



Integrated Care for the Chronically Homeless

Houston, TX | January 2016



INITIATIVE OVERVIEW

- ◆ The Houston Integrated Care for the Chronically Homeless Initiative was born out of the [Texas 1115 Medicaid Waiver](#) program and the City of Houston Health and Human Services Department. The 1115 Waiver incentivized the development of innovative care delivery models and created new funding pools to ensure providers are reimbursed for providing quality care to vulnerable individuals. The new care delivery models are designed to meet the goals of improved access, increased coordination of care, improved health status, and reduced costs.
- ◆ Healthcare for the Homeless - Houston (HHH) was chosen as one of the lead Health Centers for the Houston Integrated Care for the Chronically Homeless initiative, which is a joint effort between the health and affordable housing sectors. HHH provides on-site wrap-around services in partnership with SEARCH Homeless Services (homeless service provider in the Greater Houston community), which provides clinical case management, and New Hope Housing, Inc. providing high-quality permanent, affordable housing.
- ◆ This program targets individuals who are experiencing chronic homelessness and have a minimum of 3 emergency department visits over two years with the goal to improve health status, quality of care, and housing stability for these individuals.
- ◆ So far, the participants have shown improvement in health functioning and depression scores, and a reduction in emergency department (ED) use and unnecessary hospitalizations.
- ◆ Challenges: As with any new program, there were some challenges implementing the program including learning to work across sectors and adjusting operational processes. With investment and flexibility, these issues were addressed and the program was strengthened.
- ◆ Opportunities: A supportive community infrastructure that encourages collaboration, experiences working with vulnerable populations, and opportunities that came out of health reform, such as the 1115 Medicaid Waiver, encouraged the development of this program.

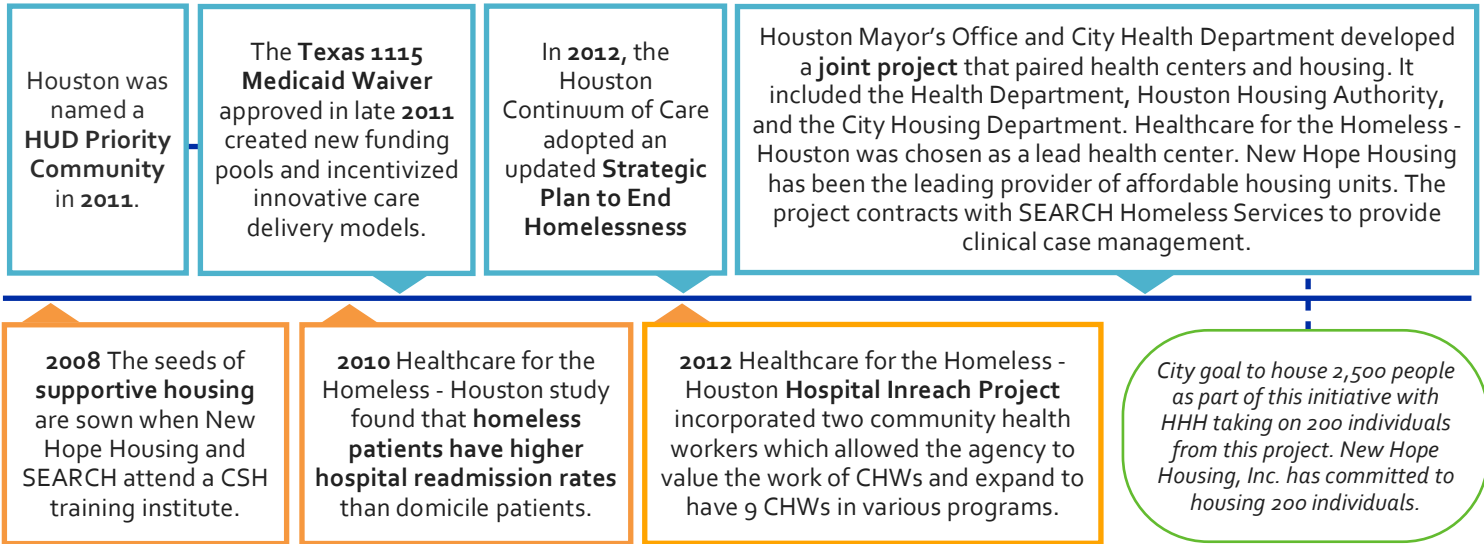
KEY FEATURES & INNOVATIONS

- ◆ **Team Approach:** A multidisciplinary care team is assembled to provide holistic services to the individuals. This team includes primary care providers, behavioral health providers, clinical case managers, medical case managers, community health workers, housing providers, and government agencies providing oversight.
- ◆ **Team Meetings:** The interdisciplinary team comes together five days a week to discuss consumer needs and work through any potential ways to address these needs.
- ◆ **Community Health Workers (CHW):** CHWs play a major role in supporting the individual with the logistical aspects of managing their physical health, behavioral health, and social needs. They may go to appointments, coordinate the logistics of care, and reinforce treatment adherence.
- ◆ **Community Collaboration:** The Houston community has created a highly collaborative system that shows investment beyond integration of care. Partners from different sectors work closely to overcome barriers and create a strategy that will best serve the consumer.
- ◆ **Connection to Housing:** Clinical case managers help individuals through the prioritization process to receive housing. Their approach emphasizes the role of housing in stabilizing health care.
- ◆ **Housing Vouchers & Rental Subsidies:** The local Continuum of Care and Housing Authority prioritized initiative participants for project based housing vouchers. Rental subsidies are provided through the Houston Housing Authority.

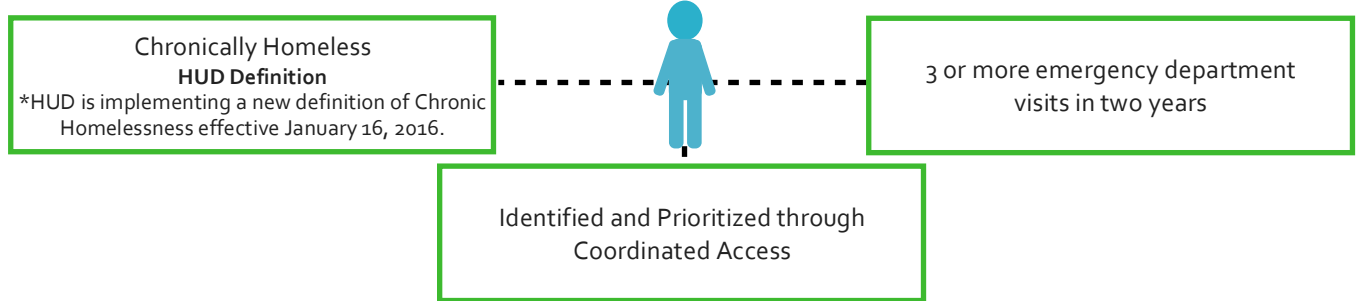
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INITIATIVE DETAILS

History

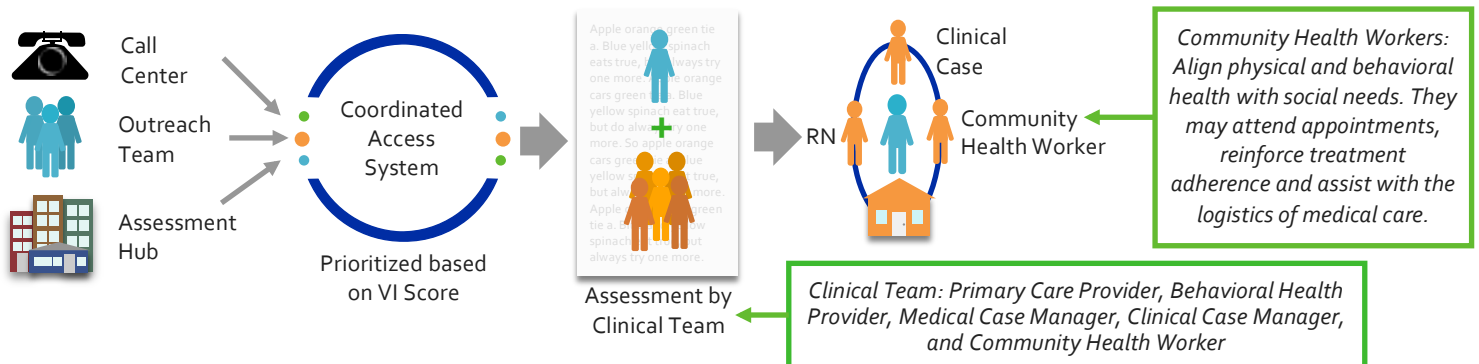


Target Population



Approach

Participants are identified through Houston's Coordinated Access process. They enter this system by completing the Vulnerability Index (VI) assessment at one of the designated assessment hubs, the call in center, or during an interaction with an outreach team. Individuals who are eligible are prioritized for the program based on their vulnerability and need. Individuals are then referred to the health center for an assessment by the clinical team. Healthcare for the Homeless - Houston (HHH) purchased their electronic health record through the county public health system, which gives them access to Harris County's health records and allows them to check the number of emergency department (ED) visits for new and established participants. When the individual moves into housing, the health center continues to provide wrap-around services through an on-site care team and offers additional services off-site. The team conducts regular staff meetings - including members of New Hope Housing's resident services and property management team - to discuss health information as well as other clinical and social elements in the individual's life to ensure they receive high-quality care that meets their needs.



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OUTCOMES

Goals: The 1115 Medicaid Waiver Program will serve 2,500 chronically homeless individuals. 200 will be served by this care team.

200 chronically homeless individuals will be placed into supportive housing and connected to integrated care team with providers from HHH, SEARCH Homeless Services, and New Hope Housing, Inc. to achieve the following goals:

Reduction in non-essential ED visits and hospital stays

Improved Health Status as measured by the SF-63 and PHQ-9

Stabilization in Housing

Increased Supportive Services and Program Participation

Quality Improvement

Increased income through SSI/SSDI, Outreach, Access & Recovery trained CHWs

Housing Retention

Improved Quality of Life

Outcomes

ED Use

While there is an expected increase in appropriate ED visits and hospitalizations (medically necessary visits) as health conditions are stabilized, there is a noticeable **decrease in inappropriate (non-emergency) ED use.**

SF-36

At the end of the first year, participants showed a **meaningful difference in health functional status on both physical and mental health**, with a greater improvement in mental health status.

PHQ-9

Within one year of program start-up, participants are showing **clinically significant response in overall depression scores** as measured by the PHQ-9.

For information on available screening tools, visit the [SAMHSA-HRSA Center for Integrated Health Solutions](http://www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf) or download the PHQ-9 at <http://www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf>. For more information on the SF-36, visit http://www.rand.org/health/surveys_tools/mos/mos_core_36item.html.

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CHALLENGES AND OPPORTUNITIES

Challenges

- ◆ **Learning to Understand Each Other:** Health Centers, social service providers, and housing providers all speak different languages and are regulated by different governing bodies, which can add strain to the relationship between providers. In Houston, SEARCH Homeless Services clinical case managers were given access to participant's medical records but there was a steep learning curve to understanding the language and coding. At times, HHH clinical staff felt isolated because their primary focus (primary care) differs from that of the other organizations (case management) and they are accountable to a different set of regulations (state medical laws and [HRSA program requirements](#)), and therefore had different priorities. It takes time, investment, and working as a team to overcome conflicts that may arise by trying to navigate the different systems to achieve the overall goal.
- ◆ **Chaotic Nature of a Start-up Program:** In a start-up program, such as this one, there is the constant need to reevaluate and sometimes restructure, processes and roles to ensure that the program is as effective as possible. This can be stressful for staff as the program continues to evolve.
 - **Staff Roles:** As the program develops and expands, staff roles may change to meet consumer needs. This program found that CHWs needed to allow more time for logistics, such as scheduling appointments, and a specific focus on health-related matters, including working with participants to prepare for surgery.
 - **Addressing and Adjusting Current Practices:** With the addition of a new program, current practices of participating organizations may have to be updated to better serve a patient population that has different needs. For example, Healthcare for the Homeless - Houston found that they needed to reconsider their clinical model that had previously focused on episodic care through necessity but now has the opportunity to focus on continuity of care.
- ◆ **Expectations and Responsibilities:** Along with learning to understand the language and priorities of each organization, there may be conflicting ideas of what are the responsibilities of each agency. For example, clinical providers and housing providers define case management differently, making it necessary to reconcile what responsibilities will fall on the clinical case manager (brief interventions, housing navigation, and assessments) and what will be the housing provider's responsibility (supplemental housing supports).
- ◆ **Dealing with Increased Number of Crises:** While Healthcare for the Homeless - Houston has always served vulnerable populations, the shift in focus for this project brought with it an increased number of health crises and chronic illnesses. They had to develop processes to handle this change as well as support the staff to prevent burn out.
- ◆ **Technology:** When service providers are working remotely, the networks did not have the capacity to manage additional user traffic. Providers had to have personal technology hotspots at housing sites in order to use their reporting software.

Opportunities

- ◆ **1115 Waiver:** The 1115 Medicaid Waiver in Texas provided an opportunity to develop the collaborative project.
- ◆ **Community Plan:** The development of a community plan to address homelessness provided a backdrop to encourage myriad organizational participation in the program. The Plan also established Permanent Supportive Housing and the Housing First model as a priority and ensure that housing vouchers were available for project participants.
- ◆ **Experience with Other Projects:** Healthcare for the Homeless - Houston's experience with another program targeting chronically homeless individuals exiting the criminal justice system with a mental health diagnosis allowed them a basis for program development and helped to inform staff experiences.



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INITIATIVE PARTNERS

Health Center: Healthcare for the Homeless - Houston (HHH)

Roles:

- ◆ On-site Primary Care
- ◆ Motivational Interviewing
- ◆ Brief Interventions including Cognitive Behavioral Therapy
- ◆ Group Therapy
- ◆ Primary Care Behavioral Health Consultation located at the Health Center
 - The Health Center has achieved level 6 integration through the ability to add Behavioral Health Consultants.
- ◆ Substance Use and Behavioral Health Counseling available at the Health Center
- ◆ Community Health Workers to assist the consumer in managing their health needs.

Homeless Services Provider: SEARCH Homeless Services

Roles:

- ◆ Clinical Case Management including more in-depth Motivational Interviewing and Cognitive Behavioral Therapy
- ◆ Work closely with Coordinated Access
- ◆ Assist in navigation between being identified in Coordinated Access as a potential program participant and getting into housing
- ◆ Conduct initial and follow-up assessment in the local Homeless Management Information System (HMIS)
 - Follow-up assessments are completed every six months

Housing Provider: New Hope Housing, Inc.

Roles:

- ◆ Property Management
 - The housing provider has dedicated nearly 450 units of their portfolio to permanent supportive housing.
- ◆ Supplemental supportive services to residents
- ◆ Coordination with service providers
- ◆ Instituted a housing first model

OPERATIONAL EXPERIENCES & LESSONS

- ◆ **Using Assessment Scores:** Staff has been able to use SF-36 and PHQ-9 scores as a teaching moment both on individual and aggregate population levels. In working with consumers, they can use these scores to provide feedback and use them as part of brief intervention, in hopes of improving the score over time. On the population level, staff is able to look at larger changes overall to identify successes and challenges.
- ◆ **Advanced Assessment:** It is easier to assess individuals in the clinic prior to enrolling them into the housing program as to their ability to live independently. In some cases, there have been individuals who have needed a higher level of care than is feasible to provide in supportive housing. This could be a physical health condition that needs supervision to maintain stability. In this case, individuals are connected to a more appropriate housing option that meets their needs through the Continuum of Care.
- ◆ **Acuity of Physical Health Conditions:** The Health Center was surprised by the acuity of the health needs. Based on the literature, they had expected behavioral health needs to spike upon entering housing, but they were not prepared for the acuity of physical health. When the program began, staff felt as though they were moving from crisis to crisis and experienced a death within the first two weeks. They had to adapt to provide the care patients needed and support for their staff.
- ◆ **Organizational Policy Changes:** The housing provider found that by nature of working with a more vulnerable population, they had to address some of their policies. They have a zero tolerance fighting policy for most of their housing units but had to adapt a more tolerant policy to ensure housing stability for program participants. In addition, New Hope Housing adopted a housing first model for this program, allowing individuals who are actively using substances to obtain and remain in housing.
- ◆ **Stepping out of the Organizational Comfort Zone:** The housing provider found that joining in a collaborative partnership required that the organization open up and is vulnerable in order to be part of the larger conversation. They had to move past negative experiences with attempted provider partnerships and work to develop a stronger relationship with new partners.

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FINANCES

Funding Sources

Start-up Funding Opportunities:

The health center was able to employ their first two CHWs through a partnership with the National Health Care for the Homeless Council as part of a **CMS Health Care Innovation Award**.

Current Funding:

1115 Waiver: The Medicaid 1115 Waiver created the Delivery System Reform Incentive Payment (DSRIP). Providers are able to receive DSRIP payments if they participate in an approved innovative care delivery model and meet certain outcome measures.

Medicaid Billing: The health center bills for services that are covered by Medicaid. However, since Texas is a non-expansion state, most services and individuals are not covered.

HRSA Health Center Program Funding: Health Center program base funding is a large portion of the Health Center's overall funding and is used to finance staff and operations.

Housing Vouchers: The Houston Housing Authority prioritized Project Based Housing Vouchers for program participants.

Grants & Private Funding: A portion of case management services were provided through various outside funding sources.

Potential Funding Opportunities:

The health center is in talks with the local **Medicaid Managed Care Organizations (MCOs)** about the possibility of receiving payment for care coordination.

Costs Savings

Cost savings have been observed but are not yet quantifiable as this is the first year of the program.

Program Costs



Roughly **90%** of program costs to the Health Center and SEARCH are for staff time



Remaining 10% includes:
 Staff Training and Education
 Pharmaceuticals
 Transportation
 Supplies
 IT Costs
 Administrative Time
 SF-36 costs

Transportation includes cost for both staff mileage and patient transportation costs.

IT Costs include laptops, hotspots and mobile phones needed to provide care away from the health center.

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All photos depict staff or consumers receiving services from Health Care for the Homeless - Houston, New Hope Housing, Inc. or SEARCH Homeless Services.

ABOUT CSH

CSH transforms how communities use housing solutions to improve the lives of the most vulnerable people. We offer capital, expertise, information and innovation that allow our partners to use supportive housing to achieve stability, strength and success for the people in most need. CSH blends over 20 years of experience and dedication with a practical and entrepreneurial spirit, making us the source for housing solutions. CSH is an industry leader with national influence and deep connections in a growing number of local communities. We are headquartered in New York City with staff stationed in more than 20 locations around the country. Visit csh.org to learn how CSH has and can make a difference where you live.

ABOUT NHCHC

The National Health Care for the Homeless Council is a network of doctors, nurses, social workers, patients, and advocates who share the mission to eliminate homelessness. Since 1986 we have been the leading organization to call for comprehensive health care and secure housing for all. We produce leading research in the field and provide the highest level of training and resources related to care for persons experiencing homelessness. We collaborate with government agencies and private institutions in order to solve complex problems associated with homelessness. Additionally, we provide support to public health centers and Health Care for the Homeless programs in all 50 states. Visit nhhc.org to learn more.

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