What is an Ideal Health System Partner?

A Health System's Journey to Create and Implement a Healthcare for the Homeless Scorecard

Tony Beltran, MBA
VP, Safety Net Transformation, Trinity Health
Carrie Harnish, LMSW
Clinical Director Community Benefit, Trinity Health
Micalah Webster, LLMSW, MPH Candidate
Social Work Intern, Trinity Health

Agenda

- Who is Trinity Health?
- Why Does HCH Matter to Us?
- Our Journey
- What Did We Gain?
- Open Discussion
  - What Matters to You?

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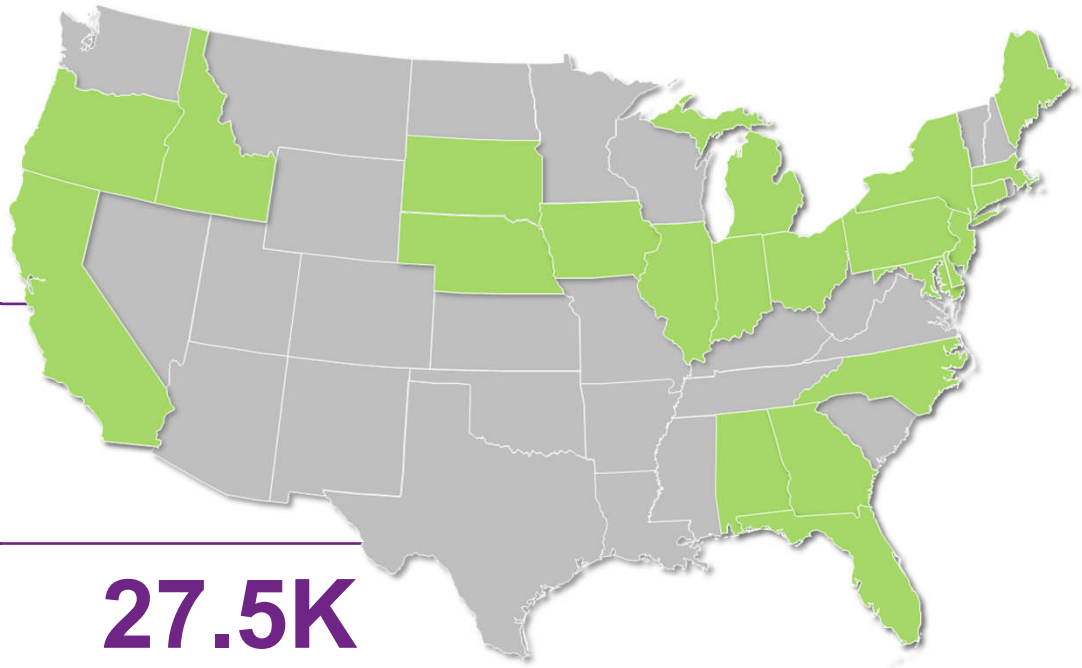
Trinity Health's 22-state diversified system

$18.3B*
In Revenue



1.4M*
Attributed Lives

$1.1B**
Community Benefit Ministry

133K
Colleagues

7.8K
Employed Physicians & Clinicians

27.5K
Affiliated Physicians

94
Hospitals*** in 22 states

23
Clinically Integrated Networks

13
PACE Programs

109
Continuing Care Locations

*Projected FY18
**Year End FY17
***Owned, managed or in JOAs or JVs

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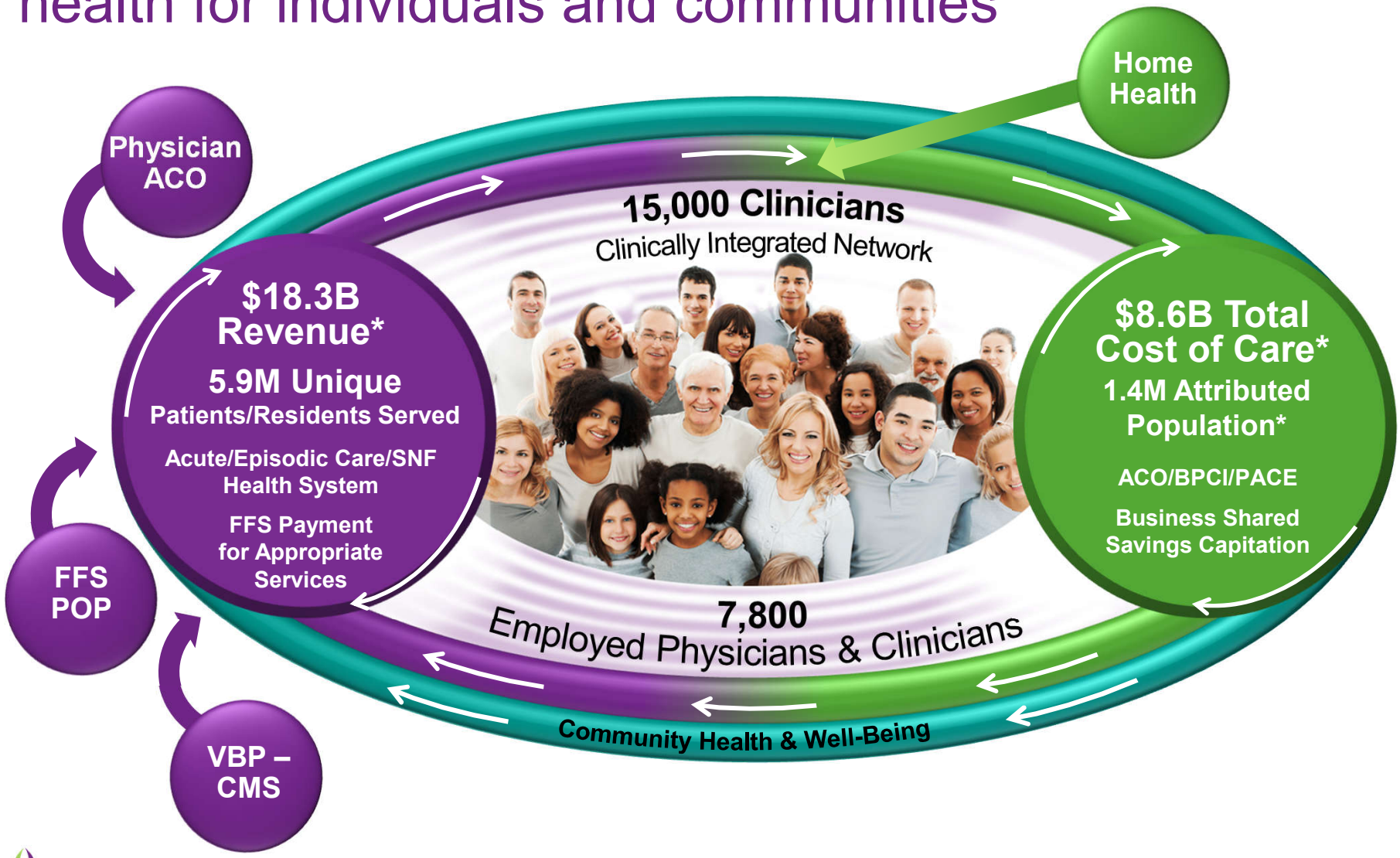
We are transforming into a People-Centered Health System that unites all three components to improve health for individuals and communities



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*Projected FY18

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Why Does Health Care for the Homeless Matter to Trinity Health?

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Our Mission drives our Vision and strategy

We, Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities.

Our Core Values

- Reverence
- Commitment to Those Who are Poor
- Justice
- Stewardship
- Integrity

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Core Values Guides this Work

- Reverence
  - Readmission to hospitals are frequent due to having no stable environment in which to recover and get proper follow-up
- Commitment to Those Who are Poor
  - Coordinated discharge planning with smooth transitions of care and additional wraparound services to vulnerable populations
- Justice
  - Improved patient outcomes with the right care at the right time for patients sensitive to the unique needs
- Stewardship
  - The way that hospitals receive payment for patients is changing
- Integrity
  - Communities need to maximize limited resources to address social determinants of health & service gaps

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Snapshot of Healthcare Cost

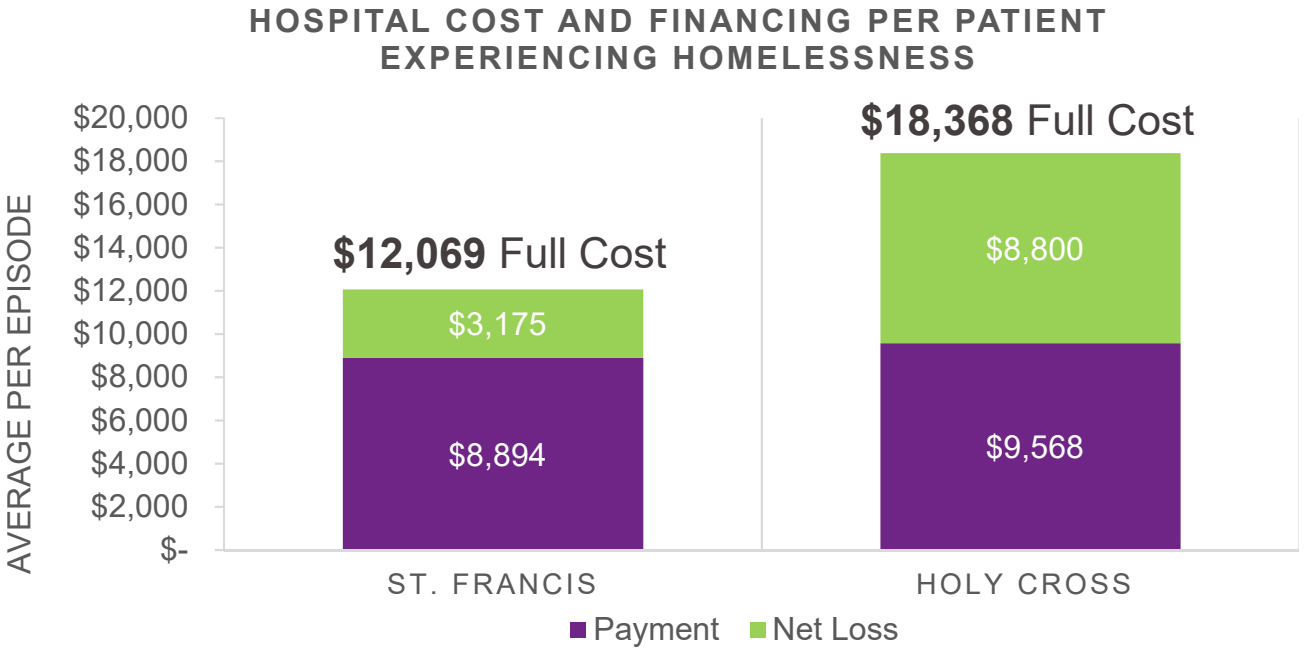
Longer Length of Stay (LOS)

- 2 days longer[1]; nationally LOS is higher than general inpatient[2]

Higher ED Revisit Rates

- 5.7 times higher and readmissions 1.7 times higher than for patients not experiencing homelessness[3]

Higher Ambulatory Costs



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Our Journey

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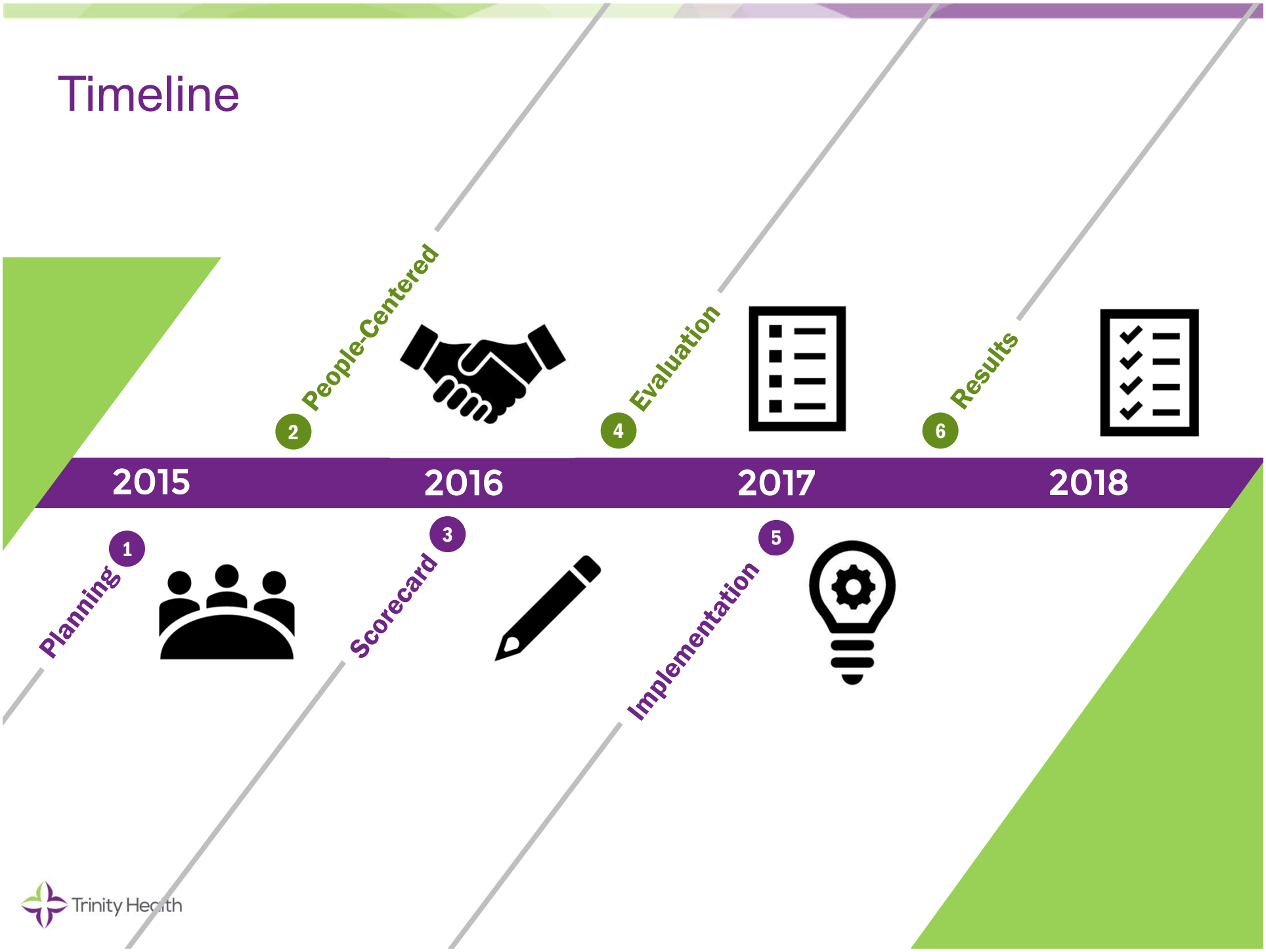
Timeline



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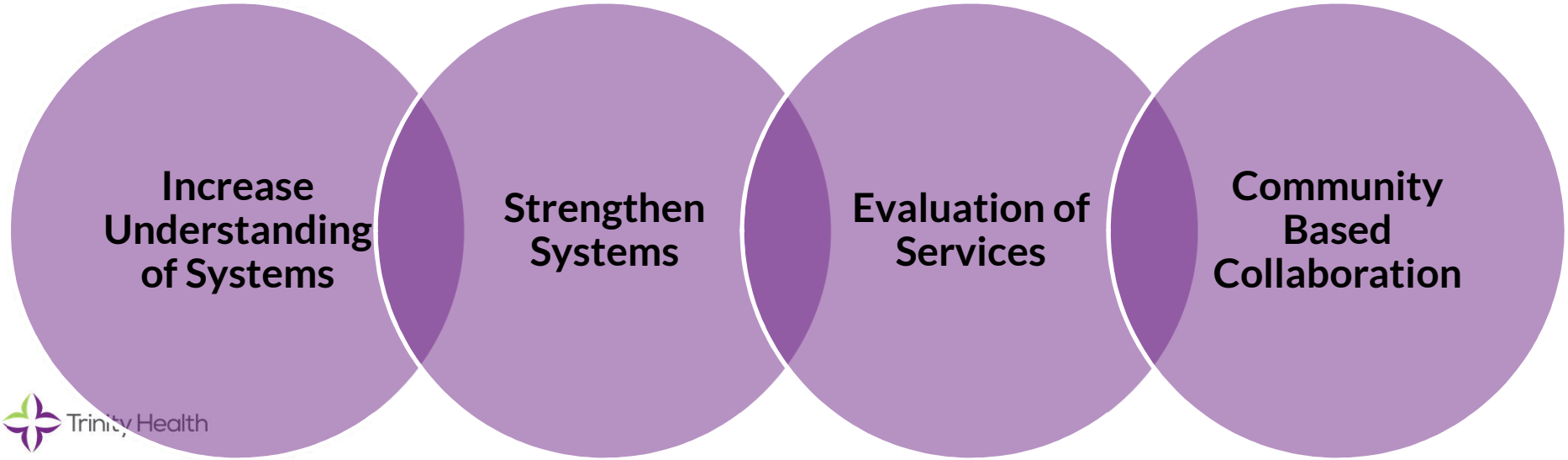
1 Planning

- In 2015, Affinity groups began discussions around medical respite
- In 2016, Trinity Health and National Healthcare for the Homeless Council developed an assessment tool to measure RHMs' work in the area
- Goals of the assessment



2 People-Centered

People-Centered Health System

Episodic Health Care Management for Individuals

Efficient & effective care delivery

Population Health Management

Efficient & effective care management

Community Health & Well-being

Serving those who are poor, other populations, and impacting the social determinants of health

Better Health • Better Care • Lower Costs

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Eight Measures Aligned with Trinity Health Framework

Episodic Health Care Management for Individuals
1. RHM screens all patients for housing instability and records status in EHRs
2. RHM provides or supports outpatient services that are accessible to persons without homes, considering location, hours and costs
3. RHM collaborates with internal and external parties to coordinate care for persons without homes
Population Health Management
4. RHM develops, shares and analyzes data on population health with providers such as community health centers, HCH programs, other safety net providers
5. RHM identifies and addresses insufficiencies and gaps in care for persons without homes
Community Health and Well-being
6. RHM participates in provider networks that serve the homeless population
7. RHM works to remedy adverse social determinants of health
8. RHM directs community benefit funds to benefit those without homes or at risk of homelessness

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3 Scorecard

- In FY17, it was added to the CHWB GPA which serves as the baseline year
  - Some added more narrative content than others
- An Excellent to one might not be an Excellent to another
- To identify areas of growth for each RHM, as well as system wide.
- Within the 21 scorecards there **were 91 different activities** reported for how an RHM met the demands of each question.

Scorecard Example

6. RHM participates in provider networks that serve the homeless population		
Excellent	**Proficient**	**Developing**
RHM meets the 3 activities	RHM is developing capacity within the 3 activities or able to do at least 1	RHM is unable to perform any of the 3 activities

Possible Activities:

- Belongs to Health Management Organizations or Accountable Care Organizations that include safety net providers
- Develops formal referral arrangements with providers of care that target persons without homes; RHMs whose service areas include Federally Qualified Health Centers with Health Care for the Homeless [Public Health Service Act Section 330(h)] funding must demonstrate contractual arrangements providing for bi-directional referrals
- Utilizes Community Health Workers to assist patients with navigating support systems and to assist the RHM in understanding the available supports

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3 Scorecard Examples of Responses

Accessible Outpatient Services

RHM 1= 61% **VS.** **RHM 2= 8%**

One of the Region's largest multi-specialty physician groups with more than 350 physicians and advanced practitioners, in more than **80 practice locations, representing more than 20 specialties including**: primary care, internal medicine, pediatrics, cardiology, endocrinology, oncology and urgent care. **Our clinics are accessible** to all members of the community and several are located within our most vulnerable neighborhoods. **Most types of health insurance are accepted** as well as our own **Financial Assistance Program** for patients having trouble paying for their medical bills. In FY17, P**rovided funds to the Interfaith Partnership** for the Homeless to **purchase a van** for the newly **formed Medical Respite Program** of the Homeless. Additionally, **donations of food, clothing, and other goods** have been donated by us and staff to area homeless shelters through clothing and food drives.

Our outpatient health centers and RHM2 Hospital and Health Center are all **located along public transportation lines**. All outpatient facilities are accessible by two or more bus lines.

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3 Scorecard Revisions

Location	Qualitative Analysis Total (max=77)	Individual Scorecard Total (max=24)
A	47	24
B	37	24
C	49	23
D	40	23
E	36	23
F	30	22
G	35	21
H	26	20
I	32	18
J	32	18
K	31	18
L	28	18
M	28	18
N	28	18
O	34	17
P	31	17
Q	31	17
R	31	17
S	23	17
T	21	17
U	16	15
V	18	14
W	16	13

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4 Evaluation

- Tier 3
  - Demonstrates a level of mastery placing RHM as a leader in that domain.
- Tier 2
  - Demonstrates a level of involvement indicating quality initiatives, activities, and engagement with additional room for improvement.
- Tier 1
  - Demonstrates a significant need for improvement and an increase in initiatives, activities, and engagement.

Tier #	Accessible Outpatient		Collabration for CC		Addressing Gaps in Care	
Tier 3	10+ pts	≥70%	11+ pts	≥71%	7+ pts	≥70%
Tier 2	6-9 pts	40%≤pts<70%	8-10 pts	50%≤pts<71%	4-6 pts	40%≤pts<70%
Tier 1	5 pts	<40%	7 pts	<50%	3 pts	<40%
	14 pts= Total		15 pts= Total		10 pts=Total	

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4 Evaluation

Location	Accessible Outpatient Services	Collaboration for CC	Addressing Gaps in Care
1	57%	40%	50%
2	29%	47%	40%
3	43%	53%	30%
4	43%	40%	10%
5	29%	20%	10%
6	64%	60%	60%
7	43%	40%	40%
8	57%	40%	40%
9	43%	53%	70%
10	29%	53%	10%
11	36%	53%	30%
12	14%	40%	20%
13	7%	47%	40%
14	50%	40%	30%
15	50%	53%	40%
16	43%	53%	20%
17	50%	73%	70%
18	29%	47%	20%
19	50%	80%	20%
20	43%	40%	50%
21	50%	47%	30%
22	50%	60%	40%
23	29%	40%	0%
System Wide	41%	49%	33%
Possible Points per site	14	15	10

Tier #	Accessible Outpatient		Collaboration for CC		Addressing Gaps in Care	
Tier 3	10+ pts	≥70%	11+ pts	≥71%	7+ pts	≥70%
Tier 2	6-9 pts	40%≤pts<70%	8-10 pts	50%≤pts<71%	4-6 pts	40%≤pts<70%
Tier 1	5 pts	<40%	7 pts	<50%	3 pts	<40%
	14 pts= Total		15 pts= Total		10 pts=Total	

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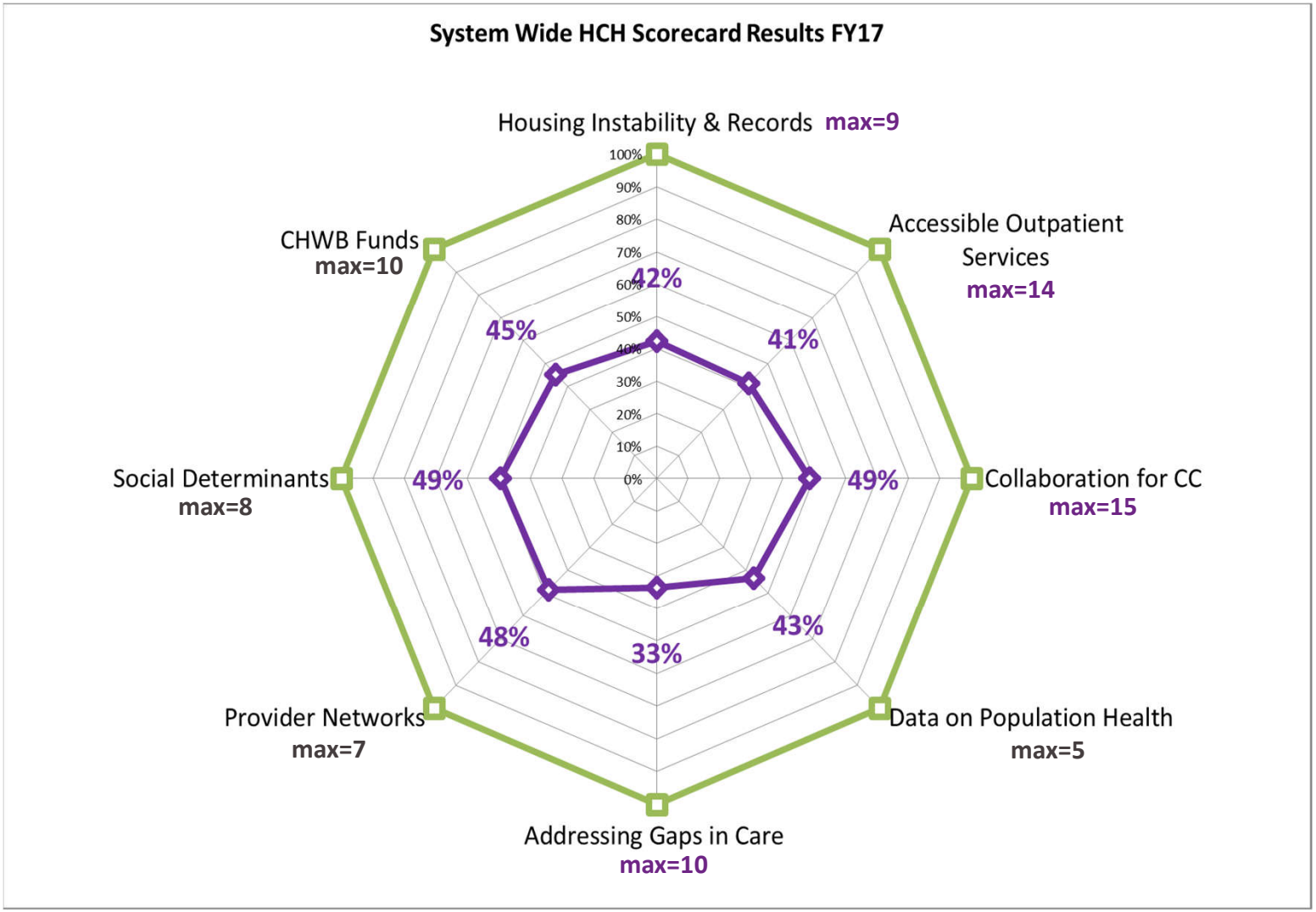
First Year Status System Wide



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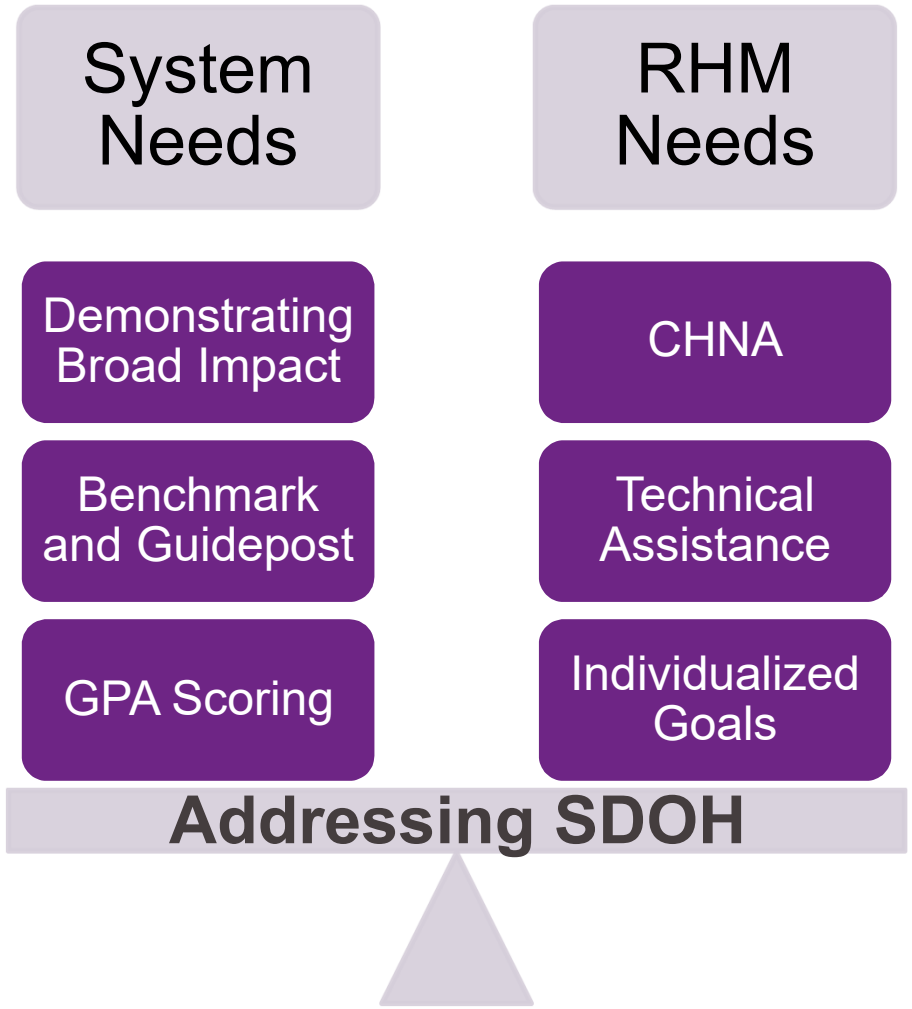
5 Implementation

- Presentation during Community Benefit Ministry Officer Monthly Meeting
- One-on-one calls with each RHM
  - Encouraged RHMs to invite any and all stakeholders to the call
  - Technical Assistance and Goal Setting
    - *What would success look like for you? To your community?*



5 Implementation

FY18 Healthcare for the Homeless Plan

Complete additional activities on the Healthcare for the Homeless Scorecard within the following domains to improve services:

1. One point for an increase of tier for each of these 3 domains:
   - Q2 – Accessible Outpatient Services
   - Q3 – Collaboration
   - Q5 – Gaps in Care
2. RHM participation in training on documentation of housing status. *

Due May 30, 2018

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6 Results

2017

- 4 Priorities identified
  - Documentation
  - Outpatient Services
  - Coordinated Care
  - Gaps in Care

2018

- So far 9 out of 19 RHMs have completed their 2018 Scorecard
- **88% have increased** activities across all 8 domains

2019

- System Office Leadership to take on Housing Instability Documentation
- Presentations by leading RHMS on best practices in the 3 RHM domains
- System-wide training and support by NHCHC for the 3 domains

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What Did We Gain?

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Deliverables

- Standardization
- Unified Direction
- Accountability
- Continuous Growth

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RHM Reports

- Letter of Support from leadership
  - In response to the ask for support in advocating for HCH initiative implementation
  - For local leaders, community partners, and internal stakeholders
- Digestible “check-list”

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July 26, 2017

People experiencing homelessness have high burdens of illness and injury accompanied by a level of need that can require a great deal of hospital resources. In utilizing these resources, the root causes may not be addressed, leading those experiencing homelessness to frequently seek out hospital services without meeting their true needs. To understand and encourage Ministry involvement in identifying and addressing the needs of this population, please find herein your local **Healthcare for the Homeless (HCH)** analysis.

Your HCH analysis is based on the scorecard responses your Community Health & Well-Being team provided over this past year that addressed local housing instability and other social determinants of health. The scorecard allowed Ministries to assess their current effort working with this population, identify areas where Ministry activities can improve, and where Trinity Health, as a system, can collectively grow.

Within each question, narratives were collected describing levels of activity, involvement, and engagement with those without homes or at risk of experiencing homelessness. These narratives underwent a qualitative analysis to help identify themes, patterns and best practices.

Your HCH analysis is provided to aid in:

1. Developing initiatives moving forward.
2. Assisting each Ministry in supporting the dignity, healing, and safety of all.
3. Collaborating with local leaders and using the information to collaborate with those in the community.
4. Exploring new opportunities and forms of engagement.
5. Facilitating connections to other Ministries who are excelling in domains you're interested in exploring. Please contact Carrie Harnish to make those links.

For FY18, the HCH initiatives that your Ministry engages in will be used to generate and drive our collective system goals, as we work together to build on this work for the future.

Trinity Health’s Vision is to become the national leader in improving the health of our communities and each person we serve. Within this Vision we stay true to our commitment to serving those who are poor and those who are most vulnerable—excluding none. Prioritizing the health and well-being of those experiencing homelessness in our communities will enable us to do precisely this.

Thank you for your collaboration. From those of us at Community Health & Well-Being at System Office, we stand with our Ministries in making this Vision a reality.

Sincerely,

Antonio Beltran,
VP. Safety Net Transformation
Interim SVP Safety Net Transformation, Community Benefit, Health and Well Being
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RHM Reports


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HCH Analysis
Regional Health Ministry
Q1: Housing Instability & Records 75% =6/8 pts
Assessment Procedure in Place
Part of Admissions Process
Part of Discharge Process
Referral to Social Services
Training Staff on How to Inquire
Working on Inquiry Tools
Unit Inconsistencies
Records Housing Status in EMR
Records Housing Status in a Different Care Database (e.g. social work database)
Asks for Address-Documentation of Housing Status
Asks for Address-No Documentation of Housing Status
No Formal Process
Q2: Accessible Outpatient Services 64% =9/14 pts Tier 2
Care Manager or Care Navigator Use
Operates in an Accessible Location
Street Outreach and/or Education
Supports Dental Care
Supports Housing First Model Financially
Supports Housing First Model w/ Staff
Staff Engagement in Meal Serving Externally
Staff Engagement in Meal Serving Internally
Provides Financial Support to Community Clinics or Service Agencies
Provides Clinical Services to Shelters, Clinics, or Soup Kitchens
Provides and/or Funds Staff to Community Clinics or Service Agencies
Accepts Referrals from Community Clinics or Service Agencies
Provides Goods to Patients Internally
Provides Goods to Patients Externally
Financial Support for Patients Internally
Serves Patients in ED
Demonstrated in a different Q#'s narrative
Paired with an "either/or" option for scoring
Noted, but not added into the final score
Identified as FY18 Priority


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HCH Analysis
Regional Health Ministry
Q3: Collaboration for Coordinated Care 60% =9/15 pts Tier 2
Address Needs Upon Admission
Address Needs Upon Discharge
Trauma Informed
Continuing Education (e.g. training)
Post-Acute/Respite Care Coordinated
Coordination for ED
Coordination for Acute Care
Coordination for Inpatient
Conducts Follow Up
External Partnerships with Organizations
Community Outreach/Education
Addressing Specialty Health Concerns (e.g. HIV/AIDS, Cancer)
Coordinates Connections to Community Agencies or Services
Care Manager, Navigator, or Planner (SW, RN, CHW, etc.)
Complex Care Coordination Teams
Q4: Data on Population Health 60% =3/5 pts
Data Analyzed and Used to Inform Interventions
Assess & Record SDOH
Data Shared in EMR Externally Between Providers and/or Orgs
Data Collected Via Visiting Advocate
Case Manager or Discharge Planner Driven Anecdotal Assessment
Closed System Internal Analysis (No Community Partners)
Involved with Homeless Management Information System (HMIS)
Formal Health Information Exchange & Analysis w/ Partners (Non-HMIS)
Potential Future Partnership
Demonstrated in a different Q#'s narrative
Paired with an "either/or" option for scoring
Noted, but not added into the final score
Identified as FY18 Priority

RHM Reports

Trinity Health

HCH Analysis

Regional Health Ministry

Q5: Addressing Gaps in Care 60% =6/10 pts **Tier 2**

- ✓ CHNA Around Homeless Needs
- ___ Conducted Focus Groups
- ✓ Support Medical Respite
- ✓ Coordinated Care with Community Orgs
- ✓ HCH Interdisciplinary Collaboration
- ✓ Identified Homelessness as a Priority
- ___ Financially Supports Clinical Services
- ✓ Financially Supports Community Agencies or Services
- ___ Organizational Member of National Health Care for the Homeless Council
- ___ Supports Expanding Behavioral Health Services (Financially or Otherwise)

Q6: Provider Networks 86% =6/7 pts

- ● ✓ Member of an ACO
- ● ___ Safety Net Provider
- ___ Follow Up Care After Discharge
- ✓ Community-Based Integrated Care/ Collaborative Team
- ✓ Offers Free Medical Care or Services for Those Experiencing Homelessness
- ✓ Utilization of RNs, CHWs, or SWs as Care Navigators
- ✓ Partnership with other Community Services/Agencies
- ● ✓ Partnership with FQHC (formal)
- ● ___ Partnership with FQHC (informal)

✓ Demonstrated in a different Q#'s narrative
● Paired with an "either/or" option for scoring
● Noted, but not added into the final score
Identified as FY18 Priority

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HCH Analysis

Regional Health Ministry

Q7: Social Determinants 75% =6/8 pts

- ✓ Offers Employees Living Wage
- ___ Participates in Consciousness Raising
- ___ Addresses SDOH in Addition to SES
- ✓ Charity Care
- ✓ Financially Supports Projects or Donates to Assessments, or Charities
- ✓ Collaboration with other Community Organizations or Agencies
- ✓ Participates in Homeless Coalition, Commission, or HUD Care Continuum
- ● ___ Mitigates Financial Hardship
- ● ✓ Ensures Medical Costs Do Not Lead to Bankruptcy

Q8: Community Benefit Funds 100% =10/10pts

- ✓ Supports Housing Initiative
- ✓ Funds Medical Respite Care
- ✓ Subsidizes Care
- ✓ Supports and/or Partners with FQHC
- ✓ Donates to Clinics
- ✓ Mobile Medical Van
- ✓ Supports Community Orgs/Agencies
- ✓ Coordinates Referrals
- ✓ Care Management
- ● ___ Partners with Safety Net Hospital or Clinic
- ● ✓ Operates a Safety Net Hospital or Clinic

✓ Demonstrated in a different Q#'s narrative
● Paired with an "either/or" option for scoring
● Noted, but not added into the final score
Identified as FY18 Priority

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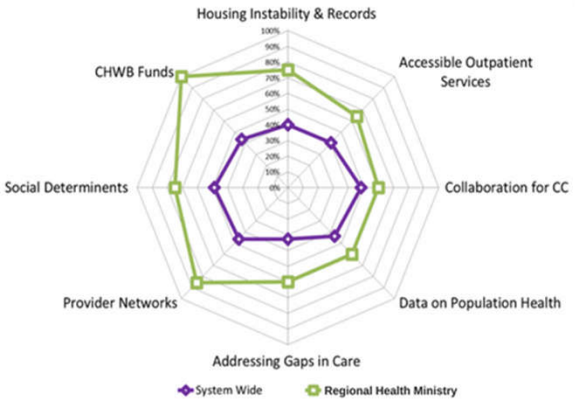
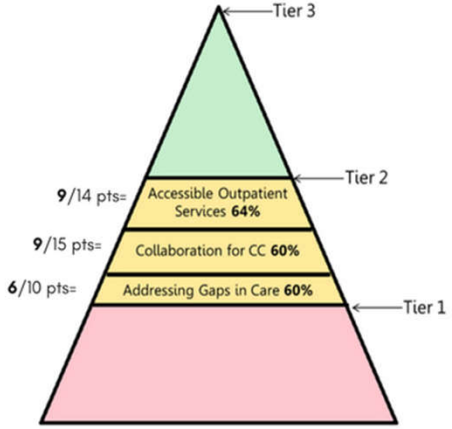
HCH Analysis

Regional Health Ministry

Regional Health Ministry v.s. System Wide Scorecard Performance



FY17 Tier Status



NEXT STEPS

FY18

- Reach out internally to stakeholders.
- Reach out externally to other organizations in your community serving the homeless population.
- Connect with other RHMs and those who have demonstrated mastery in an area you are seeking to improve in.
- Utilize the connections and support that System Office can provide.
- Keep track of your progress and changes.

Tier #	Accessible Outpatient		Collabration for CC		Addressing Gaps in Care	
Tier 3	10+ pts	≥70%	11+ pts	≥71%	7+ pts	≥70%
Tier 2	6-9 pts	40%≤pts<70%	8-10 pts	50%≤pts<71%	4-6 pts	40%≤pts<70%
Tier 1	5 pts	<40%	7 pts	<50%	3 pts	<40%
	14 pts= Total		15 pts= Total		10 pts=Total	

If you have any questions about the information provided in this tool or regarding technical assistance in terms of implementation of HCH initiatives, feel free to contact Carrie Harnish at Carrie.Harnish@trinity-health.org

- RHM Analytics
  - Benchmarking against System Wide performance
  - Scale/Tiers to monitor performance
  - Suggested next steps

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New Reporting Guide

Trinity Health Healthcare for the Homeless Services
Scorecard

People experiencing homelessness have high burdens of illness and injury accompanied by a level of need that can require a great deal of hospital resources. In utilizing these resources, the root causes may not be addressed, leading those experiencing homelessness to frequently seek out hospital services without meeting their true needs. This scorecard allows RHMs to assess their current commitment to this population, and to identify areas where RHMs' activities can be improved.

Eight measures are distributed among the three domains of Trinity's People-Centered Health System: Episodic Health Care Management for Individuals; Population Health Management; and Community Health and Well-being.

The Trinity Health Homeless Services Scorecard will be scored identify the presence of varying forms of RHM engagement in serving those experiencing homelessness. Within this scorecard please provide:

- Narratives highlighting how your RHM practices the goal represented in each item.
- Examples of the activities, forms of engagement, procedures, or processes that you have in place that allow your RHM to achieve the goal.
- Details that speak to the FY17 activities **as well as additional** activities relevant to your RHMs work in serving those experiencing homelessness.

During the analysis of the narratives provided RHMs will receive scores based on the following:

- The maximum points possible per item based on previously identified FY17 activities.
- The total score will add the points for the 8 items together and divide by the total maximum points possible, as well as across all of the 8 items for a percentage.

The **Community Health and Well-Being GPA** will utilize 3 benchmarks upon which evaluation is dependent upon the completion of the Homeless Services Scorecard for assessment, as well as 1 activity. GPA points will be awarded for achieving each of the following:

- One point for an increase of Tier for each of the FY18 Priority domains:
  - Increasing a Tier from FY17 status for Accessible Outpatient Services—1 pt.
  - Increasing a Tier from FY17 status for Collaboration for Coordinated Care—1pt.
  - Increasing a Tier from FY17 status for Addressing Gaps in Care—1pt.
- Participating in training from the National Healthcare for the Homeless Council—1pt.

Submissions can be sent to Carrie Harnish at carrie.harnish@trinity-health.org when ready, with a due date of May 31, 2018.

Episodic Health Care Management for Individuals:

Please describe your RHM's current activities in "Episodic Health Care Management" for people experiencing homelessness by **providing a detailed narrative** report for each item below. For each measure, a list of possible activity activities is provided from the FY17 analysis. If you choose to describe an activity that falls into one of these activities, please check the box next to it. Note that this list is not prescriptive or exhaustive, and that RHM creativity and initiative in going beyond these activities is encouraged. Repeat for the following sections.

There is no limit on the text boxes. Feel free to write as much as you feel is necessary in order to tell your story.

1. RHM screens all patients for housing instability and records status in EHRs

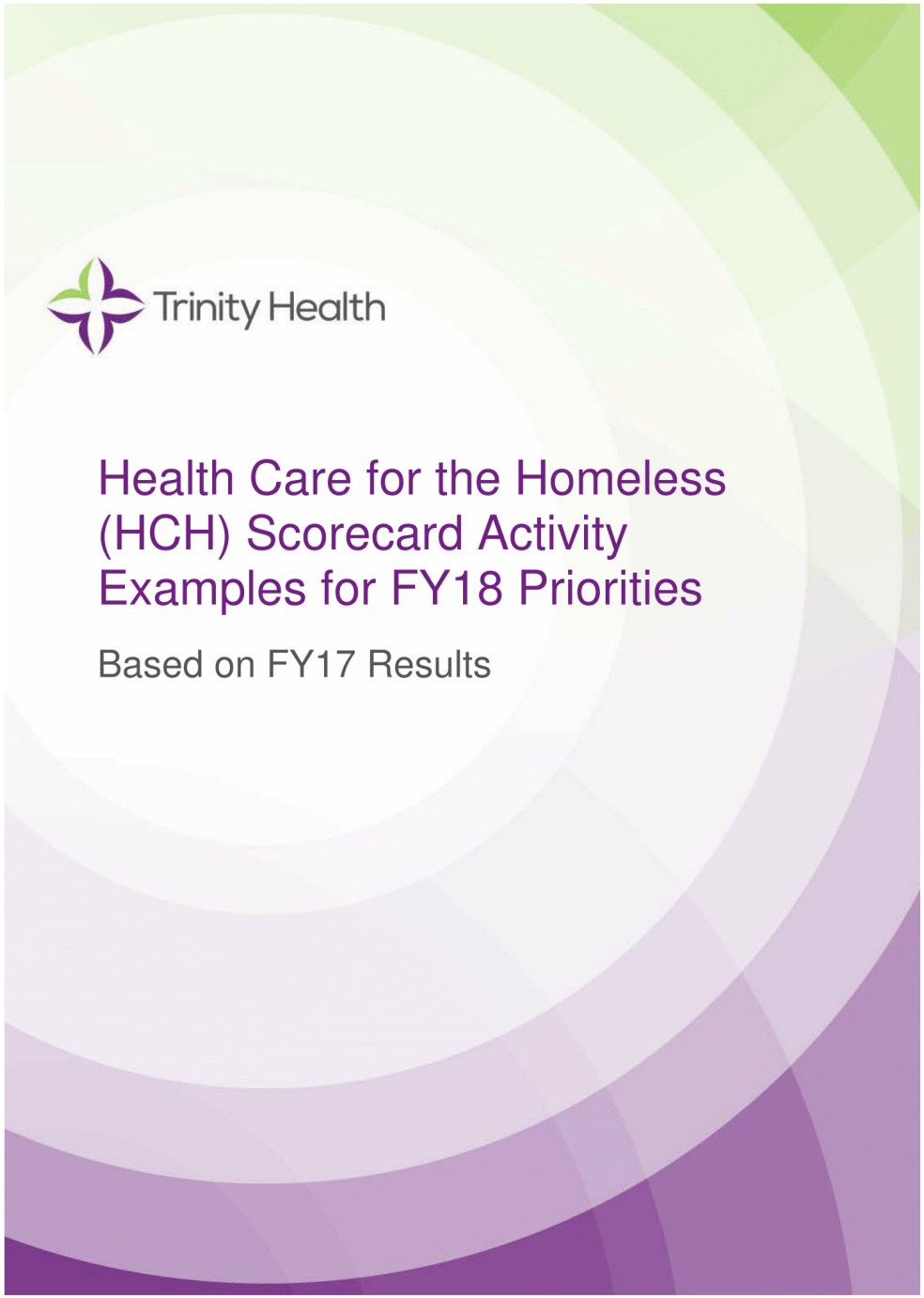
RHM Report: 100 % of the information documented in the registration system of the ER and hospital includes the patient's address and whether or not the patient is homeless. The question reads whether or not the patient is homeless, lives alone or lives with others in a social environment. Our registration team is educated and trained to ask these specific questions as part of their orientation system.

FY17 System Wide Activities:

- [x] Assessment Procedure in Place
- [x] Part of Admissions Process
- [ ] Part of Discharge Process
- [ ] Referral to Social Services
- [x] Trains Staff on How to Inquire
- [ ] Developing/Developed Inquiry Tools
- [ ] Records Housing Status in EMR
- [x] Records Housing Status in a Different Care Database (e.g. social work database)
- [x] Asks for Address in Addition to Documenting Housing Status

Best Practices

- Identified Leading RHMs
  - Breadth and depth of engagement seen in qualitative analysis
- Example Book



Example Book

- Table of Contents
  - Quickly find examples from your peers
  - Foster connections
  - Promote innovation without re-inventing the wheel

Accessible Outpatient Services

Q2: RHM provides or supports outpatient services that are accessible to persons without homes, considering location, hours and cost.

Care Manager or Care Navigator Use

Brief Definition: Utilizing a care, or case, manager or navigator to coordinated outpatient services within the RHM or through community organizations or agencies to work with people experiencing homelessness or housing instability. This can be an RN, SW, CHW, or any other helping professional that is appropriate.

Examples:
-*"Awards a grant…to support a full-time Medical Case Manager, an RN, and a Mental Health Care Manager to serve those diagnosed with a chronic disease and to connect them with long term services".*
-*"Community Health Workers are deployed to work with homeless individuals identified by local service agencies"*
-*"A staff of 18 clinicians and front line case managers service over 2,300 homeless individuals a year in 12,000 encounters in the areas of medical, mental health and case management support."*
-*"Two staff currently are involved with the program, a Program Counselor and a Psychiatric Nurse Practitioner. The Program Counselor works full time for the program. She interfaces with the Salvation Army and Rescue Mission accepting referrals for assessment and follow up care. She schedules weekly appointment times at the Salvation Army's Women Shelter and Emergency Shelter as well as the Rescue Mission. If time is available, she and the NPP also provide services to Vera House, Dorothy Day House and Catholic Charities (agencies which also serve the homeless population). Both staff work with…Inpatient Psychiatric Units as well to connect/reconnect with anyone who is in inpatient care and are known to be homeless."*

Operates in an Accessible Location

Brief Definition: Having hospitals, clinics, or mobile vans accessible to people experiencing homelessness. This can be through being located in particular neighborhoods or areas in need, offering reliable and accessible transportation for people to use in order to reach services, being in a location that is easily walked to, or have any other additional features leading to ease of access. Additional points of accessibility such as flexible or open hours or removal of barriers such as around identification can be discussed here.

Examples:
-*"Operates …in neighborhoods where poverty is most concentrated…These locations are accessible by foot for the immediate neighborhoods served and by bus".*
-*"The clinic is strategically located for easy access for community members in need".*
-*"…Clinic is located in [an area] which has been identified as a primary area for the homeless".*
-*"All 3 of these clinics are operated in our most densely populated city in our service area with a high immigrant population."*
-*"Our clinics are accessible to all members of the community and several are located within our most vulnerable neighborhoods."*
-*"located…near…a Federally Qualified Health Center. Emergency health services are available through the Mercy ED 24 hours/7 days a week. The SCHC has extended hours for patients in need of routine medical services or chronic health care management. Mercy ED has pre-established appointment (blocked) times available at the SCHC for patients that need a follow-up visit with a primary care physician. "*
-*"…operates seven Mission Clinics in accessible community locations with vulnerable populations (homeless, migrant, undocumented) in diverse, impoverished communities in zip codes demonstrated with the highest need".*
-*"provides outpatient care to homeless individuals. This is inclusive of its primary care physician offices, wound care center, and specialty medical care in geographically dispersed areas throughout the community. …Outreach team provides health services at (2) different homeless social service sites, and a (3rd) church-based location. In addition, a Mobile Unit provides access to screening services and special community based events such as a Homeless Foot Clinic are held throughout the year. These combined services provide access to our homeless population throughout the week; Saturdays, and events are often held on Sundays. [Our] County has a large geographic footprint and [Our RHM] has grown to meet the needs of its community. It strategically locates itself in high density areas making access convenient."*

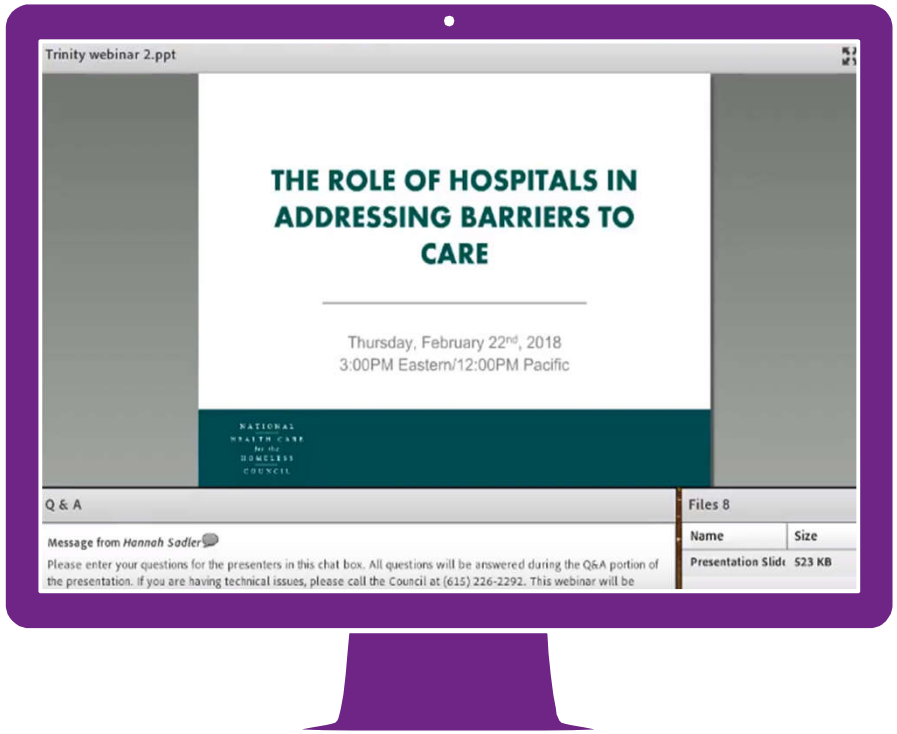
Street Outreach and/or Education

Brief Definition: Offering financial support to enable local partners to engage in mobile clinics, visiting advocates such as Community Health Workers going to social service agencies, churches, or other sites in the area where those experiencing homelessness may congregate; or offering education to those experiencing homelessness around health related or other need based information. Alternatively, the RHM itself offers the above types of activities or staff members lending their time to collaborate with external partners to do so.

Examples:
-*"Provide funds…to purchase a van for the newly formed Medical Respite Program of the Homeless".*
-*"Provides street outreach to engage and treat persons without homes, in rural communities, with multiethnic backgrounds, or persons with limited resources who may be affect by Social Determinants of Health."*
-*"Mobile clinic provides services to people who are 'housing insecure' (multiple families living in one home)".*
-*"Outreach RN is deployed to serve at designated locations where homeless individuals congregate".*

Best Practice Webinars

- Webinar Presentations from leading RHMs
  - Accessible Outpatient Services
  - Collaboration for Coordinated Care
  - Addressing Gaps in Care
- Integrating NHCHC Recommendations
  - NHCHC Webinar
- Built for Zero
- Illumination Foundation
- Technology to identify housing status utilizing data



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Social Determinants of Health

- More than just a homeless issue
  - System failures and gaps in care
- How these changes impact many vulnerable populations
  - Trauma informed care
  - Stronger relationships with community organizations and agencies
  - Complex Care teams
  - Utilization of CHWs
  - Providing oral health and dental resources
  - Continuing education and training off staff around inquiry for obtaining sensitive information

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Above All This Is…

- A **tool** to help us be a better community partner in addressing housing instability and other SDOH
- To see where everyone is at
- To provide options and ideas
- To spark connections between RHMs and within their communities

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Considerations When Partnering with a Hospital System

- Align with their mission & core values
- Understand their financial drivers
- Integrate with their Strategy
- Build upon existing frameworks and partnerships
- Consider Fit
  - What works for one group, population, community, or organization might not work for you.
- Just start somewhere

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Open Discussion

What Matters to You?

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Discussion

- What has been helpful when interacting with a healthcare system?
- What has not been helpful?
- What matters to you? What matters to them? How can we find common ground?
- How have you sought to align your priorities?

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Tony Beltran, MBA
VP, Safety Net Transformation
Trinity Health

Antonio.Beltran@Trinity-Health.org
W 734-343-1862
C 312-823-2872
20555 Victor Parkway
Livonia, MI 48152

Carrie Harnish, LMSW
Clinical Director Community Health & Well-Being
Trinity Health

carrie.harnish@trinity-health.org
W 734-343-1410
C 313-590-5267
20555 Victor Parkway
Livonia, MI 48152

Micalah Webster, LLMSW, MPH Candidate
Social Work Intern
Trinity Health

mmwebste@umich.edu
C 734-478-0977
20555 Victor Parkway
Livonia, MI 48152

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