NORTHERN CALIFORNIA/CENTRAL VALLEY HOMELESS ROUNDTABLE

WEST SACRAMENTO COMMUNITY CENTER
THURSDAY, SEPTEMBER 29, 2016 | 9:00 AM – 3:00 PM

THEME: **Housing and Health Care**

9:00 a.m.	**Gathering and Networking**
9:30	**Welcome & Introductions**
10:00	**Action Planning on Housing & Health Care**
	• Gillian Morshedi, HomeBase
11:10	**Break**
11:25	**CoC NOFA Lessons Learned – Planning for Next Year**
11:45	**CoC Roll Call**
12:15	**Lunch**
1:15	**Announcements, Funding Roundtable**
1:20	**HUD Updates**
1:30	**Legislative and Budget Updates and Actions**
	• Federal Updates: HomeBase
	• State Updates: Joe Boniwell, Housing California
2:00	**Sharing Data with Health-Care Stakeholders**
3:00	**Adjourn**

Northern California/Central Valley Homeless Roundtable History

(If no location is noted, the meeting was held in Sacramento/West Sacramento)

- **How to Develop Local Homeless Policy,** hosted by Placer Consortium on Homelessness and Affordable Housing (PCOH), in Roseville, CA, on April 29, 2004
- **The Housing First Model,** hosted by Yolo County Homeless Coalition, in Woodland, CA, on July 29, 2004
- **Discharge Planning to Prevent Homelessness**, hosted by Sacramento County & Cities Board on Homelessness, in Sacramento, CA, on Oct. 26, 2004
- **Local Corrections Systems,** hosted by HUD Sacramento Field Office and California HCD, in Sacramento, CA, on Feb. 24, 2005
- **Housing First Model, 10 Year Plans, Prop 63,** hosted by Butte CoC, in Oroville, CA, on May 5, 2005
- **Homeless Counts; Engaging Law Enforcement,** Merced Continuum of Care Collaborative, in Merced, CA, on July 28, 2005
- **Interacting with Media, MHSA, Medical Care,** hosted by City of Redding & Shasta CoC, in Redding CA, on Oct. 21, 2005
- **Advocacy Issues; Paul Boden & Megan Schatz,** hosted by Stanislaus Housing and Supportive Services Collaborative, in Modesto, CA, on Feb. 23, 2006
- **HMIS Best Practices & Input on 10 Year Plan,** hosted by San Joaquin Continuum of Care, in Stockton, CA, on July 27, 2006
- **Role & Enhancement of Roundtable Infrastructure,** Planning Committee Retreat, in Sacramento, CA, on Aug. 24, 2006
- **Housing Models & Their Application in Member CoC,** hosted by Kings/Tulare CoC, in Visalia, CA, on Oct. 19, 2006
- **10-Year Strategic Planning, Extreme Weather Preparedness,** hosted by Yolo County Homeless Coalition on Feb. 15, 2007
- **Continuum Improvement & Development**, hosted by Chico/Paradise/Butte Continuum of Care on May 17, 2007
- **Advocacy; Federal, State & Local Levels,** hosted by Fresno-Madera Continuum of Care on Aug. 16, 2007
- **Hospital Discharge Planning,** hosted by Redding/Shasta County Continuum of Care Council, in Redding, CA, on Nov. 15, 2007
- **SSI Advocacy,** hosted by HUD Sacramento Field Office, California HCD and HomeBase on Feb. 21, 2008
- **Housing Development 101: Focus on PSH**, hosted by Central Sierra CoC, in Jackson, CA, on May, 22, 2008
- **RRH for Families, Housing Operations 101,** hosted by HUD Sacramento Field Office, via Conference Call, on Aug. 28, 2008
- **Project Homeless Connect, Homeless Count,** hosted by Sacramento CoC on Dec. 4, 2008
- **Homeless Programs: Surviving and Thriving,** hosted by Yolo County Housing and Poverty Action Coalition on Feb. 26, 2009
- **How Do We Capitalize on What's Happening Now?,** hosted by Fresno-Madera CoC, in Fresno, CA, on May 28, 2009
- **HMIS Data Standards,** hosted by Roundtable Planning Committee, via Conference Call, on Aug. 27, 2009.
- **Regional Coordination**, hosted by Placer County Continuum of Care, on Nov. 19, 2009
- **HEARTH and Foundation Funding** on Feb. 25, 2010
- **Roundtable Retreat** on March 16, 2010
- **HMIS as a Planning Tool** on May 27, 2010
- **Federal Strategic Plans and CoC Coordination with Federal Mainstream Systems of Care** on August 26, 2010
- **Community-wide Performance Measurements** on December 2, 2010
- **Connecting Homeless Persons to Employment** on February 24, 2011
- **Targeting - How do we best match need to service?** on May 26, 2011
- **Food Security, 100,000 Homes, Corrections Realignment, and Healthcare Reform** on August 11, 2011
- **Linking Homeless Veterans to Housing and Services** on November 4, 2011
- **Serving Homeless Youth; Innovations in SSI Advocacy** on February 23, 2012
- **Coordinated/Centralized Assessment; Working with PHAs** on May 24, 2012
- **Interim Continuum of Care Regulations** on August 23, 2012
- ***Opening Doors* Revisited; Bringing Law Enforcement to the Table** on December 6, 2012
- **Implementing 211, Coordinating with ESG** on February 28, 2013
- **Definition of Rural, RHSP regulations** on May 23, 2013
- **Federal agencies responding to Homelessness; Serving vehicularly housed** on August 22, 2013
- **Adapting Transitional Housing; Rural Data; Extreme Weather** on December 5, 2013
- **Emergency Shelters: Increased Use and Decreased Funding** on March 27, 2014
- **Using Medi-Cal for Services in Supportive Housing** on May 22, 2014
- **Then and Now: Homelessness in Our Communities from 2004-2014** on August 28, 2014
- **Homelessness Crisis Response System** on December 4, 2014
- **Promoting Landlord Partnerships to Overcome Housing Attainment Barriers** on February 26, 2015
- **Building Positive Relationships with Law Enforcement** on May 28, 2015
- **Fair Housing & Alternative Housing Models** on September 3, 2015
- **Ending Veteran Homelessness: Progress & Strategies** on December 3, 2015
- **Building CoC Capacity** on February 25, 2016
- **Criminal and Public Records; Data Sharing in Coordinated Entry Environment** on May 26, 2016

Northern California/Central Valley Homeless Roundtable
Acronym List

Acronym	Definition
AB	Assembly Bill
ACA	Affordable Care Act (Obamacare)
ADAP	AIDS Drug Assistance Program
AHAR	Annual Homeless Assessment Report
AI	Analysis of Impediments (to fair housing), a part of Consolidated Plans
AOD	Alcohol and Drug Dependency
APR	Annual Performance Report (for HUD homeless programs)
CA	Collaborative Applicant
CalFresh	California's SNAP (Supplemental Nutrition Assistance Program) (formerly Food Stamps)
CalWORKs	California Work Opportunities and Responsibility to Kids
CBO	Community Based Organization
CDBG	Community Development Block Grant (CPD program – federal)
CDCR	California Department of Corrections and Rehabilitation
CDVA	California Department of Veterans Affairs
CH	Chronically Homeless
CSBG	Community Services Block Grant (Federal program that flows from US Department of Health and Human Services to the California Department of Consumer Services and Development to California counties
CHDO	Community and Housing Development Organization. Non-profit housing provider receiving minimum of 15% of HOME funds
CoC	Continuum of Care approach to assistance to the homeless
Continuum of Care	Federal grant program stressing permanent solutions to homelessness
Con Plan	Consolidated Plan, a locally developed plan for housing assistance and urban development under CDBG and other CPD programs
CPD	Community Planning and Development (HUD Office)
CY	Calendar Year
Davis Bacon	Statutory requirement that persons working on Federal assisted projects be paid at least minimum prevailing wage rates.
DHHS	Department of Health and Human Services (State Office)
DV	Domestic Violence
EHAP	Emergency Housing and Assistance Program Operating Facility Grants (State program. Obsolete.)
EHAPCD	Emergency Housing and Assistance Program Capital Development (State program). Not open to new applications
ESG	Emergency Solutions Grants (CPD – federal program. Flows to entitlement jurisdictions and HCD)
e-SNAPS	Electronic grants application and management system for HUD Homeless Assistance Programs
FESG	Federal Emergency Shelter Grants (obsolete program – replaced by ESG)
FHEO	Fair Housing and Equal Opportunity (HUD Office of)
FMR	Fair Market Rent (maximum rent for many HUD housing programs)
FQHC	Federally Qualified Health Center
FTE	full-time equivalent (employee) (2080 hours of paid employment)
FY	Fiscal Year
GAO	Government Accountability Office
GA/GR	General Assistance/General Relief (county assistance)
HAP	Housing Assistance Payments

Acronym	Definition
HAP	Housing Assistance Plan; Housing Plans required by CDBG
HCD	Housing and Community Development (California Department of)
HCV	Housing Choice Voucher Rental Assistance (formerly Section 8)
HEARTH Act	Homeless Emergency and Rapid Transition to Housing (HEARTH) Act of 2009, S. 896
HIC	Housing Inventory Chart (inventory of housing for the homeless conducted annually in January for same night as the PIT)
HPRP	Homeless Prevention and Rapid Re-Housing Program (obsolete)
HMIS	Homeless Management Information System
HOME	Home Investment Partnerships (CPD program)
HOPWA	Housing Opportunities for Persons with AIDS (CPD program)
HPC	High Performing Community
HQS	Housing Quality Standards (required before move in for HUD programs)
HRSA	Health Resources and Services Administration (division of US HHS)
HUD	U.S. Department of Housing and Urban Development (federal)
HUD-VASH	HUD Vouchers through Veterans' Affairs Supportive Housing
IDIS	Integrated Disbursement and Information System (CPD system)
IHSS	In-Home Supportive Services
LEA	Local Education Agency
LGBTQ	Lesbian, Gay, Bisexual, Transgender, or Questioning
LOCCS	Line of Credit Control System
MHSA	Mental Health Services Act
MOU	Memorandum of Understanding
NAEH	National Alliance to End Homelessness
NAMI	National Alliance on Mental Illness
NIMBY	Not In My Back Yard
NOFA	Notice of Funding Availability
OneCPD	Resource Exchange and email notice system for HUD CDP
PHA/ HA	Public Housing Authority
PIT Count (PITC)	Point-In-Time Homeless Count (unsheltered count conducted biennially, every odd numbered year; sheltered count, every January)
PSH	Permanent Supportive Housing
RFP	Request for Proposals
RFQ	Request for Quotations. Used to solicit price quotes under the simplified acquisition procurement method.
SA	Sexual Assault Or Substance Abuse
SB	Senate Bill
SAMHSA	Substance Abuse & Mental Health Services Administration
S + C	Shelter + Care (obsolete – replaced by CoC Program)
Section 8	Housing Assistance Payment Program (Housing and Community Development Act of 1974)
Section 202	Loans for construction/rehab of housing for the elderly or handicapped
Section 202/811	Programs for housing assistance to the elderly and people with disabilities
SHP	Supportive Housing Program (obsolete – replaced by CoC Program)
SMI	Serious Mental Illness or Seriously Mentally Ill
SNAP	Supplemental Nutrition Assistance Program (formerly Food Stamps)
SNAPS	Special Needs Assistance Program (HUD Division that deals with homelessness)
SOAR	SSI/SSDI Outreach, Access, and Recovery (SSI/SSDI Application program)

Acronym	Definition
SRO	Single-Room Occupancy housing units
SSA	Social Security Administration
SSDI	Social Security Disability Income
SSI	Supplemental Security Income
SSO	Supportive Services Only (Type of CoC grant providing services only)
SSVF	Supportive Services for Veterans Families (but can serve single adults)
TA	Technical Assistance
TANF	Temporary Assistance to Needy Families
TAY	Transition Age Youth
UFA	Unified Funding Agency
USDA	U.S. Department of Agriculture
VA	Veterans Affairs (U.S. Department of)
VASH	Veterans Affairs Supportive Housing

*Thanks to Nevada/Placer CoC for use of their acronym list.


OREGON
Del Norte
Siskiyou
Modoc
Humboldt
Trinity
Shasta
Lassen
Tehama
Plumas
Mendocino
Glenn
Butte
Sierra
Lake
Colusa
Sutter
Yuba
Nevada
Placer
NEVADA
Sonoma
Yolo
El Dorado
Napa
Sacramento
Alpine
Solano
Amador
Marin
Calaveras
Contra Costa
San Joaquin
Tuolumne
Mono
San Francisco
Alameda
Stanislaus
Mariposa
San Mateo
Santa Clara
Merced
Madera
Santa Cruz
San Benito
Fresno
Inyo
Tulare
Monterey
Kings
San Luis Obispo
Kern
San Bernardino
Santa Barbara
Ventura
Los Angeles
Orange
Riverside
San Diego
Imperial
MEXICO
PACIFIC OCEAN
CALIFORNIA'S
58 COUNTIES

NORTHERN CALIFORNIA/CENTRAL VALLEY HOMELESS ROUNDTABLE

ACTION PLANNING ON HOUSING & HEALTH CARE

SEPTEMBER 29, 2016

THE CONNECTION BETWEEN HOUSING AND HEALTH CARE NEEDS

- **Housing is a Key Determinant of Health.** Poor living conditions, caused by poverty and homelessness, affect people's vulnerability to illness and disease, and their abilities to benefit from treatment and manage their conditions. People who are homeless contend with contact with communicable diseases and infections, exposure to extreme weather, malnutrition, stress, lack of running water to maintain cleanliness, and lack of refrigeration for medication.[1]
- **People who are Homeless are at Greater Risk for Poor Health.** They have high rates of infectious and acute illnesses (skin diseases, TB, pneumonia, asthma); chronic diseases (diabetes, hypertension, HIV/AIDS, cardiovascular disease); poor mental health, substance abuse, or both; and being victims of violence. Their mortality rate is 3-4 times higher than for the general population.[2]
- **Health Issues Are Likely to Increase as the Homeless Population Ages.** The number of homeless people in the U.S. between the ages of 51-61 increased 32% from 2007 to 2013.[3] Rates of chronic health conditions and potential for extended stays in nursing homes increase with age.
- **HIV/AIDS is Correlated with Homelessness.** Many domiciled individuals face the threat of homelessness once they or someone in their family becomes infected with HIV/AIDS. Additionally, people experiencing homelessness are at risk of contracting HIV due to the prevalence of high-risk behaviors like injection drug use, unsafe sex, and "survival sex" (i.e., exchanging sex for food, shelter, or money).[4] Studies indicate the prevalence of HIV among homeless people can be as high as 20%.[5]
  - → Lack of housing has been identified as one of the top 5 barriers for HIV+ persons accessing medical care.
  - → The National Alliance to End Homelessness estimates that 3.4% of homeless people are HIV-positive, compared to 0.4% of adults and adolescents in the general population.[6]
  - → 21.7% of HIV+ respondents to a services needs survey indicated they were homeless at some point in the last year. [7]
- **Homelessness Is Correlated with High Health Care Costs.** The high proportion of complex health needs and co-occurring health and behavioral health disorders increases the number, intensity, and

[1] *Social Determinants of Health,* Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services, retrieved March 30, 2015, http://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health.
[2] http://www.cdc.gov/features/homelessness/ and Kaiser Commission on Medicaid and the Uninsured, "Medicaid Coverage and Care for the Homeless Population: Key Lessons to Consider for the 2014 Medicaid Expansion", September 2012, available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8355.pdf
[3] End Chronic Homelessness Policy Academy Team presentation delivered at Washington Legislature Adult Behavioral Health System Task Force Meeting on September 19,2014. For more information, please contact Gillian Morshedi (gillian@homebaseccc.org) at HomeBase.
[4] St. Lawrence, J., Brasfield, T.L. (1995). HIV risk behavior among homeless adults. AIDS Education and Prevention, V. 7, 22-31. Guildford Press: New York.
[5] National Coalition for the Homeless, (2007). HIV/AIDS and homelessness [Online], www.nationalhomeless.org/publications/facts/HIV.pdf
[6] National Coalition for the Homeless, (2007). HIV/AIDS and homelessness [Online], www.nationalhomeless.org/publications/facts/HIV.pdf
[7] Rickles, M. Ryan White Part A Nashville Transitional Grant Area 2015 Needs Assessment. Nashville Regional HIV Planning Council. 2015. nashrpc.com/data

scope of the services needed. Homelessness inhibits the long-term, consistent care needed for many of these conditions, aggravating the problems and making them more dangerous and costly. Homelessness increases the likelihood of excessive use of the emergency room, inpatient treatment, and crisis services.

- → Of 6,601 unique individuals identified as homeless in Contra Costa County, 3,170 also utilized mental health, primary health, or alcohol and drug treatment offered through the Contra Costa Health Services Department for a total of **$45,412,145 in public health costs.**[8]
- → A 2015 study, "Home Not Found: The Cost of Homelessness in Silicon Valley," found that more than **$3 billion** in services went to homeless residents of Santa Clara County over six years, including $**1.9 billion for medical diagnoses and the associated health care services.**[9]
- → In California, the Frequent Users of Health Services Initiative found that approximately **45 percent of individuals who were high utilizers of emergency departments were homeless**.[10]

FOCUS ON "MAINSTREAMING" AT THE FEDERAL LEVEL

The U.S. Department of Housing and Urban Development ("HUD") strongly encourages and incentivizes communities to apply the resources of a broad spectrum of health, education, human, and social services programs to the response to homelessness. This "mainstreaming" approach is also found in the Homeless Emergency and Rapid Transition to Housing (HEARTH) Act of 2009. HUD's study, "Strategies for Improving Homeless People's Access to Mainstream Benefits and Services," found that communities intent on improving access to mainstream services had success reducing structural barriers.[11]

The U.S. Interagency Council on Homelessness (USICH)'s "Opening Doors: Federal Strategic Plan to Prevent and End Homelessness," as amended in 2015, outlines an interagency collaboration that aligns mainstream housing, health, education, and human services to prevent Americans from experiencing homelessness.[12] The Plan emphasizes the full integration of targeted programs with mainstream programs, and calls on all relevant mainstream programs to prioritize housing stability for people experiencing or at risk of homelessness.

[8] Contra Costa Behavioral Health, "Cost of Homelessness: A Snapshot of Healthcare Cost to Homeless Consumers in Contra Costa County," Presented to the Council on Homelessness General Membership Meeting, July 24, 2015.
[9] Economic Roundtable, "Home Not Found: The Cost of Homelessness in Silicon Valley," 2015: 18. http://destinationhomescc.org/wp-content/uploads/2015/05/er_homenotfound_report_6.pdf
[10] Linkins, Brya, & Chandler, 2008, available at: http://www.aidschicago.org/pdf/2009/hhrpn/FUHCS/1-FrequentUsersofHealthServicesInitiative-FinalEvaluation.pdf
[11] Martha Burt, et al, "Strategies for Improving Homeless People's Access to Mainstream Benefits and Services," March 2010, http://www.huduser.org/portal/publications/povsoc/homeless_access.html
[12] U.S. Interagency Council on Homelessness, "Opening Doors: Federal Strategic Plan to End Homelessness," Amended 2015: 29,42. http://usich.gov/resources/uploads/asset_library/USICH_OpeningDoors_Amendment2015_FINAL.pdf.

MODEL STRATEGIES AND CROSS-CUTTING ISSUES

The following are five model strategies to consider in developing a housing-healthcare integration action plan:

1. **Enrollment:** Facilitate Enrollment of People Who Are Homeless and At-Risk in Medicaid and Other Benefit Programs
2. **Access:** Facilitate Access to Care, Engagement with Providers, and Appropriate Use of Health Services
3. **Integration:** Integrate Housing, Health, and Other Services to Facilitate Housing Retention and Ongoing Wellness
4. **Data:** Develop Data-Driven Service Interventions Targeted to Priority Sub-Populations
5. **Medicaid:** Maximize Use of Medicaid to Finance Services that Support Housing Stability, including Permanent Supportive Housing services and Recuperative / Transition Care

Additionally, the following **cross-cutting issues** should be considered as part of implementation planning:

- **Training:** What training will be needed for staff?
- **Partnerships:** What partnerships are needed and how can they be forged?
- **Targeting:** Should particular sub-populations be targeted? If so, how should they be identified?
- **Scale:** What will be needed to bring the strategy to a scale appropriate to meet the need?
- **Systems:** How can individual programmatic efforts be aligned into a unified system working toward shared outcomes?

A detailed framework of model strategies and supporting action steps is available at homebaseccc.org under the Resources tab.

IDEAS COMMUNITIES ARE CURRENTLY EXPLORING NATIONWIDE

Key ideas that have emerged regarding ways to facilitate coordination between housing and health care providers to improve access to health care and other supportive services include:

- Hold regular meetings with housing and health care (and other supportive services) providers, preferably building upon existing forums or coalition meetings. Consider devoting a portion of each meeting to an in-depth conversation about a specific topic (e.g., Coordinated Entry; obligations of Managed Care organizations to serve members) and strategically inviting stakeholders based on the topic. The purpose is to engage in cross-system education, about how systems operate and the needs and incentives of various providers.
- Institute case conferencing for highly vulnerable and/or higher cost clients that have housing, health, and other needs. Case conferences should include representatives from the CoC/housing system as well as health care stakeholders.
- Pilot "Frequent user" programs to identify and target resources to people with housing needs that also have health care (primary and/or behavioral) and other supportive service needs.
- Improve discharge planning protocols at hospitals, jails/prisons, psychiatric institutions. Discharge planning process should begin at point of admission and include a housing aspect/connection to the CoC.
- Develop partnerships between CoC and Federally Qualified Health Centers (FQHCs), including locating FQHC clinics on-site at shelters and/or permanent housing buildings, or having mobile vans visit shelters and outreach to unsheltered people.

- Build relationships between CoCs and managed care organizations, especially Medicaid managed care organizations.
    - CoC agencies can provide assistance with identifying, locating, and connecting "missing" members with MCOs. Possibility of MCO providing "finders" fee to CoC for this assistance.
    - Managed care organizations (or hospitals) may also be willing to fund recuperative care beds to save costs associated with patients staying in inpatient care longer than medically necessary as a result of not having an adequate place to live while finishing treatment.
- Connect health care and supportive service providers that are not part of a HUD-funded CoC system to the appropriate Coordinated Entry System.
    - Formally: e.g., non-CoC providers entering some data into HMIS; CoC agency staff located on-site at hospitals, especially emergency departments
    - Informally: non-CoC providers simply being aware of entry points into Coordinated Entry System and how to connect patients that need housing assistance to those points
- Educate housing/homeless assistance providers about how Medicaid can fund supportive services:
    - What supportive services are covered by California's Medicaid plan?
    - What existing Medicaid providers in the area provide or could provide those services, or would be willing to contract with non-Medicaid providers - such as CoC agencies - to provide those services to Medicaid enrollees?

ADDITIONAL RESOURCES

- Healthcare and Housing Systems Integration Working Tools: available for beta testing and feedback at www.homebaseccc.org under the Resources tab. This suite of resources includes a more detailed version of the Model Strategies and Framework excerpted above.
- HUD's Housing-Healthcare Integration (H^2) website: information about 20 action planning sessions conducted around the United States between December 2014 and May 2016, including emerging action plans, community-specific resource guides, and contact information for those leading the implementation efforts. www.hudexchange.info/programs/aca/h2/
- HUD's Patient Protection and Affordable Care Act website: information and resources relating to the intersection of housing and health care, including webinars, listserv messages, and a guide to key health resources for grantees and sub-recipients of the CoC, ESG, and HOPWA programs. www.hudexchange.info/programs/aca/h2/

NORTHERN CALIFORNIA/CENTRAL VALLEY HOMELESS ROUNDTABLE

WHAT NOW?

SEPTEMBER 29, 2016

WHAT AM I GOING TO DO BEFORE THE NEXT ROUND TABLE?

- ☐ Learn more about the connection between housing and health care and what other communities around the state or country are doing in this area
  - What specifically do I want to explore further?
    - ☐ Background information and evidence supported housing as a determinant of health
    - ☐ Information about specific types of health care stakeholders
    - ☐ Frequent user studies and/or programs
    - ☐ Discharge planning
    - ☐ Involving health care providers in Coordinated Entry
    - ☐ Medicaid
    - ☐ Data sharing
    - ☐ Other: _____

      _____

      _____
  - Where will I begin looking? _____

    _____

- ☐ Share information about the connection between housing and health care
  - With whom? _____

    _____
  - How? _____

    _____

- ☐ Make a list of potential health care partners in my community
  - Initial ideas: _____

    _____

- ☐ Reach out to 1 or more potential new health care partners in my community
  - Which ones? _____

    _____

☐ Invite at least one health care stakeholder to a housing-centered meeting

- Potential meetings: _____

  _____

  _____

- Potential topics: _____

  _____

  _____

- Potential health care invitees: _____

  _____

  _____

☐ Other: _____

_____

_____

_____

_____

FUNDING OPPORTUNITIES

SEPTEMBER 29, 2016

PLEASE NOTE: This is a collection of funding opportunities that HomeBase has seen become available recently. These may not be appropriate for all applicants, and any summaries may not be fully accurate. Please refer to the original grant materials or original source for additional information.

RESIDENTIAL (SHELTER) SERVICES FOR UNACCOMPANIED CHILDREN

Agency: Office of Refugee Resettlement/Division of Children's Services (ORR/DCS) within the Administration for Children and Families (ACF)

Description: ORR/DCS released a funding opportunity announcement (FOA) seeking shelter care providers, including group homes and transitional foster care (TFC), to provide temporary shelter care and other child welfare-related services to unaccompanied children (UC) in ORR custody. Although the UC population generally consists of adolescents 12 to 17 years of age, with males representing a higher percentage of the overall population, ORR is seeking applicants who can provide services for a diverse population of UC of all ages and genders, as well as pregnant and parenting teens. UC come from all over the world, but most are from El Salvador, Honduras, Guatemala, and Mexico. Unless otherwise specified, successful applicants are expected to provide services for UC from any country. Applicants must describe their overall program design for either shelter and/or TFC and how it is sensitive to the culture, native language, sexual orientation, and special needs of UC. Since UC are placed with foster families but do not attend local/neighborhood schools, TFC providers must provide the educational component at a central location, operated and run by care provider staff. Other required services such as clinical and case management services must be provided at the care provider site as well.

Eligibility: Care providers are required to be licensed or license eligible (temporary, provisional or an equivalent license) with license being issued, by a state licensing agency, within 60 days of award to provide residential, group or foster care services for dependent children. Applications from individuals (including sole proprietorships) and foreign entities are not eligible and will be disqualified from competitive review and from funding under this announcement. Faith-based and community organizations that meet the eligibility requirements are eligible to receive awards under this funding opportunity announcement. Cost sharing/matching is not required for this funding opportunity.

Anticipated Total Program Funding: $100 million
Expected Number of Awards: 10
Award Ceiling: $45 million per budget period
Award Floor: $600,000 per budget period
Due: October 31, 2016
Link: https://ami.grantsolutions.gov/files/HHS-2017-ACF-ORR-ZU-1132_1.pdf

ASSETS FOR INDEPENDENCE DEMONSTRATION PROGRAM

Agency: Administration for Children and Families (ACF) Office of Community Services (OCS)

Description: The ACF's OCS is accepting applications for grants to administer projects for the Assets for Independence (AFI) demonstration program. AFI grantees administer projects that provide individual development accounts (IDAs) and related services to low-income individuals. Participants open an IDA and save earned income that is matched by project funds. The combined participant savings and project matching funds will be used for an allowable asset: a first home, a business, or post-secondary education or training. Projects also assist participants in obtaining the skills and information necessary to achieve economic self-sufficiency. Grantees are encouraged to tailor the strategies and services they offer to the needs of their project participants and the opportunities in their community, for example: financial education, asset-specific training, financial coaching, credit-building services, credit/debt counseling, and assistance with tax credits and tax preparation. Applicants must outline a plan of action that describes the scope and detail of how the proposed project will be accomplished and account for all functions or activities identified in the application. Moreover, applicants must describe any design or technological innovations, reductions in cost or time, or extraordinary social and/or community involvement in the project.

Eligibility: Eligible participants include: non-profit entities with 501(c)(3) status; state or local government agencies, or tribal governments, applying jointly with a non-profit with 501(c)(3) status; financial institutions that are federally certified as either a Low-Income Credit Union or a Community Development Financial Institution and that demonstrate a collaborative relationship with a local community-based organization whose activities are designed to address poverty in the community and the needs of community members for economic independence and stability; and entities deemed eligible under Section 405(g) of the AFI Act.

AFI projects must be funded with a combination of the federal AFI grant and cash from non-federal sources. And, the amount of cash from non-federal sources must be at least equal to the federal AFI grant amount.

Anticipated Total Program Funding: $13.25 million
Award Ceiling: $1 million
Due: October 31, 2016 and April 3, 2017
Link: http://www.grants.gov/web/grants/view-opportunity.html?oppId=275744

YOUTH HOMELESSNESS DEMONSTRATION PROGRAM

Agency: Department of Housing and Urban Development

Description: HUD will select up to 10 communities to participate in the Youth Homelessness Demonstration Program (YHDP) to develop and execute a coordinated community approach to preventing and ending youth homelessness. The purpose of the YHDP is to learn how communities can successfully approach the goal of preventing and ending youth homelessness by building comprehensive systems of care for young people rather than implementing individual or unconnected projects that serve this population. In order to effectively implement a system that addresses the needs of youth experiencing homelessness, Continuums of Care (CoCs) must understand the subgroups of unaccompanied youth and the unique challenges they face within their communities. Additionally, CoCs

must ensure that the appropriate type of housing assistance is available within the community. Furthermore, CoCs must reach out and partner with a comprehensive set of traditional and non-traditional youth homelessness stakeholders that provide youth with resources and services, advocate for them, and set policy on their behalf. Finally, CoCs must incorporate the experiences of homeless or formerly homeless unaccompanied youth into the YHDP coordinated community plan and awarded projects.

**Eligibility: ***Only CoC Collaborative Applicants may apply to this NOFA* City or township governments, State governments, Nonprofits having a 501(c)(3) status with the IRS (other than institutions of higher education), and County governments

Anticipated Total Available Funding: $33,000,000
Award Ceiling: $15,000,000
Award Floor: $1,000,000
Due: November 30, 2016
Link: https://www.hudexchange.info/programs/yhdp/?utm_source=HUD+Exchange+Mailing+List&utm_campaign=0e2549ea30-Correction%3A+YHDP+Application+Available+-+8%2F19%2F16&utm_medium=email&utm_term=0_f32b935a5f-0e2549ea30-19369953

HOUSING TRUST FUND (HTF)

Agency: Department of Housing and Urban Development (HUD), administered in California by the Department of Housing and Community Development (HCD)

Description: The National Housing Trust Fund (HTF) is a new federal program administered by the U.S. Department of Housing and Urban Development (HUD) that will allocate approximately $174 million to states to increase and preserve the supply of affordable housing. This year, 100% of the HTF funds must benefit Extremely Low Income (ELI) households (i.e. households with incomes not exceeding 30% of area median income) or households with incomes at or below the poverty line, whichever is greater. To help meet the state's housing priority needs, preference will be given to projects with units dedicated to homeless and/or other special needs populations. For fiscal year 2016, HTF will be paired with one or more state programs in a joint Notice of Funding Availability (NOFA). The Veterans Housing and Homelessness Program (VHHP) and the Supportive Housing component of the Multifamily Housing Program (SHMHP) are two of the state program that may be paired with the HTF. Under the joint NOFA, the HTF requirements and the companion program's evaluation criteria will be utilized to rate the applications. Extra points will be awarded to eligible recipients who apply for a project that is already receiving federal funds.

This is the first year HUD has awarded HTF funds to state agencies, and the $10.1 million allocated to California will be administered by the Department of Housing and Community Development (HCD). HCD has developed a proposed HTF Allocation Plan, with supporting documents, and has taken public comment on the program. HCD has proposed limiting the use of HTF funds to new construction of permanent housing for extremely low-income households. On the other hand, HUD guidelines outline a range of other eligible activities, including rehabilitation of affordable housing, assistance to first-time homebuyers, loan forgiveness, and other programs. More information regarding the state's proposed implementation of the plan will be available in the near future.

Eligibility: The state will distribute funds by selecting applications submitted by eligible recipients. Eligible recipients include: individuals, joint ventures, partnerships, limited partnerships, trusts, corporations, limited liability corporations, local public entities, duly constituted governing bodies of an Indian Reservation or Rancheria, other legal entities, or any combination thereof that meet program requirements.

Anticipated Total Program Funding: $10.1 million to California ($174 million nationwide)
Due: TBD
Links: https://www.hudexchange.info/programs/htf/ ; http://www.hcd.ca.gov/housing-policy-development/housing-resource-center/reports/fed/

NORTHERN CALIFORNIA/CENTRAL VALLEY HOMELESS ROUNDTABLE

FEDERAL LEGISLATIVE UPDATE

SEPTEMBER 29, 2016

FEDERAL POLICY

On September 9th, the Social Security Administration (SSA) published a Notice of proposed rulemaking in the Federal Register, proposing several revisions to its definition of Acceptable Medical Evidence. These revisions would expand the list of Acceptable Medical Sources to support SSI/SSDI claims to include Advanced Practice Registered Nurses, and possibly even Physicians Assistants (PAs) and Licensed Clinical Social Workers (LCSWs). The SSA has invited the public to comment on the new definition, and is especially interested in comments concerning the inclusion of PAs and LCSWs.

Current practice requires disability applicants to have been diagnosed by a physician or psychiatrist; however, this no longer reflects how most people in the United States are receiving care – especially among low-income individuals and persons experiencing homelessness, whose medical history often includes diagnoses from other types of practitioners. Most homeless assistance programs have little or no access to medical doctors for their clients, and broadening the definition of Acceptable Medical Evidence will help these individuals get connected to SSI/SSDI more quickly and reliably.

The SSA also proposes it will no longer give "controlling weight" to any prior administrative medical finding or opinion, and instead find "supportability" and "consistency" to be the most persuasive evidentiary factors. These changes to the definition regarding the "weight" of medical evidence show a decreasing reliance on the *source* of the medical opinion and a greater focus on the *content*.

To help further guide these revisions, the SSA is requesting that interested parties submit their comments no later than November 8th, 2016. HomeBase has already drafted a letter with such comments to circulate to Roundtable participants, and will plan to incorporate additional comments into a finished draft to send to the SSA before the cut-off date. Agencies and CoCs may wish to submit letters as well.

FEDERAL BUDGET

Fiscal Year 2016 comes to a close tomorrow, and appropriations bills have almost all been passed in the Senate and House Appropriations Committees. Anticipating that spending bills would not be finalized before tomorrow's deadline, on September 22nd the Senate Appropriations Committee released a short-term Continuing Resolution (CR), (also known as a stop-gap funding measure) to allow the process to continue into the new fiscal year, which will maintain government operations through December 9, 2016.

A component of the CR is the FY 2017 MilCon-VA Appropriations Act, which will fund the Department of Veterans Affairs and family housing priorities through the end of FY2017. Enactment of this bill, which provides record funding for veterans, would mark the first time since 2009 that a regular appropriations bill has been signed into law before the end of the fiscal year.

On May 24, 2016, the House Appropriations Committee approved the FY 2017 Transportation, Housing and Urban Development funding bill passed by the Senate. In total, the bill reflects an allocation of $58.2 billion in discretionary spending - $889 million above last fiscal year, but $4.9 billion below the President's request. The bill allocates $27.4 billion for Public and Indian Housing, enough to continue assistance to all families and individuals currently served by the Section 8 program.

LEGISLATION

Over the summer and early this Fall, several new bills were introduced that focus on assisting and prioritizing vulnerable subpopulations and amending key pieces of legislation affecting persons experiencing homelessness. Many new bills highlighted Veterans, concerned with keeping the commitment to ending Veteran homelessness in 2017 (S.3249), and prioritizing the provision of services to Veterans with children in reintegration programs (H.R.5407). Others were dedicated to protecting victims of domestic violence, such as the **Fair Housing For Domestic Violence and Sexual Assault Survivors Act of 2016** (S.3164), which would amend the Fair Housing Act to prohibit discrimination against survivors of domestic violence or sexual assault in the sale or rental of housing and related activities.

Additionally, two bills introduced earlier this Summer propose revisions to legislation affecting those receiving Rental Assistance:

S.3083 Housing Opportunity Through Modernization Act of 2016:

Introduced in the Senate on June 22nd, and with hearings held in the Committee on Banking, Housing, and Urban Affairs Subcommittee on Housing, Transportation, and

Community Development on September 22nd, this bill proposes to amend the United States Housing Act of 1937 and other housing laws to modify how the Department of Housing and Urban Development (HUD) provides rental assistance. The bill revises the requirements for Public House Agencies (PHAs) to inspect dwelling units before making housing assistance payments to ensure that units comply with housing quality standards; the requirements would be revised to allow payments to be made if the unit possesses "non-life-threatening conditions," and would allow a 30 day grace period for such defects to be fixed before the agency can withhold assistance payments. The bill also includes additional paragraphs detailing the frequency and the reasons for which the PHA will review the incomes of assisted families in dwelling units, including a provision that would require income review any time family income is expected to increase by 10 percent or more in annual adjusted income.

The bill also proposes to amend technical points in the McKinney-Vento Homeless Assistance Act to require HUD to define the term "geographic area" for purposes of the Continuum of Care Program. If passed, the bill would allow local governments receiving Emergency Solutions Grants to distribute all or part of the assistance to PHAs or Local Redevelopment Authorities. (Distribution of the grants is currently limited to nonprofit organizations). The bill also proposes to revise the formula and requirements for distributing funds under the Housing Opportunities for Persons With AIDS (HOPWA) program.

H.R. 5401 Landlord Accountability Act of 2016:

Introduced in the House on June 7th and referred to the Subcommittee on the Constitution and Civil Justice on June 10th, this bill proposes to amend the Fair Housing Act to make it unlawful for a landlord to discriminate in connection with the rental of a dwelling because the current or prospective tenant holds a Section 8 housing voucher for rental assistance. The amendment would prohibit landlords from doing anything to the unit "with the intent to make the unit insufficiently decent, safe, sanitary, or inhabitable so that the dwelling fails to qualify for assistance within the jurisdiction of the Department of Housing and Urban Development (HUD)."

The bill also aims at taking measures to improve HUD's complaint process, increasing the amount of staff to handle calls on its Complaint Line (operated by its Multifamily Housing Clearinghouse). To improve transparency of the process, the bill would require that HUD post information about each complaint on its website, identifying the multifamily housing project to which the complaint relates.

The bill also proposes to amend the Internal Revenue Code to allow an eligible landlord a low-income housing maintenance credit of $2,500 (multiplied by the number of low-income housing units owned up to a certain maximum for the landlord's annual low-income housing maintenance expenses). If a landlord rents to three or more Section 8 voucher holders, the bill would also require the landlord to post on every floor a

conspicuous notice of tenant rights under federal law, which includes the phone numbers for the Multifamily Housing Complaint Line and for a regional or local HUD office. It also provides that HUD may make grants to states, Indian tribes, local governments, and nonprofit, nongovernmental affordable housing organizations to develop or assist tenant harassment prevention programs meeting specified requirements.

FEDERAL UPDATES

RESOURCES FROM HUD

HUD has recently released several resources, tools, and guidance documents to help Homeless Assistance Programs:

HMIS Data Standard Tutorials: Designed as a resource for HMIS Lead agency and CoC project staff, HUD released a set of Homeless Management Information System (HMIS) Data Standard Tutorials, in partnership with the U.S. Department of Health and Human Services (HHS), and the U.S. Department of Veterans Affairs (VA), to allow for standardized data collection on individuals and families. These multi-segmented tutorials explain select required data elements in greater detail, providing a deeper understanding of each data element to supplement local HMIS data standard trainings. The tutorials provide information about when a data element is collected, who the data is collected from, how to collect the data, and where to report it. For more information, see: https://www.hudexchange.info/programs/hmis/guides/data-element/

Spotlight Webinar Series on Evidence-Based Practice: Put on by the Substance Abuse and Mental Health Services Administration (SAMHSA), this webinar series from August focused on innovative homelessness solutions to use when working with the individuals SAMHSA grantees serve. Among other objectives, the webinar discussed the benefits of collaboration with subject matter experts (SMEs) to strengthen and implement evidence-based interventions for mental, emotional, and behavioral health promotion. To view the content from each webinar, please follow the links below:

- *Critical Time Intervention:* http://legacy.nreppadmin.net/ViewIntervention.aspx?id=367
- *Permanent Supportive Housing:* http://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4510
- *Motivational Interviewing:* http://legacy.nreppadmin.net/ViewIntervention.aspx?id=346

RESOURCES FROM FEDERAL PARTNERS

Presentations from 2016 National Conference on Ending Homelessness: To view the presentations from the National Alliance to End Homelessness (NAEH) Annual Conference on August 9th in Washington, D.C., please visit: http://www.endhomelessness.org/library/entry/presentations-from-national-conference-on-ending-homelessness

Using Medicaid to Pay for Services in PSH: Steps for CoC Leads to Get Started (Toolkit): The NAEH, the Technical Assistance Collaborative, and CSH have developed this "how to" guide to help Continuum of Care (CoC) and other service system leaders work with health care systems to explore how Medicaid can finance supportive services in permanent supportive housing. To access this toolkit, please see: http://www.endhomelessness.org/library/entry/using-medicaid-to-pay-for-services-in-psh-steps-for-coc-leads-to-get-starte

September 29, 2016

To: Social Security Administration

From: Northern California/Central Valley Homeless Roundtable

Re: Docket No. SSA-2012-0035, Revisions to Rule Regarding the Evaluation of Medical Evidence

The Northern California/Central Valley Homeless Roundtable is led by delegates in homeless Continuums of Care (CoCs) in the Northern California and Central Valley communities, and is comprised of homeless providers, consumers, advocates, and CoC leaders from approximately 20 CoCs. Created in 2004, its goal is to create regular opportunities for homeless continua participants to foster exchange of information and to build community between continuum communities.

By adopting a more inclusive policy regarding Acceptable Medical Evidence, processing of applications for SSI/SSDI will become faster, and therefore more equitable, to applicants who are among the most vulnerable members of society. For this reason, we believe the proposed changes to this Rule have the potential to drastically improve the lives of persons experiencing homelessness in our CoC areas. The Northern California / Central Valley Homelessness Roundtable is grateful for this opportunity to submit the following comments in response to the Social Security Administration's Notice of proposed rulemaking regarding revisions to Acceptable Medical Evidence issued on September 9, 2016.

1. The Rule proposes to allow testimony from Advanced Practice Registered Nurses as an Acceptable Medical Source, but SSA does not define that term in the regulation itself, only in the commentary (Federal Register, Vol. 81, No. 175, page 62568). For the sake of clarity, we request that the regulation itself explicitly define the APRN category as including Certified Nurse Midwives, Nurse Practitioners, Certified Registered Nurse Anesthetists, and Clinical Nurse Specialists.

2. The Rule invites comments on whether Physicians' Assistants (PAs) should be allowed to give testimony, and expresses concern that the requirements for becoming licensed as a PA might not be sufficiently uniform from state to state (Federal Register, Vol. 81, No. 175, page 62569). We request that PAs absolutely be allowed to give testimony as an Accepted Medical Source. It would be inappropriate to accept testimony from Registered Nurses and Nurse Practitioners but not Physicians Assistants, who often have more training in diagnosis and assessment of disabilities.

   According to the American Association of Surgical Physician Assistants, PAs are licensed health care professionals trained in the same format as physicians. The training is roughly two-thirds the length of medical school with over 100 weeks of general primary care education. The average physician assistant has a bachelor's degree and four and a half years of health care experience prior to entering a PA program.

In every state, a prospective physician assistant must complete an accredited academic program. Surgical PAs are licensed by each state to practice and must take a national certification exam given by the National Commission for the Certification of PAs (NCCPA). Each hospital board then credentials the surgical PA for specific practice privileges. Therefore, surgical PAs are able to work anywhere the supervising surgeon has practice privileges. Because the licensing, education, and training requirements for PAs are rigorous and consistent across States, PAs should be considered AMSs for the purposes of the Rule.

3. The Rule invites comments on whether Licensed Clinical Social Workers (LCSWs) should be allowed to give testimony (Federal Register, Vol. 81, No. 175, page 62569). We request that the regulation allow for testimony from LCSWs as AMSs. LCSWs are highly trained mental health professionals; according to the Board of Behavioral Sciences of the California Department of Consumer Affairs, to become licensed LCSWs are required to achieve a minimum of a Master's Degree in a qualifying field, must register with the Board to begin post degree experience, then must earn 3,200 hours of work under a licensed Supervisor, before passing a Clinical examination. Additionally, LCSWs must adhere to high standards regarding ethics and confidentiality as provided by the state board (which usually involves signing an ethics pledge or oath, and in California, the passage of the California Law & Ethics Examination). They are empowered to assess and make clinical evaluations of client's mental health and diagnose mental illness, using researched based practices, and can be involved in direct therapy with patients in a private practice or as part of a team.

   Most importantly, LCSWs are the easiest and most commonly available source for medically evaluating homeless clients; in many cases, people experiencing homelessness do not have access to <u>any</u> care providers other than LCSWs. If LCSWs are not accepted a source of medical evidence, then people experiencing homelessness will not receive the benefits that would allow them to connect with a more advanced level of medical care. In these instances, for these individuals and families, the choice isn't between LCSWs and APRNs -- the choice is between LCSWs or being totally disconnected from treatment, benefits, and medical advice. For these reasons, we request that LCSWs be considered AMSs for the purposes of the Rule.

Sincerely,

Northern California/Central Valley Homeless Roundtable

September 29, 2016

NORTHERN CALIFORNIA/CENTRAL VALLEY HOMELESS ROUNDTABLE

SHARING DATA WITH HEALTH CARE STAKEHOLDERS

SEPTEMBER 29, 2016

BENEFITS OF DATA COORDINATION AND SHARING

- Provides a more comprehensive understanding of clients – both individually and collectively
- Reduces burden on clients
- Allows for prioritizing most vulnerable people and coordinating housing, services, and treatment
- Leads to better client outcomes and lower system costs
- Allows for more accurate tracking of health outcomes, service utilization, and costs to facilitate continued quality improvement and to make the case for additional funding for successful interventions

OBSTACLES AND OPPORTUNITIES

OBSTACLES

- Privacy concerns
- HIPAA, FERPA and other legal limitations
- Resistance to change

OPPORTUNITIES

- Revise consent forms (coupled with client and provider education)
- Start with aggregate data review and analysis
- Offer data
    - Results from other communities – to demonstrate potential benefits
    - Data from your own system(s) – to demonstrate feasibility and willingness

STRATEGIES TO CONSIDER

STRATEGIC DATA COLLECTION

Both the housing/homeless systems and the health care system have client databases in place that allow for collecting information about both housing and health care needs. The following strategies are aimed at ensuring accurate and strategic data collection by providers in both systems.

- Determine what housing-related data is (or could be) collected by health care stakeholders in your community.
- Educate housing/homeless system providers about how to accurately collect and enter health-related data into HMIS or other housing-side databases.

- Educate health care system stakeholders about how to accurately determine homelessness or housing instability and the benefits of collecting/tracking that data.
    - The International Classification of Diseases, or ICD-10, is a health care classification system that provides diagnostic codes for classifying information relating to a patient's condition and inpatient procedures, including specific diseases, symptoms, causes, abnormal findings, and social circumstances. The data categories within the ICD-10 system relating to housing and homelessness include:
        - Z59.0 Homelessness
        - Z59.1 Inadequate Housing
        - Z59.5 Extreme Poverty
        - Z59.8 Other Problems Related to Housing and Economic Circumstances
        - Z59.9 Problems Related to Housing and Economic Circumstances, Unspecified
    - Federally Qualified Health Centers (FQHCs) maintain patient-level data necessary to report annually to the Health Resources and Services Administration (HRSA) through the Uniform Data System. All health centers report on selected patient characteristics for all patients that receive at least one face-to-face visit during the calendar year. Those characteristics include:
        - Homeless
        - Public Housing
        - Income
        - Medicaid/CHIP, Medicare, Other Third Party

CASE STUDY: VETERANS HOMELESS RISK ASSESSMENT

To improve the Department of Veterans Affairs (VA)'s ability to identify veterans who are at risk of homelessness—or experiencing homelessness but not accessing services—the VA National Center on Homelessness Among Veterans, in collaboration with the VA National Clinical Reminders Committee, developed a two stage **Homelessness Screening Clinical Reminder (HSCR)** to conduct an ongoing, universal screen for homelessness and risk among veterans accessing health care services. The objective of this screening instrument is to enhance the rapid identification of veterans who have very recently become homeless or are at imminent risk of homelessness, and to ensure that they are referred for the appropriate assistance to stabilize their housing crisis or to rapidly rehouse them. The HSCR is comprised of two primary questions intended to assess current housing instability and imminent risk of housing instability:

1. In the past 2 months, have you been living in stable housing that you own, rent, or stay in as part of a household? ("No" response indicates veteran is positive for homelessness.)
2. Are you worried or concerned that in the next 2 months you may NOT have stable housing that you own, rent, or stay in as part of a household? ("Yes" response indicates Veteran is positive for risk.)

Veterans who screen positive are asked two additional questions: (1) Where they have lived for most of the previous 2 months, and (2) Whether they want to be referred to social work or homeless services. Veterans' responses to the HSCR are stored in the VA's Corporate Data Warehouse along with additional information captured through their medical records, such as demographics, diagnoses, and services utilization.

DATA SHARING AND INTEGRATION

Data Matching/Sharing

Most public agencies have data collection systems and can identify families who have had contact with child welfare and homeless systems. However, these systems are largely uncoordinated. Cross-system administrative data matches (for example between child welfare agency data systems and Homeless Management Information Systems) may be used to identify households who overlap and have frequent contacts with multiple systems.

Feasibility of a data match depends on the breadth of data collected, quality of the data, and the sophistication of data systems. In the most sophisticated data systems, a human services agency may be able to track households across multiple departments of the agency (e.g., child welfare, homeless, TANF, mental health, etc.). In this scenario, public agencies or departments have Memorandums of Understanding (MOUs) that allow staff from any of the partnering agencies to view all of the data pertaining to a family. If data and systems permit, this matching approach is particularly effective and efficient for identifying a community's highest-need/highest-cost families to target for intensive services.

Potential housing-health care data matches:

- Managed care organization (MCO) member data + HMIS membership lists to facilitate connections to care
- CoC/HMIS data + Medicaid enrollment data to identify potentially-eligible clients who are not enrolled
- Cross-system data matches (e.g., EMS, criminal justice, Medicaid, HMIS) to identify individuals who frequently come into contact with multiple systems of care and/or frequently use high-cost services in more than one system of care and target services to those vulnerable individuals

CASE STUDY: TEXAS MCO/HMIS DATA MATCH

UnitedHealthcare (UHC), an MCO with members that include individuals with very low incomes, requested HMIS data from a local CoC. The CoC provided a list of members, which UHC compared to its member rolls. UHC then provided the CoC a list of shared clients/members that UHC had not been able to locate or connect to medical care. For each such member that the CoC was able to locate, UHC provided the CoC with a "finder's fee."

CASE STUDY: UTAH MEDICAID DATA MATCH

The Utah Department of Workforce Services (DWS) successfully conducted a match of the data available in HMIS and eREP (Medicaid eligibility system) for the state. Utah DWS has used the data match to create aggregate data to evaluate current performance, historical trends, and evaluate performance expectations at the time of contract renewals. This increase in Utah's cross-system integrated data capacity helps the state facilitate better understanding of system level operations, effectiveness, and efficiency, and supports their goal to engage in data-driven decision-making around homeless health and housing service provision.

Data Integration

- Encourage health care stakeholder participation in HMIS or other housing-side databases.
- Explore possibilities for homeless service providers to leverage health care system databases.
- Create a data warehouse to allow for aggregate data analysis across systems.
    - Central database integrating information from more than one source of the same type of system (e.g., multiple Homeless Management Information Systems (HMIS)) and/or from more than one source of different systems (e.g., multiple mainstream systems such as health care, foster care, corrections, and education)
    - Rearranges the data into a structure that allows for more effective and efficient reporting and analysis

CASE STUDY: ALLEGHENY COUNTY DEPARTMENT OF HUMAN SERVICES DATA WAREHOUSE

The Allegheny County Department of Human Services' (DHS) Office of Information Management created a central repository of human services data to allow DHS agencies to track client demographic and service data across all DHS program offices. HMIS client and service level data is a direct internal source of data for the Allegheny County DHS Data Warehouse. Other internal sources populating the DHS Data Warehouse include: child welfare, behavioral health, developmental disability, aging services, employment and training, and several low income services such as low income energy assistance and medical assistance transportation. The DHS Data Warehouse also collects data from external sources including: Allegheny County Jail, Adult and Juvenile Probation, Allegheny County's Medical Examiner, city and county housing authorities, and the Pennsylvania Department of Public Welfare (including TANF, general assistance, food stamps and Medical Assistance). Historical data from all operating applications is also included, which allows data analysis to go back further than the inception of the DHS Data Warehouse itself.

STRATEGIC UTILIZATION

Frequent User Programs

"Frequent User" programs and partnerships use health service utilization data to identify the most frequent users of health services and engage them in more appropriate and cost-effective services, including primary and preventive health care, treatment services, social services and supports, and connections to stable housing. When care management and flexible services linked to stable housing are provided to "frequent users" who are experiencing homelessness, the results include housing stability, significant reductions in the utilization and costs of emergency health services, and better treatment for complex health issues.

CASE STUDY: COMMUNITY CARE OF NORTH CAROLINA (CCNC) PRIORITY PATIENTS PROGRAM MEDICAL CENTER COORDINATED CARE CLINIC

CCNC built a partnership between a large funder of health care (Medicaid), primary care physicians, and other local health care providers to achieve quality, utilization, and cost

objectives in the management of care for Medicaid recipients across North Carolina. CCNC's Priority Patient Program was initiated in 2011 and focuses on about 5% of the overall CCNC population who are considered "super-utilizers" based on potentially preventable inpatient admissions and/or Emergency Department visits. Priority patients are determined through the following data:

- Claims data to estimate expected spending for each beneficiary given his/her clinical history
- CCNC has an electronic data exchange that receives weekly updated statewide Medicaid claims data as well as real-time hospital admission data, laboratory results, and clinical data from the primary care medical record.
- Uses Clinical Risk Grouping software from 3M Health Information System to assign patients to a risk category, estimate average cost of care for patients in each category, and flag those with hospital spending at least $1000 above the level expected for their category.

Priority patients are then connected with care managers who review their case histories and develop an individualized approach for outreach and intervention to prevent unnecessary hospital costs.

Frequent User Systems Engagement (FUSE) Model

FUSE identifies and works to engage and stabilize people who are frequent users of both the shelter system and the criminal justice system, using a Housing First model of permanent supportive housing (PSH). A core component of the FUSE model is Data-Driven Problem Solving. Data is used to identify a specific target population of high-need individuals who are shared clients of multiple systems, including jails, homeless shelters, and crisis health services. Data analysis is used to identify those individuals who are caught in a "revolving door" with repeated contacts with several systems. Cross system data is also used to track implementation progress and measure outcomes.

CASE STUDY: FUSE 10TH DECILE PROJECT, LOS ANGELES, CA

Goal: To identify the 10% of homeless patients with the highest public and hospital costs, place them into PSH, and surround them with supportive medical and mental health homes.

Data and Tools Used: A triage tool is used to screen for high cost, high need homeless individuals to differentiate homeless individuals with the highest public costs from other homeless individuals with less severe conditions. This cost spread is based on health conditions and history of using public services. The tool uses an array of variables (51 pieces of information are collected and combined) to determine the probability that the homeless individual is in the top cost-decile.

Intervention: Participants are enrolled with experienced community-based homeless service providers. The transition from hospital or clinic to a navigator takes place through a warm handoff. A health provider staff member, usually a social worker, briefs the navigator on the patient's social and medical background, personal characteristics, history of hospital use, presenting issues, diagnoses, and underlying problems, and then personally introduces the navigator to the patient. The navigator assumes responsibility for assisting the individual, including assessing the type of temporary housing needed,

providing transportation to the housing site, visiting an FQHC to arrange immediate care, facilitating the process of obtaining the documentation and benefits needed to access PSH, linking those in PSH with a medical home, and providing post-housing follow-on support.

Outcomes:

- Total annual average public and hospital costs/person for those who obtained housing decreased from $63,808 to $16,913 (73%) – excluding housing subsidy costs.
- Total health care costs/person – including jail, medical, and mental health – for those housed declined from $58,962 to $16,474 (72%).
- Every $1 spent on navigation, housing, and services produced a net savings of $2 in the first year and $6 in subsequent years through reduced public and hospital costs.

Analysis of Medicaid Encounter Data

Encounter data are the records of services delivered to Medicaid beneficiaries enrolled in managed care plans that receive a capitated, per-member-per-month payment. These records allow the Medicaid agency to track the services received by members enrolled in managed care. Encounter data typically come from billed claims that providers submit to managed care plans to be paid for their services. In response to the increase in homeless and at-risk members since Medicaid expansion, some MCOs have been using encounter data, among other data sources, to develop a homelessness predictor tool.