Changing the Terms:
How Communities are Leveraging Health Care for Permanent Supportive Housing Capacity
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Together4Health ~ A Care Coordination Entity (Chicago)

- A collaboration of providers that develop and implement a Care Coordination model – an integrated delivery system; risk-based payment based on health outcomes
- Must include participation from hospitals, primary care providers, and behavioral health providers
- Provider network → full risk health plan
Together4Health, LLC ~
34 owner organizations

- 5 Hospitals (safety net → academic medical center)
- 8 Federally Qualified Health Centers
- 11 Behavioral Health Organizations
- Social Service Organizations (housing; grocery & nutrition; supported employment; financial literacy; senior day centers)
- Organization members (CSH, AFC, TASC)
- Health Information Network (Alliance of Chicago Community Health Services)
Why Together4Health?

● The needs of the people we serve
  – Economic realities
  – Policy shifts
  – Emerging health demands
  – Need for holistic services (housing, employment, food security, social supports) that impact health

● Opportunity to become a provider led network
  – Proactive response to changes in how health care is provided and paid for
Together4Health ~ Goals

- Ensure that our participants experience the highest quality care
- Improve the health of vulnerable populations (high utilizers of Medicaid)
- Reduce the per capita cost of health care
- Reduce health disparities
- Share accountability for the outcomes of patient care across the partnership
- Address social determinants (lack of housing, employment, food security, and social supports) that have a negative impact on health
- Continue to revise and improve the model, according to input from research partners who evaluate and report on network services, outcomes and disseminate findings
Board Of Managers

Executive Committee

Management Company

IT & HIT Work Group

Marketing Work Group

Constituency Groups

Finance Committee
Care Coordination & Quality Management
Network Development & Provider Relations
Planning, Policy & Advocacy
Risk Policy Committee

Contract Negotiation Team
Health Home Hubs

Advocacy & Policy Work Group
Together4Health ~ Financial Model

- Shared risk, shared revenue opportunity
- Owner capital investment
- Per member per month care coordination fee
- Intergovernmental transfer and payment reform
- Cost savings based on Medicaid savings and achieving health outcomes → estimated over three years to save over $11M
Together4Health ~ Housing = Healthcare

- Requires transformation of culture, service delivery and financing
  - No magic bullet
  - Focus on quality and service matching rather than one size fits all
  - Intergovernmental Transfer ~ T4H pilot
  - State solutions ~ 1115 waiver
  - CMS State Innovation Model ~ global payment
  - Dedicating Opportunities to End Homelessness partnership with HUD
Together4Health ~ Opportunities to Build Housing Capacity

- Leverage Olmstead consent decree business
- Intergovernmental Transfer
- Employ housing partner care managers part-time as T4H care coordination team members
- T4H bonus structure → incentivize system transformation, T4H goals across and specific to T4H provider organizations and sector
- T4H chooses to invest shared savings achieved into housing capacity
Want to learn more?

Care coordination webinar

Chicago Health & Social Innovation Research Center
DHHS ASPE Case Study Reports
Commonwealth Foundation Case Studies
Four fundamental questions

» Whose Homeless in my Community?

» What are the Evidenced Based Practices that effectively serves them?

» Does my community have the right models?
  ◦ Affordable Housing
  ◦ Supportive Housing
  ◦ Housing First
  ◦ Street Outreach

» Does my community have the capacity to serve whose homeless here? E.g. do we have ENOUGH of the above to meet the need.
1.5 million people

Percentage below the poverty level = 25.6%

Unique individuals enrolled in Philadelphia Medicaid in 2012 = 569,236

Approximately 20,000 people experience homeless in Philadelphia in a year
Capacity and Resources

- 24/7/365 Street Outreach Services
- 11 safe haven programs with capacity to serve 283 people
- 121 slots in Specialized Addiction Treatment for persons experiencing Chronic Homelessness
- Behavioral Health funded Case Management in all city funded shelters
Coordinated Funding Streams allows for ...

Approximately 3589 Units of PSH
  1996 units are McKinney Supported
    About 25% of these are Housing First
  1000 Housing Authority Vouchers
    593 DBHIDS funded
Pipeline of FLOW from McKinney funded PSH to Housing Choice Vouchers.
Expanding partnership between the COC and the local Housing Authority.

25% decrease in PIT count between 2007 and 2012. Includes a 70% decrease in persons with serious mental illness.
Strategic Financial and Administrative Structures to Support

Department of Behavioral Health and Intellectual disabilities

- Office of Mental Health
- Office of Addiction Services
- Office of Intellectual Disabilities
- Community Behavioral Health
» Determines who receives care? What kind of care? How much? How often?

» Develops a provider network

» Determines how much provider organizations are paid to deliver that care.

» Manage vast amounts of information regarding the health care of the “Covered Lives” they are responsible for

» In 2011, Government funds spent on Medicaid totaled approximately $411 billion dollars, per Kaiser Health Plan.

» Most recent available HUD budget in 2010 was $46 billion.
Comprehensive Medicaid Managed Care Penetration by State, October 2010

U.S. Overall = 65.9%

NOTE: Includes enrollment in MCOs and PCCMs. Most data as of October 2010. SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.
Entitlement services

- MUST be delivered IF
  - the service is in the state’s Medicaid Plan
  - the person meets Medical Necessity Criteria

Non Entitlement Services can have wait lists, persons who would benefit from care, but can’t access the care because of lack of funding and resources.
Managed Care not Fee For Service Financing Structure

Managed Care organization is a Not for Profit.

Local Control of the Managed Care organization in a Risk Based Contract.
3 Innovations with Medicaid to serve Eligible Individuals with Behavioral Health Challenges

» Specialized Clinical Care for Vulnerable Persons with Complex Needs

» Using Managed Care Organizations Profits to expand capacity in Housing First or Safe Havens

» Managed Care Organizations Profits fund Housing Subsidies for specialized populations.
Specialized Clinical Care for Vulnerable Persons with Complex Needs

• These decisions live with whoever is directly managing care.
  – Special Code or alerts for persons who are chronically homeless
  – Specialized care management services for high priority persons
  – Specialized programming for chronically homeless persons including a year long inpatient addiction treatment program for chronically homeless persons that coordinates discharge with supportive housing.
  – Integrated data that allows for data based prioritization.
None of these resources were developed as part of ending homelessness, a 10 year plan etc. Yet they have an enormous effect on our communities ability to meet the goals of your 10 Year Plan.

If your community has persons who are homeless AND have a behavioral health disability, then the same could be true for you!
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»Twitter: @Cella65
  @PhillyRecovery

»Facebook: Department of Behavioral Health and Intellectual disAbility Services
Changing the Terms: How Communities are Leveraging Health Care for PSH Capacity

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Central City Concern

- **Mission:** Providing comprehensive solutions to ending homelessness and achieving self-sufficiency one person at a time

- **Who we serve** – yearly, more than 13,000 individuals (throughout the Portland, Oregon metro area.)

- **Our programs** – integrated primary and behavioral healthcare, addictions treatment, affordable housing, employment services
Four Dimensions to Mission

- Housing – 1,600 units

- Integrated Care FQHC – 150,000 visits

- Peer Support – 42,700 hours of service

- Employment – 460 jobs
CCC Health Home Model

CCC Federally Qualified Health Center:

• Old Town Clinic
• Hooper Detoxification & Stabilization Center
• CCC Recovery Center
• Old Town Recovery Center (pictured)
• Recuperative Care Program
CCC’s Old Town Clinic was certified by the State of Oregon in 2011 as a Patient-Centered Primary Care Home based on meeting multiple measures under the following criteria:

- Access to care
- Accountability
- Comprehensive whole person care
- Continuity
- Coordination and integration
- Person and family-centered care
Important Components of CCC Health Home Model

- **Barrier free access** – ability to get same day/next day appointments, reach care team directly by phone

- **Team-based care**: Four teams include primary care provider, behaviorists, pharmacist, wellness and chronic pain services to minimize risk of opiate use in patients with chronic pain

- **Highly integrated mental health and addictions treatment** into primary care setting

- **Resources to support wellness** and holistic approach to disease: occupational therapy, tobacco cessation, diabetes, depression
CCC Health Home Model: Challenges

- **Pharmacy**: Patients with very high medication needs, many lack insurance; a difficult business model to maintain. Goal is to reduce multiple medications by emphasizing wellness.

- **High acuity client population**, multiple diagnoses

- **Access to housing**: some patients live in CCC housing but there is an unmet need for affordable supportive housing
Figure 3 | Impact of Behavioral Health Comorbidities on Per Capita Costs among Medicaid-Only Beneficiaries with Disabilities

- Asthma and/or COPD: $14,081 (No Mental Illness and No Drug/Alcohol), $15,862 (Mental Illness and No Drug/Alcohol), $16,058 (Drug/Alcohol and No Mental Illness), $24,598 (Mental Illness and Drug/Alcohol)
- Congestive Heart Failure: $9,488 (No Mental Illness and No Drug/Alcohol), $15,257 (Mental Illness and No Drug/Alcohol), $16,058 (Drug/Alcohol and No Mental Illness), $24,927 (Mental Illness and Drug/Alcohol)
- Coronary Heart Disease: $8,788 (No Mental Illness and No Drug/Alcohol), $15,430 (Mental Illness and No Drug/Alcohol), $15,634 (Drug/Alcohol and No Mental Illness), $24,443 (Mental Illness and Drug/Alcohol)
- Diabetes: $9,498 (No Mental Illness and No Drug/Alcohol), $16,267 (Mental Illness and No Drug/Alcohol), $18,156 (Drug/Alcohol and No Mental Illness), $36,730 (Mental Illness and Drug/Alcohol)
- Hypertension: $15,691 (No Mental Illness and No Drug/Alcohol), $24,693 (Mental Illness and No Drug/Alcohol), $24,281 (Drug/Alcohol and No Mental Illness), $35,840 (Mental Illness and Drug/Alcohol)
History: healthcare transformation in Oregon

Governor Kitzhaber
Old Town Clinic – Feb 2011

Governor Kitzhaber
Old Town Recovery Center– May 2012
$1.9 Billion Federal Support for CCOs!

- 5 year Investment
  - Cut cost growth by 1% pts after 2 years, then 2%
  - Measurably improve quality and access
    - 17 P4P metrics, 2% global budget bonus at risk
    - 1% timely reporting withhold for quarterly data

- 6 Key Transformation “Levers”
  - Focus on “those with multiple or complex conditions”
  - Alternative payment methods focused on outcomes
  - Integrated physical, behavioral, oral models of care
  - Administrative simplification / new models of care
  - “Flexible services”
  - Learning systems for accelerating innovation spread
Central City Concern role in Health Share of Oregon

- Founding member
- Strategic education
- Portland metro area Community Health Centers
- Tri-County Community Behavioral Healthcare Network
- Workgroups
Health Share of Oregon Board of Directors

Founding Members

**Hospital Systems:**
- Adventist Health
- Kaiser Permanente
- Legacy Health
- Oregon Health & Science University
- Providence Health & Services
- Tuality Healthcare
- **Counties**
  - Clackamas County
  - Multnomah County
  - Washington County

**Other**
- CareOregon (MCO)
- Central City Concern

**Elected Board members**
- Primary Care Provider physician
- Specialist physician
- Nurse Practitioner
- Mental Health Treatment Provider
- Addiction Treatment Provider
- Dentist
- Community-at-Large – two members
- Chair of Community Advisory Council
Center for Medicare & Medicaid Innovation (CMMI) grant

- Three– year $17 million grant focused on re-designing service delivery from the Center for Medicare & Medicaid Innovation (CMMI)

- Focusing on high utilizers of hospitals and Emergency Departments

- Strategies include care coordination and intensive patient support services, including supportive housing, through community-based and cross-disciplinary care teams
Supported Housing Work Group

1. Identified cross jurisdictional interests in serving high impact individuals
2. Identified evidence based supportive housing services required
3. Commitment to repurposing local funds
4. CCO’s invest in rental subsidy and capital for housing developments.

Recommend CCO and Risk Accepting Entity receive training on role of supported housing and EBP models
Promising Healthcare/Housing Partnerships

Cedar Sinai Park Housing With Services Collaborative

- CCC is a service partner in a new project still in the conceptual stage, focused on aging in place + improved health outcomes for 500+ elderly/disabled residents of 3 downtown Section 8 buildings

- Project development funded by CMMI State Innovation Model grant, national Leading Age collaborative, Weinberg Foundation, Enterprise Foundation
Portland Housing Bureau responsibility includes -
  - Homeless system for singles
    - 10 Year Plan to End Homelessness
    - Fund outreach services to chronically homeless, and
    - Site-based staff for housing retention

Affordable housing development & sustainability
  - Priority funding for housing affordable to people with incomes at 30% area median income and below
  - Fund the acquisition of housing for an aging in place model
  - Previous requirement of PSH units
    - Lack of funding for rent subsidy and supportive services has changed this requirement to a preference
Commitment to Housing

- There are services currently paid for with local public funds that starting in 2014 can be paid by Medicaid, in theory:
  - Identify exactly which services are Medicaid eligible, and
  - Transform the delivery system to bill for them

- Elected leadership at the City and County level recognize that solving problems in Community Justice and Mental Health also come back to the availability of supportive housing

- City and County Director level staff have committed to using money saved by billing Medicaid for housing. Ideally, it will leverage services and rent subsidy to provide supportive housing.
10 Year Plan “Reset”

- Jointly convened by local jurisdictions to review past progress
- Priority Populations - Focus on those most vulnerable
  - Families with children
  - Unaccompanied Youth
  - Adults with physical or mental disabilities
  - Women
  - Veterans
- Address racial and ethnic disparities among people who are homeless
- 22,000 units of affordable housing needed
Major Recommendations – Policy

Six Focus Areas

1. Housing
2. Income & Benefits
3. Health Care
4. Survival & Emergency Services
5. Access to Services
6. Systems Coordination
Changing the Terms: How Communities are Leveraging Health Care for PSH Capacity

NAEH Conference July 2013
FrontLine Service is a not-for-profit, 501(c)(3) corporation founded in 1988, providing mental health and supportive services in Cuyahoga County for more than 20,000 adults and children each year.

It operates the most comprehensive single-agency continuum of care services for homeless people in Ohio. 18 homeless assistance programs provide assertive outreach, emergency shelter, residential services, case management, and psychiatric services. The services assist clients to achieve and maintain permanent housing and recovery from their mental disorder.

The FrontLine Service Mobile Crisis Team operates the County’s 24 hour suicide hotline and is the sole County provider of 24 hour mobile crisis intervention services for children and adults.
Enterprise Community Partners

Founded in 1982 by urban visionary Jim Rouse and his wife Patty, our mission is to create opportunity for low- and moderate-income people through fit, affordable housing and diverse, thriving communities. Since 1982, Enterprise has invested more than $11 billion to build or preserve more than 280,000 homes across the United States.

Enterprise in Ohio

Providing finance and policy leadership across Ohio while serving Cleveland with on-the-ground solutions

Key Results

- 14,000 affordable homes and $318M in investment across Ohio since 1987
- 576 supportive housing units for Cuyahoga County adults with long histories of homelessness
- 44,000 tax returns for low-income citizens of Cuyahoga County resulting in $57 million in refunds
- 3,500 affordable homes meeting Green Communities Criteria
Housing First Initiative of Cuyahoga County

• Convened in 2002 by Enterprise Community Partners, the Sisters of Charity Foundation and the Cleveland-Cuyahoga County Office of Homeless Services to scale up the evidenced-based solution to chronic homelessness—permanent supportive housing

• Centralized intake process based on length of time homeless, vulnerability and use of other public systems works to ensure that every apartment is targeted to the person that needs it the most.

• Both single-site and scattered site apartments available; resident choice is paramount.

• Lead service provider is FrontLine Service; many community partners

• Progress: 576 apartments occupied or underway
Housing First Tenant Profile

- Severe and Persistent Mental Illness – 78%
- Severe Alcohol or other Drug Dependency – 36%
- Chronic Physical Health Issues – 50%
- Past Criminal Justice Involvement – 70%
- Average Days Homeless Prior to moving in – 700 days
- Employment Rate at Entrance – <1%
- Average Income at Entrance - $294
- Male – 67%
- African-American - 66%
- Veterans – 19%
- Average Age – 51 years old
Outcomes and Impact

**Housing Stability**
- 73% have remained in their apartments
- 25% have moved to other permanent housing
- Less than a 2% return to homelessness

Chronic homelessness has decreased by 65%.

Cuyahoga County
Point In Time Count

- Chronically Homeless Persons
Need for Permanent Supportive Housing

Housing First re-assessed the need for permanent supportive housing among chronically homeless single adults and examined the need for supportive housing among long-term homeless families with children and young adults.

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<th>Year 2</th>
<th>Year 3</th>
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</tbody>
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With the supportive housing already completed or underway, this brings the total amount of permanent supportive housing required by chronically homeless individuals and families to 1,271 units.

This level of production combined with targeted leasing of annual turnover could end chronic homelessness in Cuyahoga County by the year 2020.
Can We Reach our Goal?

• Do we have the capacity to produce, operate and/or service the PSH needed?
  – Providers
  – Overall system

• Do our residents have access to the most robust and appropriate service mix to meet their health and stability needs?
  – Seven residents died due to difficulties with chronic illnesses in 90 days in Summer 2011; how do we enhance what we currently offer?

• Do we have the resources necessary to grow our inventory?
  – What are our costs? Can we diversify and decrease our reliance on the Continuum of Care?

• Will we be able to maintain our inventory, including the supportive services, over the long-term?
  – What increased role can Medicaid and mainstream dollars play?
  – What might we need to change to make this happen?
Our Approach to Health Care & PSH

1. Understand our portfolio and opportunities under the Affordable Care Act
   - Convened public hospital system, FQHCs, homeless system providers and public agencies in fall 2011; NAEH shared what was possible under the law
   - Carol Wilkins and Tom Albanese of Abt Associates reviewed portfolio costs, revenue sources and Medicaid revenue potential in early 2012

   - 75% of tenant population Medicaid-eligible, enrolled or dually eligible
   - 100% of tenant population would be Medicaid-eligible if expanded as permitted by ACA
   - Incentivized Health Home rates
   - Medicaid = 10% - 30% of current revenue; potential to double this
Our Approach to Health Care & PSH

2. Build the capacity of providers to seize opportunities and create greater accountability

- Provided FrontLine Service a competitive grant to fund a consultant to help meet ODMH Health Home requirements in 2nd Quarter 2012
- FrontLine Service assessed local landscape and determined Care Alliance Health Center to be the right primary care partner
- Engaged National Council for Community Behavioral Healthcare to develop Health Home policies and procedures and economic model
- Substantial work on overcoming differences in organizational cultures and service philosophies; built trust throughout organizations
- FrontLine Service has raised resources to purchase Electronic Medical Record, hire Health Home Team Leader and Director of Integration
- ODMH to implement the Health Home state option in October 2013
- If Medicaid is expanded, outreach and enrollment capacity will need support
- Refined Housing First project standards to require capacity to bill Medicaid; project monitoring now includes questions regarding enrollment
Our Approach to Health Care & PSH

3. Bring primary care to Housing First residents

- Focus group with residents initiated through Health Home work indicated a desire to have access to health care at home
- Worked with FrontLine Service and Care Alliance to design a mobile health clinic dedicated to Housing First permanent supportive housing residents
- Sought and obtained funding from the Ohio Housing Finance Agency to seed the mobile health clinic; goal is sustainability through sufficient medical encounters
- Benefits of the mobile health clinic model:
  - Dedicated staffing – can build trust with case management staff and residents
  - Co-location can help advance integrated care
  - Engagement opportunities with residents who are more reluctant to participate in services
  - Mobile health clinic can help connect residents to more comprehensive care
  - Ability to reach more residents more quickly and obtain more medical encounters
Looking Ahead

• Implement the Health Home, with goal of Patient-Centered Medical Home recognition

• Continue collaboration with advocacy organizations to expand Medicaid in Ohio

• Evaluate the mobile health clinic – are we improving health, reducing use of emergency departments?

• Build the business case for funding services and speak the language of the health care system and its payers

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Leveraging Health Care for PSH Capacity

HEARTH CONNECTION, Rich Hooks Wayman
Hearth Connection
www.hearthconnection.org

- Hearth Connection is an innovative nonprofit dedicated to ending long-term homelessness in Minnesota.
- 3 Regional Collaboratives
- Intermediary Role- securing resources
- Serve over 1,300 children, adults, and youth each year
- PSH - Break the cycle of homelessness and achieve housing stability and health recovery.
- Data focused on outcomes – CoPilot Data Base (HMIS)
Supportive Housing Model – Intermediary Resource Development

• Supportive Services Funding (ICM)
  – State LTHSSF
  – HUD SHP
  – Medicaid TCM

• Rental Assistance
  – HUD SHP
  – HUD S+C
  – State Housing Trust Fund
MN Medicaid Expansion 2012

MN ‘Early Adopter’ under ACA

• The Affordable Care Act’s goal: decrease the number of uninsured persons and expand Medicaid to people with incomes up to 133% of the federal poverty level.

• ACA allows states to receive additional federal Medicaid matching funds to get an early start on this expansion.

• A BIG CHANGE – before this change in state law, homeless persons could only get Medicaid if they were poor AND disabled. Now we only have to show that homeless people are poor.

• The additional persons = MN subcontracts with MCOs / Health Plans.
Medicaid Targeted Case Management Services

• Hearth Connection & TCM
• We use TCM services to pull down federal Medicaid
• Minnesota allows MH-TCM – requires 50% local match
• Examples:
  – $1,000/month/participant service cost
    • $800 TCM (50% local match - $400 State funds)
    • $200 State LTH services funding
Managed Care Option – Minnesota Health Plans
New Opportunities....
Enrollment of Medicaid Members - MCOs

- Minnesota uses managed care organizations to finance and deliver health care to Medicaid members.
- Medicaid members enrolled (can opt out) of MCO coverage – expansion = large influx new members.
- MN contracts with Health Plan – capitated rate – incentive to decrease hospitalization.

- Hearth Connection’s pitch – PSH cheaper than continued frequent use of ED’s and hospital care!
MEDICA SUPPORTIVE HOUSING

• This initiative will offer participants supportive housing designed to achieve housing stability, improved well-being, and decreased reliance on emergency and inpatient medical care.

• 85 individuals in the Twin Cities

• 5 individuals in Duluth
Frequent Health Care Users & Long-term Homeless

- Very low-income;
- Have a chronic health condition that require restorative, palliative and curative interventions in community-based settings; (CD/MI/)
- Are long-term homeless;
- Are high utilizers (frequent users) of crisis health care or treatment centers;
- Are either single adults, parents with children, or unaccompanied homeless youth; and
- Are individuals who require support to maintain stable housing and achieve health or functional recovery.
Permanent Supportive Services Model

Essential components of this service approach are:

- Intensive Case Management
- Housing First
- Harm Reduction
- Trauma-Informed Services
- Mobile Collaborative Teams

DISTINCT from Health Plans delivery of CARE COORDINATION Services.
 ROLE: Hearth Connection

- Securing and distributing funding for services;
- Securing and distributing funding for rental assistance;
- Offering financial oversight;
- Programmatic administration of the project;
- Implementing orientation and training;
- Maintaining Co-Pilot database;
- Collecting and analyzing data;
- Ensuring fidelity to service model (audits)
ROLE: Community Service Agency

• Offer participants intensive case management services (comprehensive, wrap-around);
• Partner with participants to achieve results in rapid access to affordable housing; improved well-being; and lower utilization of crisis, emergency health treatment;
• Commitment to the collection and entry of data;
• Fidelity to Hearth Connection's service model
ROLE: Medica Health Plan

- Identify potential participants from health plan members (algorithm);
- Deliver Care Coordination Services;
- Share data on participants regarding utilization of health systems/care;
- Provide data analysis and research (outcome measures);
- PURCHASE SERVICES – pay for services and project operational costs.
PROJECT GOALS – Medica Supportive Housing

• Achieve housing stability (end Homelessness)
• Improve individual health and well-being
• Improve access to preventative and primary health care services – decrease reliance on crisis and emergency care, and hospitalizations
• Decrease health care cost of participants (frequent users)

• Research and data analysis staff dedicated by Hearth Connection and Medica Health Plan.
• 3 year initiative.
Contact Information

Hearth Connection

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Break
Dialogue and Discussion