicaid Managed Care, Fee For Service, or uninsured); no requirements for interfacing with managed care plans (MCPs)
- Administered by county based "Local Entities"



Enhanced Care Management

- Care coordination as a MCP contract requirement
- Medi-Cal Managed Care members only
- MCP administered with care management delivered through community providers

Community Supports

- Optional services, but strongly encouraged
- Medi-Cal Managed Care members only
- MCP administered with services delivered through community providers and integrated with ECM

What is ECM?

ECM is a new Medi-Cal benefit to support comprehensive care management for enrollees with complex needs that must often engage several delivery systems to access care, including primary and specialty care, dental, mental health, substance use disorder (SUD), and long-term services and supports (LTSS).

- ECM is designed to address both the clinical and non-clinical needs of the highest-need enrollees through intensive coordination of health and health-related services, meeting enrollees wherever they are – on the street, in a shelter, in their doctor's office, or at home

- ECM is part of broader CalAIM Population Health Management system design through which MCPs will offer care management interventions at different levels of intensity based on member need, with ECM as the highest intensity level

For more details, see ECM Policy Guide (May 2022).

Launch and Expansion of ECM

- ECM went live **January 1, 2022** in the 25 counties that had participated in WPC/HHP, with **95,000** Medi-Cal members transitioning into ECM from WPC/HHP who are:
  - High utilizer adults (such as multiple emergency department visits and/or hospital/short-term skilled nursing facility stays)
  - Individuals and families experiencing homelessness
  - Adults with SMI and/or SUD
- Starting on **July 1, 2022**, ECM will go live statewide for:
  - Individuals and families experiencing homelessness
  - High utilizer adults (such as multiple emergency department visits and/or hospital/short-term skilled nursing facility stays)
  - Adults with SMI and/or SUD
- Starting on **January 1, 2023**, ECM will extend statewide to:
  - Individuals at risk for institutionalization and eligible for long-term care
  - Nursing facility residents transitioning to the community

What are Community Supports?

Community Supports are services that Medi-Cal managed care plans (MCPs) are strongly encouraged but not required to provide as substitutes for utilization of other services or settings such as hospital or skilled nursing facility admissions, discharge delays, or emergency department use.

- Community Supports are designed as cost-effective alternatives to traditional medical services or settings.

- Community Supports are designed to address social drivers of health (factors in people's lives that influence their health).

For more details, see Community Supports Policy Guide (April

What are Community Supports?

Pre-Approved DHCS Community Supports

1. Housing Transition Navigation Services
2. Housing Deposits
3. Housing Tenancy and Sustaining Services
4. Short-Term Post-Hospitalization Housing
5. Recuperative Care (Medical Respite)
6. Respite Services
7. Day Habilitation Programs
8. Nursing Facility Transition/Diversion to Assisted Living Facilities
9. Community Transition Services/Nursing Facility Transition to a Home
10. Personal Care and Homemaker Services
11. Environmental Accessibility Adaptations (Home Modifications)
12. Meals/Medically-Tailored Meals or Medically-Supportive Foods
13. Sobering Centers
14. Asthma Remediation

For more details, see Community Supports Policy Guide (April 2022).

Who is Eligible for Community Supports?

- Each Community Support has specific eligibility criteria linked to each service
- Enrollees in Medi-Cal Managed Care may be eligible for Community Supports, which are voluntary to the enrollee
- Given Community Supports are optional to MCPs, there is a mix of how what Community Supports are available with each plan and each county

For more details, see Community Supports Policy Guide (April 2022) and Community Supports Elections (January

Where are Community Supports Available Today?

- MCPs are phasing in Community Supports selections across counties in 2022 and 2023, with **over 10 of the 14 Community Supports offered in 16 counties** starting July 1, 2022
  - Riverside, Sacramento, and San Diego counties will offer **all 14 Community Supports**
  - **97% of all California counties** (56 out of 58) will offer at least 6 Community Supports
- MCPs can opt-in to offering new Community Supports every 6 months, in January or July

Relationship Between ECM/Community Supports, PATH, & IPP

Enhanced Care Management (ECM) / Community Supports (CS)

Providing Access & Transforming Health (PATH)

- PATH is a five-year, $1.85 billion initiative included in the **CalAIM 1115 waiver**.
- PATH provides resources for community providers to **build capacity and infrastructure** to successfully **deliver ECM and Community Supports**.

PATH and IPP funding will complement and not duplicate one another.

Incentive Payment Program (IPP)

- IPP is a **voluntary incentive program** intended to support the **implementation and expansion of ECM and Community Supports** by incentivizing managed care plans (MCPs), in accordance with 42 CFR Section 438.6(b).

Innovations in Financing

Overview of CalAIM and Incentive Programs

The *California Advancing and Innovating Medi-Cal (CalAIM)* is a long-term California Department of Health Care Services (DHCS) initiative to transform and strengthen Medi-Cal, offering Californians a more equitable, coordinated, and person-centered approach to maximizing their health and life trajectory. This includes **launching Enhanced Care Management (ECM) benefit and optional Community Supports (CS).** DHCS has developed several incentive programs in order to support CalAIM implementation:

CalAIM Incentive Payment Program (IPP)

Funds flow from DHCS to MCPs to:

1. Support implementation and expansion of ECM and CS
2. Invest in provider capacity and delivery system infrastructure;
3. Bridge current silos across physical and BH care service delivery;
4. Achieve improvements in quality performance;

Housing and Homelessness Incentive Program (HHIP)

Funds flow from DHCS to MCPs to:

1. Reduce and prevent homelessness
2. Ensure MCPs develop the necessary capacity and partnerships to connect their members to needed housing services

Providing Access and Transforming Health (PATH)

Funds flow from DHCS to counties, WPC Lead entities and other providers to:

1. Maintain, build, and scale services, capacity and infrastructure for providers to ensure successful implementation of CalAIM
2. PATH is focused on justice involved, WPC transitioning and other initiatives

Behavioral Health Quality Improvement Program (BH-QIP)

Support Behavioral Health Plans (BHPs) to prepare for CalAIM participation changes. BHPs include:

1. Mental Health Plan (MHP),
2. Drug Medi-Cal State Plan (DMC-SP) or
3. Drug Medi-Cal Organized Delivery System (DMC-ODS)

Behavioral Health Continuum Infrastructure (BHCIP)

1. Competitive grants awarded to qualified entities to invest in infrastructure, including mobile crisis, to expand the community continuum of BH treatment resources.
2. Funds flow from DHCS to Counties, cities, tribal entities, non-profit and for-profit entities.

Funding Opportunities Cheat Sheet

CalAIM All Comer Webinar: PATH Collaborative Planning and Implementation

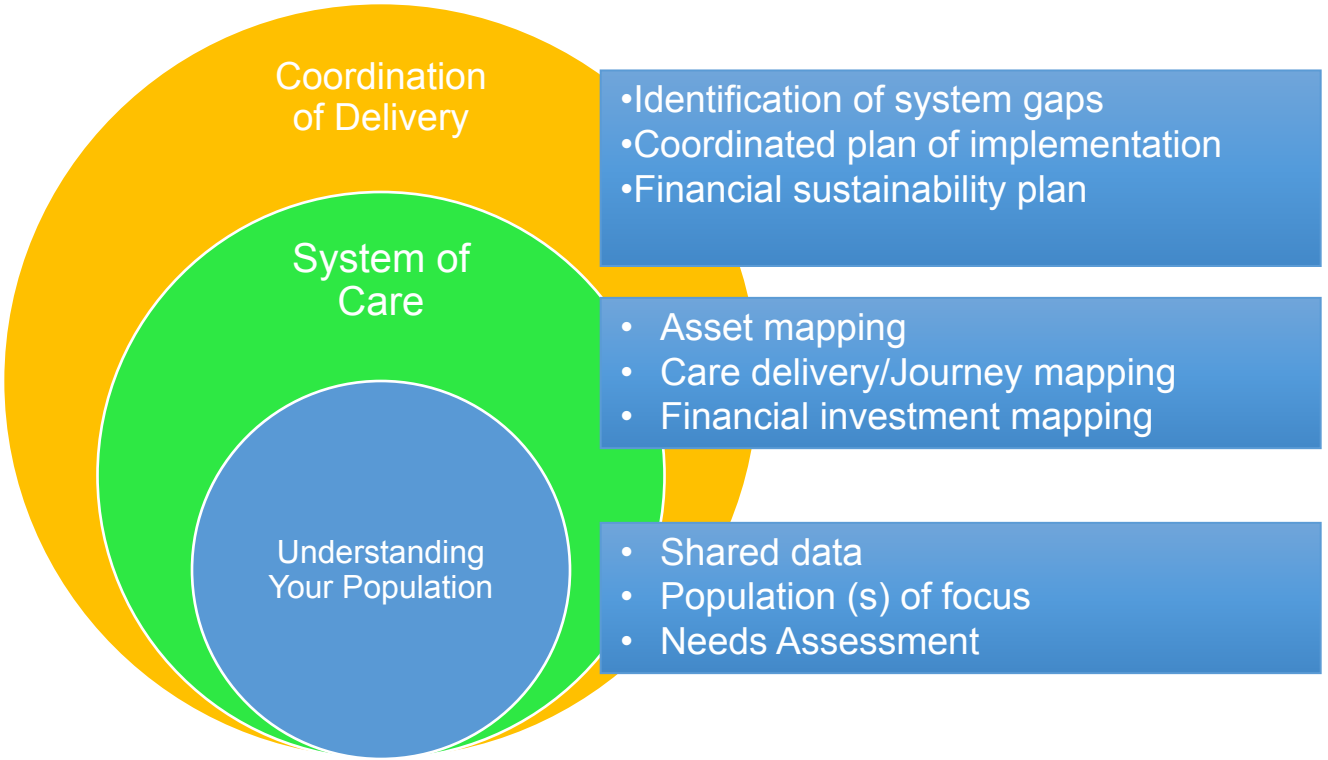
Innovations in Housing & Homeless Services

New Resources & Partners in Delivery

- Rapid build of street medicine/outreach
- Rapid build of navigation centers and recuperative care
- Rapid integration of data with HMIS & Health Plans
- New focus on affordable housing stock and housing retention

- MCPs (health plans) will attend the CoC board meetings
- MCPs will collaborate to deliver incentive dollars and initiatives in the community
- New VC models are landing to fill gaps in delivery
- Many incentive dollars require collaboration across providers and sectors

Connected Communities of Care



New Community Approaches

- Network Lead Entity
- Cross Sector Collaborative
- System of Care Approach
- “Care Traffic Control” roles

How can you keep in the loop?

- Join the roundtables:

Home - CalAIM Roundtables

Read the previous meeting slides

Innovations in Training & Education

Training and Education

- Root Cause Assessment
- System of Care Assessment
- Cross Sector Case Conferencing
- Anticipatory management
- Ecosystem Approach
- Ecosystem Value Case
- Building a connected network
- System of Care Enhancement
- Process Improvements

Hardin, L. & Mason, D. (June 2020). *Lessons from complex care in a Covid-19 world.* **JAMA Health Forum**. https://jamanetwork.com/channels/health-forum/fullarticle/2768610

Hardin, L., Trumbo, S. & Wiest, D. (October 2019). *Cross-sector collaboration for vulnerable populations reduces utilization and strengthens community partnerships.* **Journal of Interprofessional Education and Practice.** https://doi.org/10.1016/j.xjep.2019.100291

Adventist Health (April, 2018). *Project Restoration* https://www.youtube.com/watch?v=5ltCGJTofrM

Hardin, L., Kilian, A., Spykerman, K. (February 2017). *Competing Health Systems and Complex Patients: An Interprofessional Collaboration to improve outcomes and reduce Healthcare Costs.* **Journal of Interprofessional Education and Practice. *Journal of Interprofessional Education and Practice, 7, 5-10.* http://jieponline.com/article/S2405-4526(16)30103-3/pdf**

Hardin, L., Kilian, A., Muller, L., Callison, K. & Olgren, M. (December 2016). *Cross Continuum Tool is Associated with Reduced Utilization and Cost for Frequent High-Need Users.* **Western Journal of Emergency Medicine.** The Western Journal of Emergency Medicine, 18(2), 189–200. doi:10.5811/westjem.2016.11.31916

Hardin, L., Kilian, A., & Olgren, M. (September 2016). *Perspectives on Root Causes of High Utilization that Extend Beyond the Patient.* **Population Health Management. *Population Health Management*. doi:10.1089/pop.2016.0088**

Hardin, L. (January 2016). *Restoring Dignity for Vulnerable Populations*. **Health Progress.** *https://www.chausa.org/docs/default-source/health-progress/restoring-dignity-for-vulnerable-populations-changing-the-system-for-complex-patients.pdf?sfvrsn=0.*

Vaida, B. (September, 2019). *For the Uninsured in Memphis, a Stronger Safety Net.* **Health Affairs.** https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.00999

Data Sharing

Institute for Healthcare Improvement

Action Period: Fall 2022/Winter 2023

As a Pilot Team....

Participate in Pilot Site Coaching Calls
Participate in All Pilot Site Monthly Calls
Continue testing projects in your portfolio
Prepare for Reporting Process Measures
Recommitment to Pilot Year 3
Prepare for Workshop 5

Wrap up Day 1, Look ahead to Day 2

In the chat please share **what went well** today….

In the chat please share **it would be better if**….

(try to focus on changes that can be made for tomorrow's sessions)

Institute for Healthcare Improvement

COMMUNITY SOLUTIONS

Healthcare and Homelessness Workshop #4 - Day 2

September 2022

Institute for Healthcare Improvement

COMMUNITY SOLUTIONS

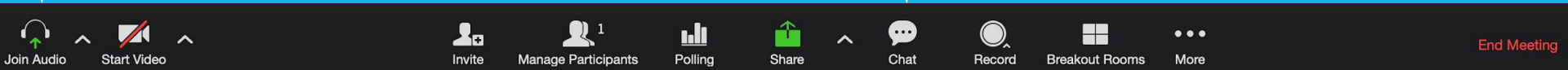
Welcome!

Mute your audio!

Turn on your video!

Say hi in the chat box! Tell us:

- Name
- Community
- Agency/Role
- What's squared away/what's circling?



Agenda - Day 2: September 15, 2022

Time	Agenda Item
2:00 - 2:10 pm ET 11 - 11:10 am PT 10 - 10:10 am AKT	**Welcome Back**
2:10-2:45pm ET 11:10 am - 11:45 pm PT 10:10 am - 10:45 am AKT	**Telling your Pilot Sites' Story Part II**
2:45-3:25 pm ET 11:45 - 12:25 pm PT 10:45 - 11:25 am AKT	**UFO/Capsule Session**
3:25 - 3:55 pm ET 12:25 - 12:55 pm PT 11:25- 11: 55 am AKT	**Keynote: Don Berwick**
3:55 - 4:00 pm ET 12:55 - 1:00 pm PT 11:55 am - 12:00 pm AKT	**Wrap-up and next steps**

Telling your Pilot Sites' Story - Part II

Institute for Healthcare Improvement


Anchorage, Alaska

ANCHORAGE COALITION TO
END HOMELESSNESS

PROVIDENCE
Health & Services
Alaska

ANCHORAGE, ALASKA

Nathan Johnson, Regional Director, Providence Alaska
Dakota Orm, Healthcare & Outreach Programs Manager, Anchorage Coalition to End Homelessness

Our Community: Anchorage, Alaska

Unique Characteristics

- Cultural diversity
- Geography and climate
- History of community collaboration
- Spirit of helping one another
- Sophisticated Tribal Health System
- Belief that homelessness is solvable

Interesting Challenges

- Racial equity
- Historical and present trauma
- Health inequities
- Resources & capacity restrictions
- **Volatile local government**
- COVID disparities

Our Team

Celia MacLeod, ACEH
Director of Programs & Services
Learned to knit through YouTube

Dakota Orm, ACEH
Programs Manager
Previous snowboard instructor

Terria Ware, ACEH
Systems Improvement Admin.
Previous biology major who volunteered at a youth shelter and realized her passion for sociology

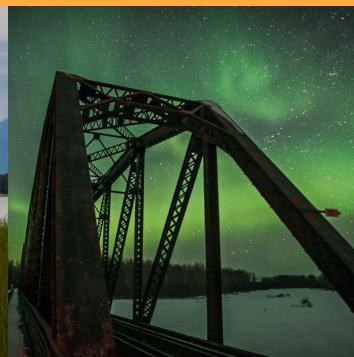
Bob Doehl, Rasmuson Foundation
Senior Fellow
Favorite & most recommended backpacking trip is the Kesugi Traverse

Nathan Johnson, Providence
Regional Director
Built a wooden kayak & paddled 330mi down the Alaskan Inside Passage from Haines to Ketchikan

Pilot Initiative Aim for Anchorage

Improve the well-being of individuals experiencing homelessness by expanding connections between health care and the homeless response system to ensure that appropriate and equitable care is received at the right time and in the right setting



Our project portfolio & how we will know we're make an impact

Project	**Project status**	**Outcomes:** How do we know the work is having an impact?	**Processes:** How do we know the work is progressing as planned?
Complex Care Shelter	In operation	Meeting previously unmet needs in the shelter community	• Defined needs intake & criteria, and admission • All 81 beds are full
Care Coordination	In operation	Connections to existing services outside of homeless response	• 19 individuals housed in 10 mo • Connecting individuals with Assisted Living Facility, Medicaid Waiver, Primary Care
Hospital Connecting with Coordinated Entry	In planning phase	Hospital clients directly connecting to CE & HMIS	• Active hospital discharge engagement in HPRS & CE • CHW Hospital Liaison pilot training in CE and Case Conferencing

Telling the story of the pilot in **Anchorage**

Anchorage: Story from our work

- Complex Care Shelter
  - New shelter created to fill a gap in our community
    - People not well-served in a congregate shelter
      - Those with underlying health conditions that create additional barriers to housing
    - Accommodates 83 guests
      - 81 beds, 2 Q&I
  - Required cross-sector collaboration
    - Homeless response system and private sector businesses

Q&A

Sacramento, California

Sacramento County HxH Pilot Site

Dignity Health. KAISER PERMANENTE® Sutter Health UCDAVIS HEALTH

SACRAMENTO STEPS FORWARD

Ending Homelessness. Starting Fresh.

Our Community

- Sacramento is one of the most diverse cities in the United States
- Sacramento County has rural and urban areas, and there can be challenges on how to divide resources at the county level
- There is a great history of collaboration in this community. The organizations that are part of the Pilot Team have years of experience collaborating across sectors.
- Specifically, there are four major health systems that have collaborated well in the past
    - The flip side of this is that the health care sector is quite dynamic and both complicated to manage and complicated for people to navigate.
- Funding is both an asset and a challenge in Sacramento. On the plus side, there are a lot of funders. This sometimes leads to services being driven by the funder as opposed to a coordinated effort from someone.
- Sacramento is the state capitol and the city is engaged in work to reduce homelessness--however this requires additional coordination with government agencies.
- There are seasonal changes in terms of what housing resources are available and this can be difficult for the health care sector to keep up with. The Covid pandemic has also impacted this.
- Outward migration from the San Francisco/Bay Area is constraining the housing market--Sacramento has one of the fasted growing rental markets in the Country.

Our Team

Core Working Group

- Lisa Bates: Sacramento Steps Forward, CEO (CoC Lead Agency)
- Elissa Southward: Dignity Health, Director, Community Health and Outreach
- Nicole Wilson: CommonSpirit Health, Project Manager, Community Homeless Health
- Brian Heller de Leon: KP Greater Sacramento Community Health Manager
- Leslie Wise: KP Strategic Consultant, National Housing for Health Team
- Kelly Brenk: Sutter Health Community Health Manager
- Ryan Loofbourrow: Sutter Health, Government Affairs Manager
- Angie Drake: UC Davis Health, Clinical Professor, Department of Psychiatry
- Ellen Brown: UC Davis Health, Director Community Integration

Key Stakeholders

- Michele Odell: KP, Public Affairs
- Richard Robinson: KP, Public Affairs
- Kelly Bennett: Sacramento Covered
- Erin Johansen: Hope Cooperative
- Jen Ablog: KP, Community and Government Relations
- MK Orsulak: UC Davis, Department of Family Medicine
- Malinda Ellis: Dignity Health, Director of Care Coordination
- Shahla Rasul: Dignity Health, Social Work Manager
- Yvonne Speer: KP Continuum Administration
- Rachel Bereza: Sacramento Steps Forward, Deputy CEO

Sacramento: Aim Statement & Project Scope

Community Aim	Sacramento will reduce the number of individuals experiencing chronic homelessness with regular encounters with the health systems by 15%, from A to B by July 31, 2023.
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.
Data Scope	(Pending initial data review) • Chronically homeless single adults on HMIS, active on by name list (BNL = approx 1800) • ***With** "regular encounters with health systems" = **X** ED visits or more than **Y** hospital days/yr. Possible age criteria (50 y/o and above), depending on patient volume..
Intervention Scope	Chronically Homeless individuals from BNL with regular* encounters with all four regional health systems will be referred to centralized "HMIS Hub" for: • HMIS validation and entry to Coordinated Entry System • CalAIM "matching" for case management and/or enrollment, • SDOH services & pre-housing supports -- with the end goal of housing placements.

Sacramento - Project Portfolio (Completed Projects)

ToC Pillar	Project	Owner/Point Person	Impact/Effort
Commitment /Finance	**Develop HxH pilot messaging doc** to demonstrate (financial, operational, leadership) commitment of all four health systems to a centralized, coordinated system-of-care in the county. Messaging doc will be used for September Community Solutions blog post and with Sacramento stakeholders. (Emerging/New) Leverage commitment of four health systems to establish **county-wide funders collaborative** to align key stakeholders around system-wide/integrated approach. - City, county, financial institutions, and business community to be engaged, with health system CEOs & SSF as initial conveners.	All health systems + SSF/CS	Major Projects
Financing	**Complete a full funding assessment** of system-wide and individual CB investments focused on housing and homelessness continuum. **Align funding requirements of all four health systems** to include HMIS and Coordinated Entry participation (template language from SSF) **Evaluate potential partner agencies** for hub/referral intervention	All health systems	Quick Win
Commitment	**Complete process map** of health systems' internal (ED/IP) triage and referral process for homeless patients.	All health systems	Major Project

SSF/CoC Work on Racial Equity Action Plan & Centering ‘Lived Expertise’

Sacramento has adopted a racial equity action plan focused on 6 key areas:

1. Using data with racial equity lens
2. Provide ongoing training and education
3. Build staff and leadership diversity
4. Improve Coordinated Entry assessment and prioritization to address bias and inequities
5. Improve language access
6. Develop equitable funding streams

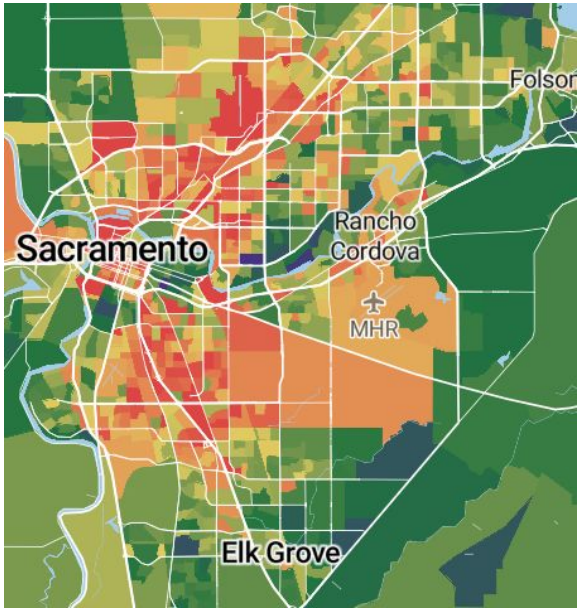
Current work underway:

- Developing racially equitable assessment process for Single Families and Adults
- Increasing access points, referrals, and placement into housing for black, indigenous, and persons of color that are dispersed geographically.
- Incorporating PLE as training consultants into problem solving training program
- Bringing Wilton Rancheria Tribe to the CoC membership
- Assessing language access needs for CBO housing/service providers
- Establishing a PLE council

Sacramento - Project Portfolio (Commitment ToC)

Project	Outcomes	Processes
Data Sharing across CoC and health systems. A data-sharing agreement between Sac Steps Forward (CoC lead agency in Sac County) has been escalated to enterprise-level legal and/or compliance and is under review by all four health systems Goal of DSA: To "map" the By Name List from Sacramento Steps Forward (of people experiencing chronic homelessness) to health system patient records, for the purposes of: - Setting baseline to measure success of proposed hospital-level interventions - Better understand impact of CH population on entire health system across Sac County - Develop "proxy measures" to help hospital care teams better ID and triage CH patients	How quickly someone is ID'd as experiencing chronic homelessness. Access to services (e.g. weeks to case mgmt, months to housing placements)	# completed data agreements Matching w/ health system data (check 1x per month) Sharing aggregate analysis with SSF Matching characteristics ID'd on BNL & HC data and come up with predictors
Establish an "Intake & Referral Hub" between Health Systems and Sacramento County's Homeless Response System Main Interventions - Warm hand-off from hospital care team to Hub agency (at bedside or at discharge) - HMIS Entry, Vulnerability Assessment, entry to Coordinated Access System for housing placement options - Assess for existing MediCal plan & case management under CalAIM - Triage for immediate service needs	Improved access to SDOH services, housing Decreased hospital utilization by CH patients for non-acute care Increased demand for housing	# referrals of CH patients to hub agency # successful intakes, HMIS/CES entries # of SDOH + pre-housing services provided

The Story of the HxH Pilot in Sacramento County



Stories of Our Work

1. Strong, cross-sector collaboration:
    a. **Joint health system funding** of THREE new positions at SSF.
        i. One consultant is already in place to support launch of the Sac Funders Collaborative
        ii. Funding will also support increased Process Improvement, Case Conferencing, and Policy & Communications capacity at SSF
    b. **Aligned hospital-based interventions** with chronically homeless patients - opportunities for cross-learning, sharing best practices, data collection, etc.
2. Example of engaging new stakeholders:
    a. **Funders Collaborative** to bring increased education and alignment among private & public sector stakeholders and funders (financial institutions, private business owners, etc)
3. An “aha” moment that has come out of your work:
    a. **The importance of the learning process** between the four health systems & SSF …
    b. **Collaborating together (leveraging our collective power)** to move Sacramento towards a NEW SYSTEMIC & COLLABORATIVE approach, informed by data (rather than one-off, project specific funding, or “pet projects” of elected officials)

Q&A

Storytelling Template

We have a storytelling template to share with you all

UFO/Capsule Sessions

Institute for Healthcare Improvement

Instructions

- In this session, three Pilot Sites will have a chance to present a situation that they would like feedback on
  - This could be a challenge you are facing in one of your projects
  - This could be a barrier you want to overcome around data sharing
  - This could be a situation where you aren't sure how best to proceed and would like recommendations
- After you present your situation, anyone will have a few minutes to ask clarifying questions
- Then, the presenting Pilot Site will not add any more details as the other Pilot Sites discuss the situation as if it was their own, providing ideas, recommendations, solutions or additional questions to be answered

UFO SITUATION: Challenging Situations & Systems in Sacramento

Coordination Challenges Across Health Systems:

- **Internal system dynamics vary widely across the four health systems** -- in approach to homelessness, legal processes, approach to data-sharing, and history of individual programs that we need to pivot/align.
- **Each system operationalizes programs differently**, yet need to work with the same community partner
  - (For the intervention side of the pilot, no additional $$ was provided to support, so we're having to get creative about leveraging existing positions/functions.)
- **We *aspire* to have aligned interventions and data-sharing** so that we can actually measure the impact of these interventions over time.

Political Context in Sacramento: City and County are not in alignment. CoC Lead Agency is caught between these two massive stakeholders - makes things exceptionally complicated.

Gaining Traction for System-Level Work when it doesn't feel action-oriented or concrete. Hard to get buy-in from electeds and broader public. SSF is embarking on a communications + public education campaign that can highlight concrete action at system-level and accomplishments to electeds and the public.

UFO SITUATION: BAKERSFIELD

Establishing a regional approach to medical respite care in Kern County. In addition to the space being created through the expansion of the Brundage Lane Navigation Center (and the Open Door Network) in Bakersfield, there needs to be additional solutions for the outlying areas also being served so the city does not take on the full impact of addressing this homeless subpopulation.

UFO Activity: Chattanooga

Looking ahead, how do we facilitate safe post-respite planning and ongoing case management, especially when our clients are experiencing complex medical conditions or behavioral health issues in addition to recovering from acute illnesses? How do we do safe, helpful discharge planning for the end of respite care?

Complicating issues:

- Lack of affordable housing units
- Lack of supportive services for individuals with behavioral health and substance abuse issues
- Lack of health insurance options–Tennessee is a non-expansion state
- Limited staffing in CoC and hospital systems

UFO SITUATION: WASHINGTON COUNTY

We would like advice from other sites around **tracking/reporting on outcomes** from case conferencing:

Relationship-building and informal networking between systems - hard to measure, but so valuable - how do others report on this?

Self-reported health status from participants/patients?

Longitudinal tracking of health outcomes in our EHRs, utilization, etc.?

What have others have used as success and outcomes metrics?

Keynote: Don Berwick

Institute for Healthcare Improvement

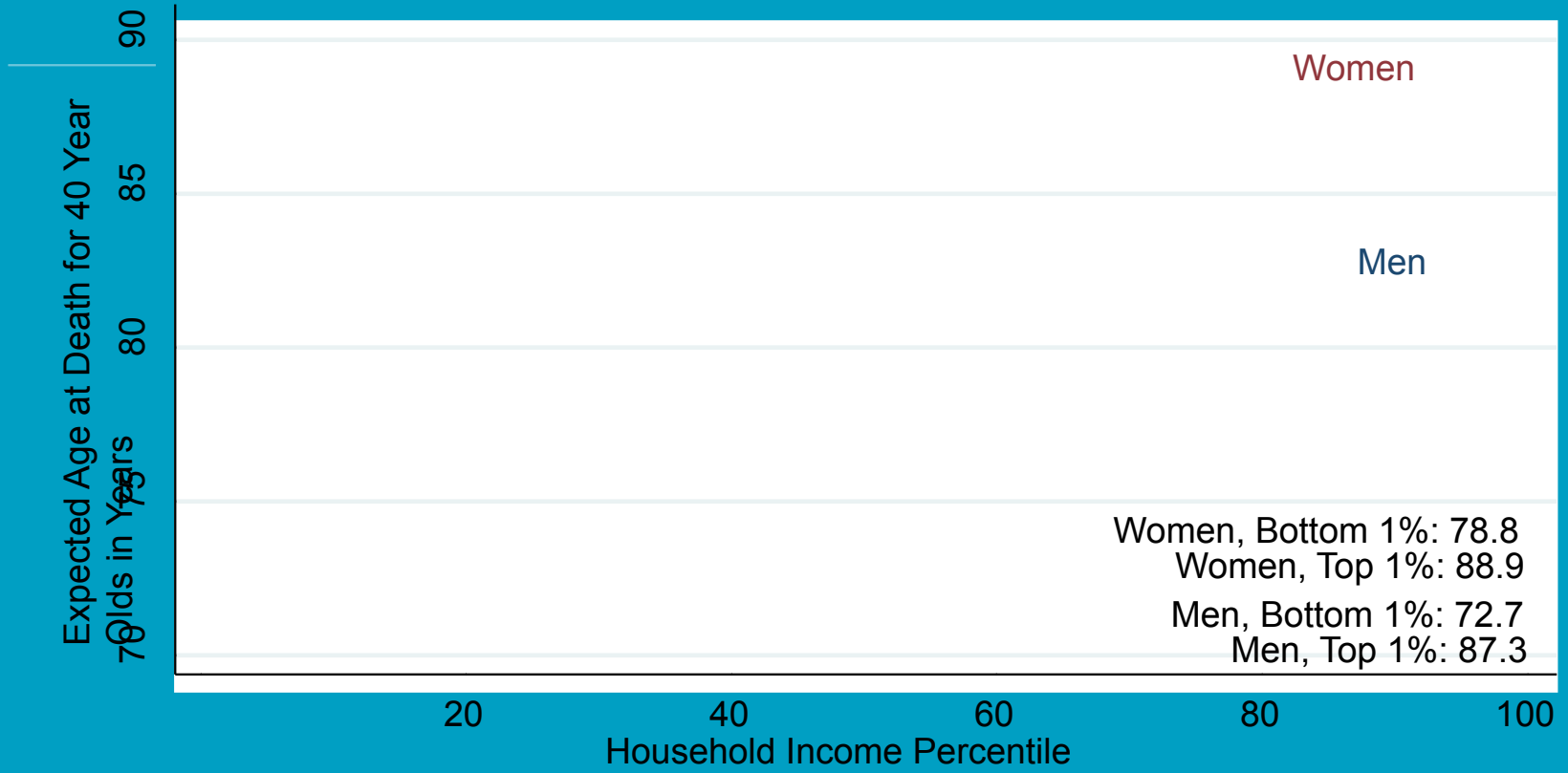
Institute for Healthcare Improvement

IHI Community Solutions Workshop
September 15, 2022

Ten Teams: Health Care's Great Power and Great Responsibility

Donald M. Berwick, MD. MPP
President Emeritus and Senior Fellow
Institute for Healthcare Improvement

Expected Age at Death vs. Household Income Percentile By Gender at Age 40



Chetty R, Stepner M, Abraham S, et al. The association between income and life expectancy in the United States, 2001-2014. JAMA 2016; 315: 1750-1766.

Life Expectancy and the London Tube

Life Span and Life Circumstances

Life Expectancy

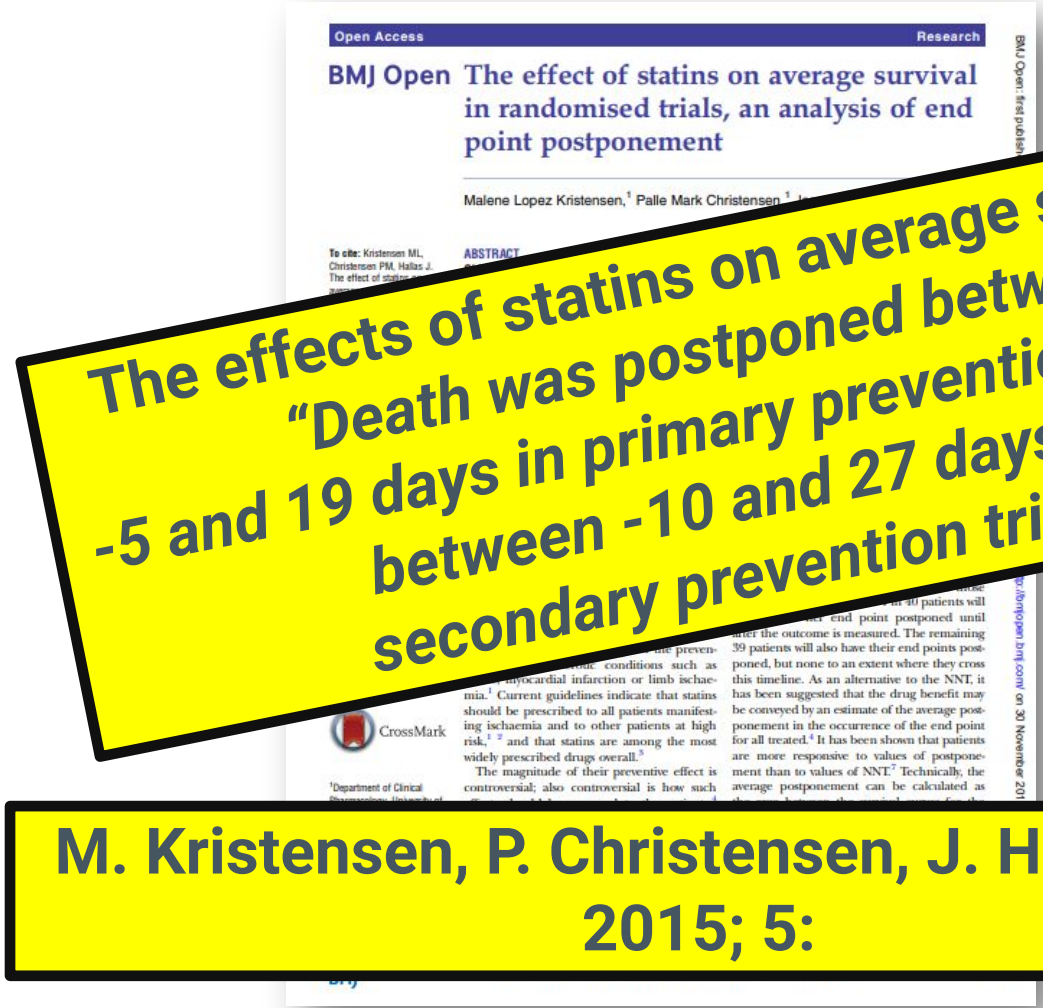
Δ 10 years

Loss of Life:

6 Months/Minute

2.3 Years/Mile

“6 months for every minute on the subway; 2.3 years for every mile travelled.”



The effects of statins on average survival....
"Death was postponed between
-5 and 19 days in primary prevention trials and
between -10 and 27 days in
secondary prevention trials."

M. Kristensen, P. Christensen, J. Hallas; BMJ 2015; 5:

20 Days of Your Lifespan Equals:

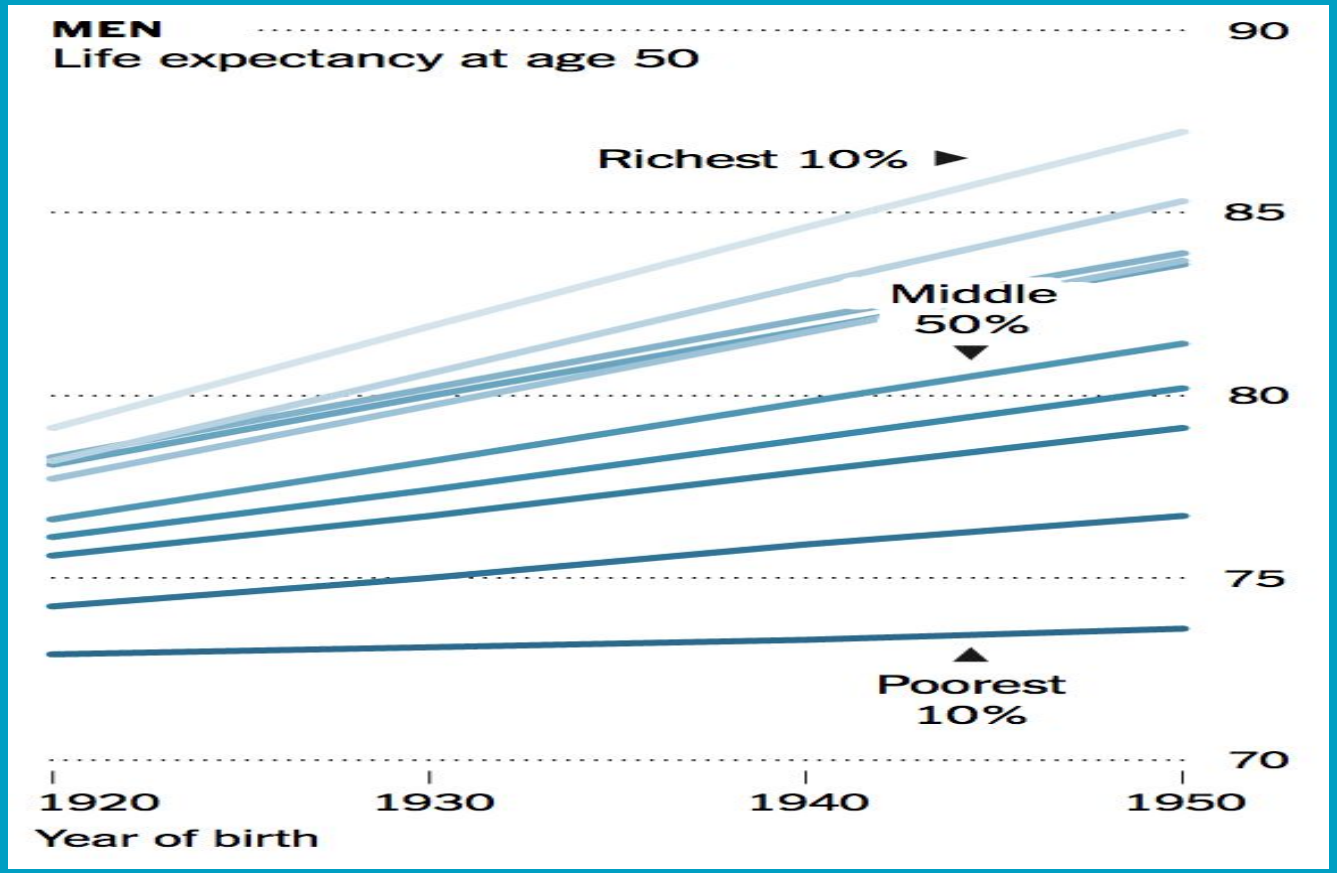
Taking Statins for 20 Years

Riding the D Train for 7 Seconds

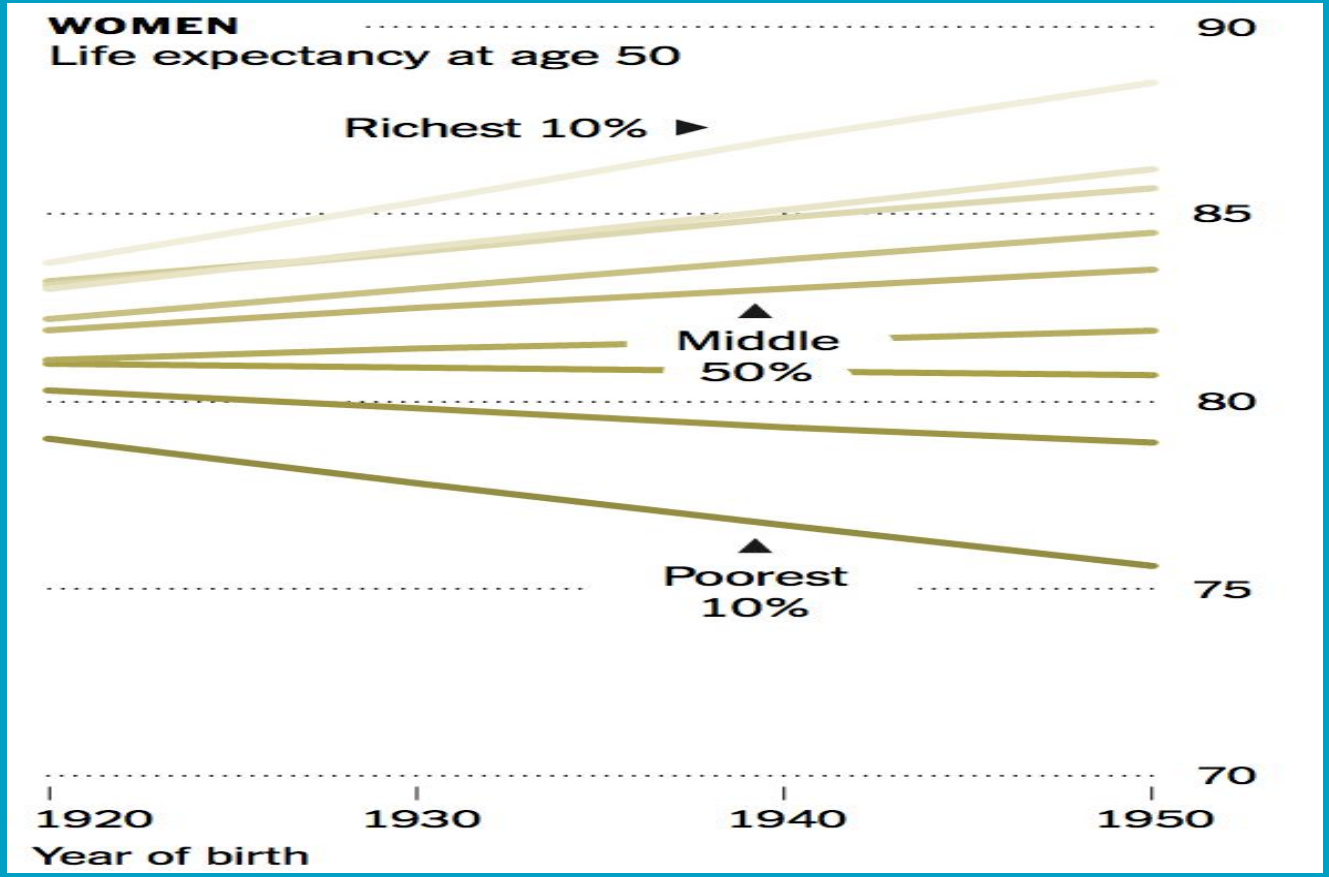
Riding the Glasgow Bus for 43 Feet

Image Source: AARP, B.C. Lorio via Flickr, Raymond Okonski via geograph.org/uk

US Life Expectancy by Year of Birth

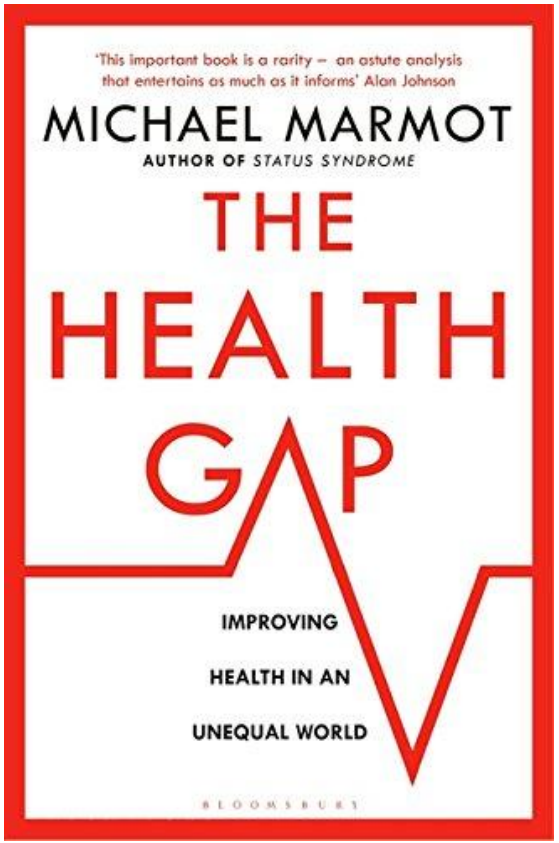


US Life Expectancy by Year of Birth

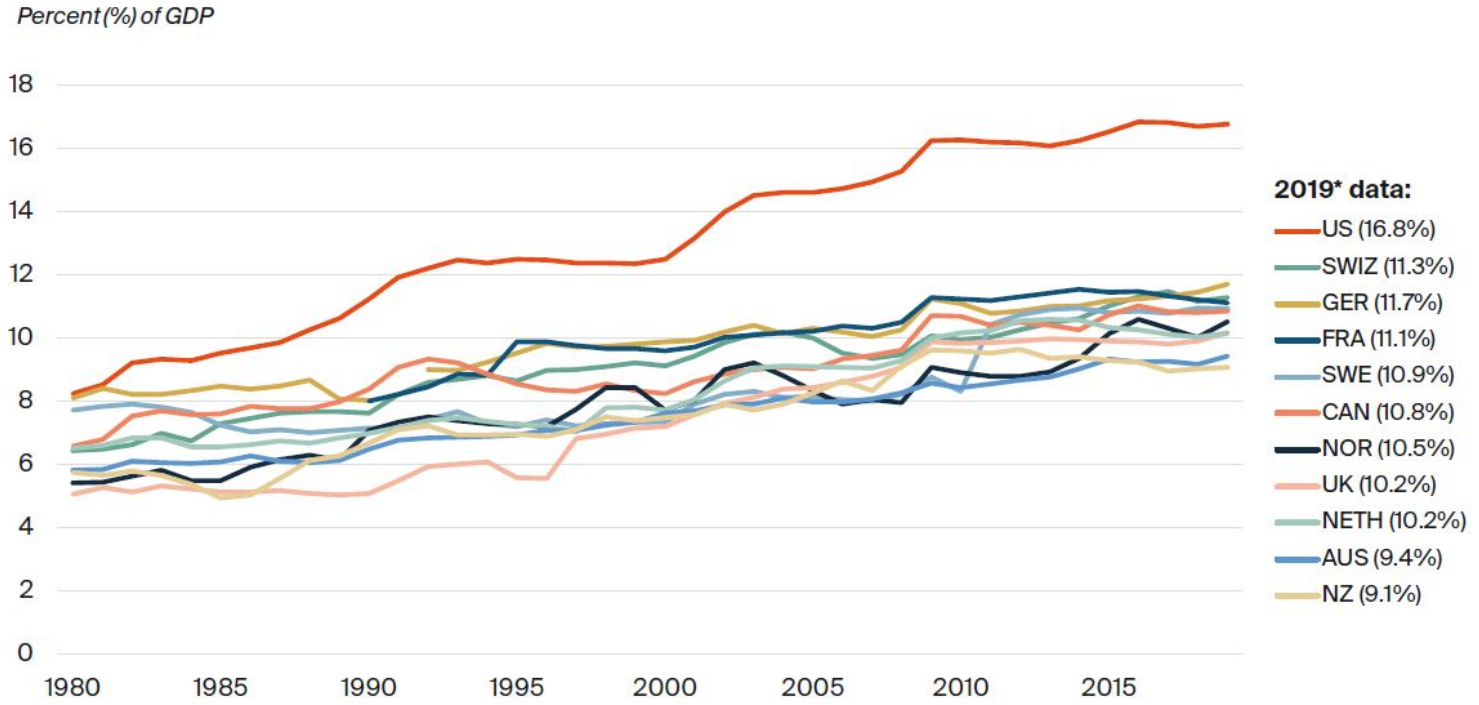


Social Determinants of Health

1. Early childhood stress
2. Education systems
3. Workplace conditions
4. Supports for aging
5. Community infrastructures (housing, transportation, recreational opportunities, food security, violence, environmental exposures)
6. **Fairness**



Health Care Spending as a Percentage of GDP, 1980–2019



Notes: Current expenditures on health. Based on System of Health Accounts methodology, with some differences between country methodologies. GDP refers to gross domestic product.
* 2019 data are provisional or estimated for Australia, Canada, and New Zealand.
Data: OECD Health Data, July 2021.

Source: Eric C. Schneider et al., *Mirror, Mirror 2021 — Reflecting Poorly: Health Care in the U.S. Compared to Other High-Income Countries* (Commonwealth Fund, Aug. 2021).

The Commonwealth Fund

Ten Teams

1. Health Coverage
2. Food Security
3. Housing Security
4. Immigrant Needs
5. Corrections and Prison Health
6. Climate and Decarbonization
7. Voting Rights
8. Education Supports
9. Early Childhood Supports
10. Elderly and Loneliness

Team Composition

1. Senior Sponsor
2. Board Sponsor
3. Budget
4. Designated Leader with weekly reporting to Senior Executive Group
5. Resources and encouragement / license
6. Active member of relevant learning Collaboratives

Exemplar: ProMedica, Toledo, OH

ProMedica National Social Determinants of Health Institute

Clinical SDOH Screening, Interventions, and Outcomes

As an organization, ProMedica is committed to addressing th
setting. Integrating non-clinical needs such as food, housing,
connect with resources to allow them to focus on their health
critical part of the process. Our community care hub, social w
a plan to allow the patients to not only address their socioec

27,000 people served in the food clinic

Interventions

As need is identified, patients are connected to ProMedica and co y partner supports and programs.

Nearly 120,000 screenings by our patients, members, and residents.

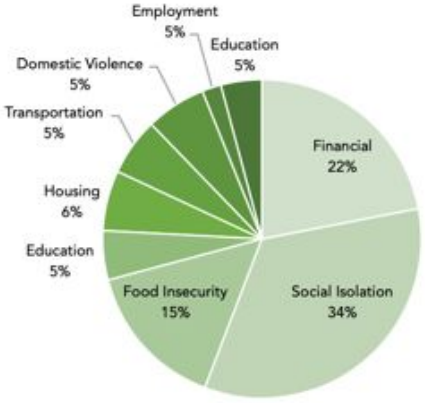
More than 18,000 connections were made to our foo , financial coachin programming, e nal opportunities, an various inter

Launched grocery delivery program for oncology patients to decrease risk of COVID-19 exposure.

Financial Wellness: 1,900 individuals supported with financial wellness services

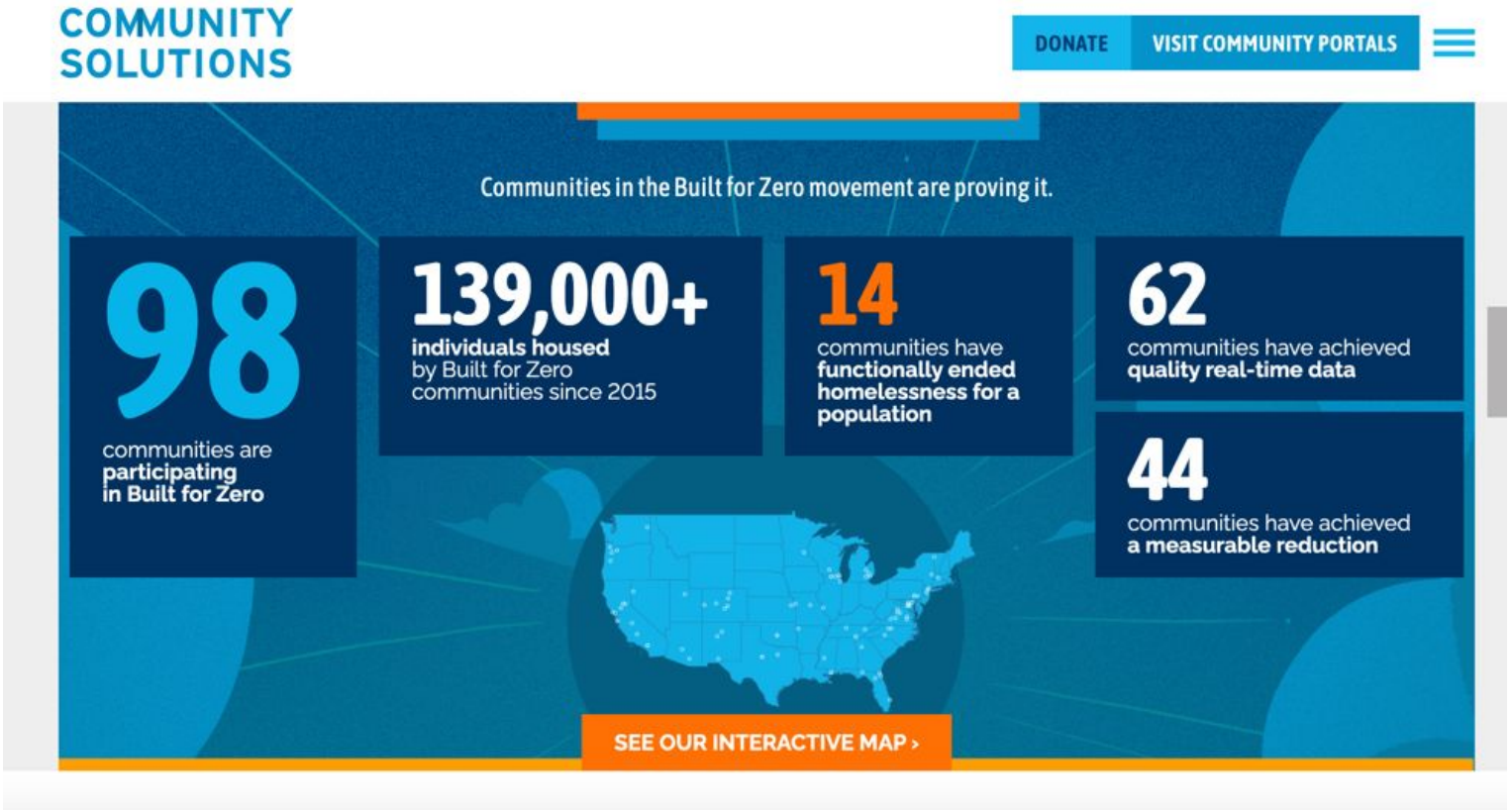
27,000 people were served in the food clinic impacting **8,357 households** and providing **67,535 days'** worth of food to our community

Nearly **7,000 individuals** living in **rural communities received fresh produce**



2020 Core SDOH Identified Risks in Primary Care Settings

Community Solutions: Join “Built for Zero”



Exemplars: Transitions Clinic Network

Transitions Clinic Network

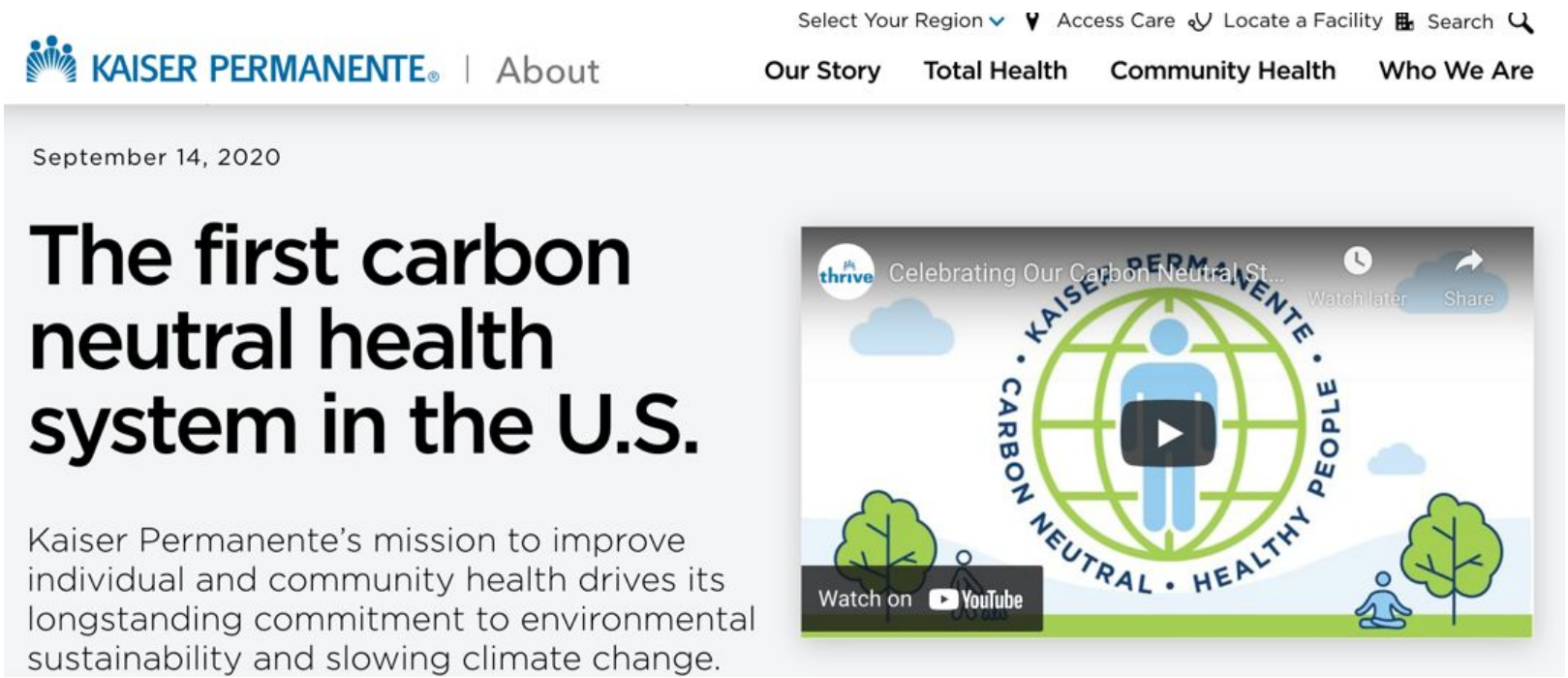
The Transitions Clinic Network is building an innovative healthcare model for individuals returning to the community from incarceration.

- Primary Care
- Continuity of Care
- Career Pathways
- 62% Decrease in Reincarceration

Coaching: 1. National Academy of Medicine
2. Health Care Without Harm

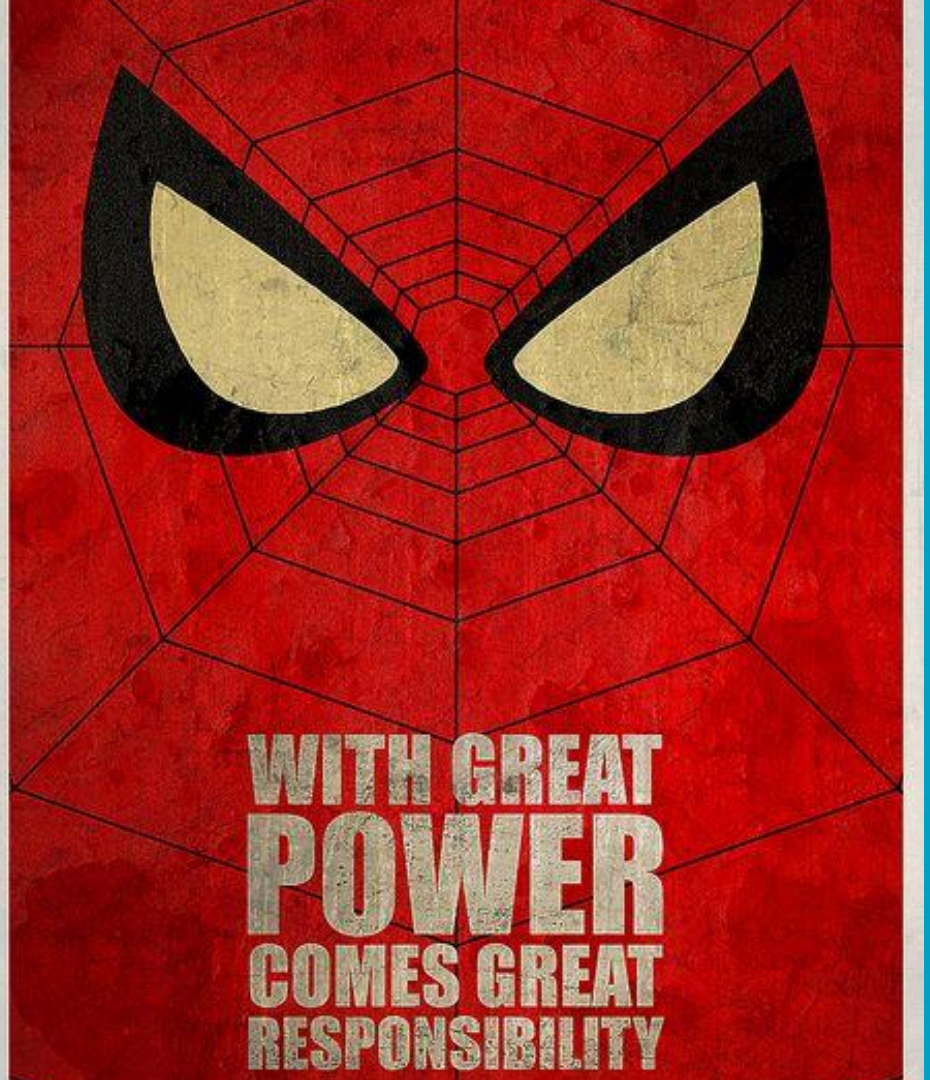
NATIONAL ACADEMY of MEDICINE
ACTION COLLABORATIVE ON
DECARBONIZING THE
U.S. HEALTH SECTOR

Exemplar: Kaiser Permanente



“You have no idea how much people are waiting to be invited to do something great.”

- Joe McCannon



"With great power comes great responsibility."

Closing and Wrap Up

Institute for Healthcare Improvement

Action Period: Fall 2022/Winter 2023

As a Pilot Team....

Participate in Pilot Site Coaching Calls
Participate in All Pilot Site Monthly Calls
Continue testing projects in your portfolio
Prepare for Reporting Process Measures
Recommitment to Pilot Year 3
Prepare for Workshop 5: In February, In Person!

Wrap up - Please share in the chat...

In one word….how are you feeling right now?

Institute for Healthcare Improvement

COMMUNITY SOLUTIONS

Wrap up - please share in the chat...

What is the first action you plan on taking as a result of this workshop?

Our Journey Together in the Pilot

Kick-Off Call
December 2020

Foundations Phase
December & January 2020

Virtual Workshop 1
Jan 28 & 29, 2021

Action Period 1
Feb - June 2021

Virtual Workshop 2
June 23 & 24 2021

Action Period 2
June - December 2021

Celebration Call
December 2021

Continued Action Period
Jan + Feb 2022

Virtual Workshop 3
March 1 & 2 2022

Action Period 3
March - Summer 2022

Virtual Worksh... 4
September 2022

Action Period 4
September 2022-Jan 2023

In person Workshop 5
February 2023

Action Period 5
Summer 2023

Workshop 6 and Site Harvesting/Dissemination
Oct 2023-Dec 2023

Thank You

Institute for Healthcare Improvement

COMMUNITY SOLUTIONS