Understanding HHIP Performance Metrics

Homebase
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This resource summarizes the performance measurements for each HHIP metric for Performance Measurement Period 2, and the information MCPs need to provide to DHCS by December 2023. It is intended to help CoCs better understand DHCS's expectations so they can partner more effectively with their local MCPs to maximize the HHIP incentive award funds available in their local communities.

As explained in greater detail in the Homebase-developed resource, "The Housing & Homelessness Incentive Program (HHIP)," to receive payments of HHIP incentive funds, MCPs must file reports to the Department of Health Care Services (DHCS) at the end of each of two measurement periods and demonstrate that they have met specific DHCS performance metrics. The reports for Measurement Period 1 (covering May 1, 2022-December 31, 2022) were due March 10, 2023. Measurement Period 2 reports (covering January 1, 2023-October 31, 2023) are due in December 2023.

While on its face, HHIP is a program to incentivize MCPs, it has the potential to result in significant additional investment (of funding and other resources) in local community efforts to prevent and end homelessness. Collaboration between CoCs and MCPs can increase the potential to meet DHCS metrics and maximize the amount of incentive funds awarded to MCPs and available to invest back into the community's homelessness response. CoCs may be aware of DHCS' HHIP Priority Areas and the 15 metrics they will use to evaluate MCPs, but most are not familiar with the specific information DHCS requests for each metric and how they define performance measurements.

Meeting Performance Metrics

HHIP metrics are either Pay for Performance or Pay for Reporting.

Pay for Performance means MCPs must demonstrate their performance, usually by submitting numerical data, to earn points toward incentive funds.

Pay for Reporting means MCPs are awarded points for a narrative report containing requested information, rather than for meeting a specific performance measure.

HHIP Metrics & How DHCS is Measuring MCP Performance

DHCS evaluates MCPs seeking HHIP incentive funds based on how they meet the priority areas and all 15 metrics. They have identified 7 high priority metrics, indicated with red font below, which can earn MCPs additional points.

The following pages provide details about each of the 15 performance metrics, including:

- A brief description of each metric;
- What MCPs are required to report to DHCS;
- How DHCS defines and measures full performance of each metric; and
- Ways CoCs can help ensure MCPs meet the metric.

Metric 1.1: Engagement with the local CoC

MCPs must engage with the CoC in various ways to improve partnership and collaboration. Engagement may include, but is not limited to:

- Attending CoC meetings;
- Joining the CoC Board;
- Joining a CoC subgroup or workgroup; and/or
- Attending a CoC webinar.

MCPs initially submitted a Local Homeless Plan (LHP) to DHCS in mid-2022 that included the types and percentages of CoC meetings they would attend (e.g., 100% of CoC membership meetings or Coordinated Entry Work Group meetings).

Information required

The number and type of meetings held during the measurement period that MCPs said they would attend and the number they actually attended during the measurement period.

MCPs must also describe any engagement with other city and county housing and homelessness partners (including social services, housing development agencies, Public Housing Authorities, and health services and public health), including efforts to coordinate data, referrals, and service delivery.

To meet the performance measurement

This is a Pay for Performance Metric; MCPs must have attended 100% of the meetings that they said in their LHP they would attend.

How CoCs can assist

How well the MCP can meet this measure depends on what they committed to in the LHP. CoCs should check with their local MCPs about their LHP commitments and ensure MCPs are aware of and invited to all relevant meetings. Working with MCPs to ensure they understand the purpose of each type of meeting and discussing ways they can actively participate will encourage attendance and also ensure their attendance is mutually beneficial and productive.

Metric 1.2: Connection and integration with the local Coordinated Entry System

MCPs need to better understand the Coordinated Entry (CE) System in each county where they operate, consider becoming CE access points, coordinate with the CoC on members' housing needs, and make and receive referrals where appropriate. In their LHP, MCPs reported to DHCS the feasibility of becoming a CE access point. In their Measurement Period 1 report, MCPs submitted an action plan based on that feasibility assessment.

Information required

A narrative description of updates made to the CE process as a result of the MCP's involvement, including how health factors and risks have been incorporated into the CE assessment and prioritization process, as well as the MCP's progress toward becoming a CE access point based on the action plan submitted as part of their Measurement Period 1.

To meet the performance measurement

This is a Pay for Reporting metric; MCPs are awarded for the narrative description on progress.

How CoCs can assist

Work with their local MCPs to explain how CE works locally and discuss the possibility and desirability of them becoming access points or ensuring their members experiencing homelessness are referred to access points. CoCs and MCPs should discuss the health-related factors that can be incorporated into CE prioritization and assessment processes to improve the overall equity and operation of CE. CoCs might:

- Invite MCPs to participate in CE committees;
- Invite MCPs to review CE policies and procedures and the prioritization protocol;
- Develop and add medical vulnerability screening questions into CE intake procedures in partnership with their local health partners;
- Revise prioritization to include medical vulnerability factors;
- Train MCP staff and their contracted providers about CE and how it works in the community; and
- Support MCPs or their contracted providers to become CE access points or assessors, as appropriate.

Metric 1.1 Formula:

$$\frac{\text{\# of relevant meetings MCP attended during time period}}{\text{Total \# of relevant meetings held during time period}}$$

Example

In its LHP, the MCP committed to attend all CoC Board Meetings, General Membership meetings, CE committee meetings, HMIS data sharing meetings, and strategic planning meetings.

Between Jan 1, 2023 and October 31, 2023: The MCP attended 6 CoC Board meetings, 1 CoC General Membership meeting, 2 CE Committee meetings, 4 HMIS Data Sharing meetings, and 1 Strategic Planning meeting.

The CoC held a total of 19 total meetings: 8 Board meetings, 1 CoC General Membership meeting, 4 CE meetings, 4 HMIS Data Sharing meetings, and 2 Strategic Planning meetings.

The percentage of relevant meetings the MCP attended = 73% (14/19) so the MCP would not satisfy DHCS's 100% participation requirement.

Metric 1.3: Identifying and addressing barriers to providing Community Supports and other housing-related services to MCP members experiencing homelessness.

MCPs must identify and address barriers to providing medically appropriate and cost-effective housing-related Community Supports (CS) services or other housing-related services to MCP members experiencing homelessness.

Information required

MCPs must explain the approach they took to address barriers described in their LHPs, as well as information on the sustainability of the approach and how the MCP will continue to address the barriers beyond HHIP.

To meet the performance measurement

This is a Pay for Reporting metric.

How CoCs can assist

Provide insight to MCPs on strategies and approaches most likely to help overcome existing barriers for people experiencing homelessness to access housing-related CS and other services. CoCs might:

- Train CoC housing and service providers to refer and connect individuals experiencing homelessness to CS services;
- Track data about CS referrals;
- Follow up with housing and service providers on the success rates of connecting individuals experiencing homelessness to CS; and
- Facilitate trainings and case conferences between MCP CS providers and homeless services providers.

Metric 1.4: Partnerships with counties, CoCs, and other organizations that deliver housing services with which the MCP has a data sharing agreement that allows for timely exchange of information and member matching.

MCPs need to exchange information and conduct member matching on a timely basis with counties, CoCs, and organizations that they contract with to deliver housing services (i.e., interim housing, rental assistance, supportive housing, outreach, prevention/diversion). Specifically, MCPs must be able to access information about their members' housing status.

Information required

The total number of providers that the MCP has contracted with to deliver housing-related services and the number of those providers who are actively sharing MCP member housing status information under a local Data Sharing Agreement (DSA) or California's Data Exchange Framework Data Sharing Agreement. If the DSA is through an intermediary, the MCP must be able to access the members' information related to their housing status.

To meet the performance measurement

This is a Pay for Performance Metric. At least 75% of the providers the MCP has contracted with to deliver housing-related services must be actively sharing MCP member housing status information.

How CoCs can assist

Work with their local MCPs to develop a DSA that facilitates information exchange and member matching between HMIS and MCP client records. Identify the process required to engage in data exchange and provide sufficient time to engage in that process. CoCs can ensure the MCPs are able to access member housing status information for all HMIS-participating providers. Seek bi-lateral data exchange so information about clients is coming back to the CoC, which can facilitate housing stability.

Metric 1.5: Data sharing agreement with county mental health plans and drug Medi-Cal organization delivery system

MCPs must have DSAs in place with county Mental Health Plans (MHP) or Drug Medi-Cal Organized Delivery System (DMC-ODS) – if applicable – that includes the ability to perform member matching and sharing information on housing status.

Information required

MCPs must report whether they have a DSA in place with county MHPs or DMC-ODS (if applicable) that includes the ability to do member matching and information sharing on member housing status.

To meet the performance measurement

This is a Pay for Performance Metric. MCPs must have an agreement in place as described above.

How CoCs can assist

As this is an agreement with county partners, CoCs are unlikely to be involved.

Metric 1.6: Partnerships and strategies the MCP will develop to address disparities and equity in service delivery, housing placements, and housing retention

MCPs must develop strategies and partnerships to address disparities and equity in service delivery, housing placements, and housing retention. In their LHPs, MCPs provided a narrative description of how they planned to work with housing partners to identify: 1) disparities and inequities that currently exist in the county related to housing; and 2) their approach to partnering with local organizations to address the stated disparities and inequities as they relate to service delivery, housing placements, and housing retention.

Information required

A narrative evaluation of the MCP's implementation of partnerships with local organizations to address the disparities and inequities they included in their LHPs.

To meet the performance measurement

This is a Pay for Performance Metric. MCPs must have fully implemented the approach they described in their LHPs.

How CoCs can assist

CoCs can share their goals and progress to address disparities and inequities, especially from their Homeless Housing, Assistance and Prevention (HHAP) grants. They can review the approaches MCPs outlined in their LHPs and suggest ways they can partner to address the identified disparities and inequities.

Metric 1.7: Lessons learned from development and implementation of the Investment Plan

MCPs were required to develop an Investment Plan in collaboration with their local CoCs and/or counties to outline the investments they planned to make to ensure they met the HHIP metrics. MCPs were expected to work with their local CoCs to implement the Investment Plans. This metric aims to elicit information about the success of the investments and what the MCPs learned from developing and implementing the Investment Plans.

Information required

A narrative description outlining:

- Which investments were successful in progressing the HHIP program goals (i.e., to ensure MCPs have the necessary capacity and partnerships to connect their members to needed housing services and reduce and prevent homelessness);
- Which investments were not successful in progressing the HHIP program goals;
- Lessons learned from developing and implementing the Investment Plan; and
- Which investments have the capacity to sustain HHIP program goals going forward, and alignment with ongoing CalAIM efforts.

To meet the performance measurement

This is a Pay for Reporting metric.

How CoCs can assist

CoCs and MCPs can partner to evaluate each activity and investment. CoCs can share any data and success stories about the impact of the investment. CoCs and MCPs can discuss which investments should be sustained going forward. CoCs can share their insights regarding lessons learned in working to implement their Local Homeless Plans and Investment Plans.

Metric 2.1: Connection with street medicine team providing health care for individuals who are homeless

Street Medicine is defined as health and social services developed specifically to address the unique needs and circumstances of unsheltered homeless individuals delivered directly to these individuals in their own environment. See *Medi-Cal and HHIP Coverage for Street Medicine* in this Toolkit. This metric is aimed at ensuring MCP members experiencing homelessness can access care via street medicine programs.

Information required

The percentage of MCP members experiencing homelessness during the measurement period who received care from the MCP's street medicine partner (or for MCPs operating in a designated rural county where a street medicine team is not present, the alternative services provided directly by the MCP).

To meet the performance measurement

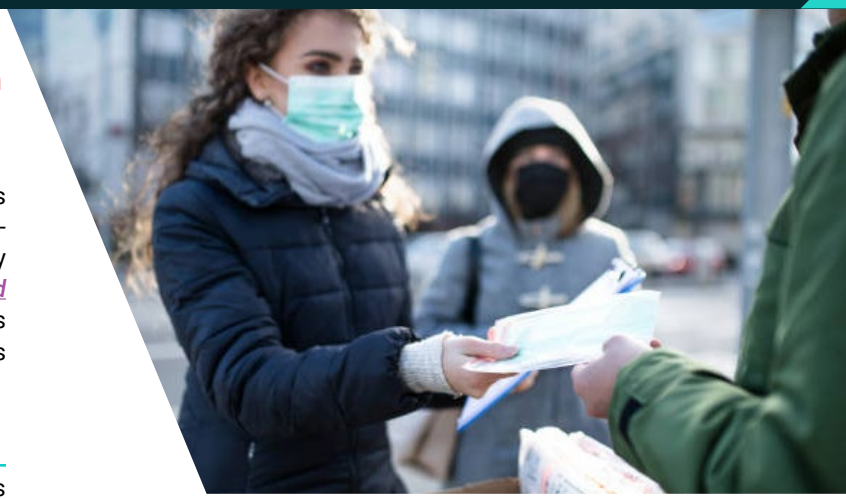
This is a Pay for Performance Metric. MCPs must report a 10% increase as compared to Measurement Period 1 submission.

How CoCs can assist

CoCs can collaborate with MCPs to identify their current street medicine programs, if any. They can make connections with health care providers who either have street medicine programs or would be open to participating in street medicine with associated funding. CoCs can share best practices with MCPs on how they coordinate street outreach, which can be applied to street medicine efforts. They can also connect street outreach teams to partner with street medicine providers. They can strategize with MCPs on what is needed to begin or expand street medicine so that additional people are able to access street medicine services. This may require additional financial investment (e.g., staffing or technology to accurately track service provision), which MCPs can provide.

Street Medicine

The 10% increase must be the proportion of members experiencing homelessness who have received street medicine services. For example: If 10% of the MCP's members experiencing homelessness were served via street medicine during Measurement Period 1, 20% of the MCP's members experiencing homelessness must be served via street medicine during Measurement Period 2. It would not necessarily be enough for the number of members served via street medicine to increase by 10% (e.g., 100 people served during Measurement Period 1 and 110 during Period 2).



Metrics 2.2: MCP connection with the local Homeless Management Information System (HMIS)

A critical component of HHIP is the ability of MCPs to work with their local CoCs to leverage the information contained in the local HMIS, ideally through direct access or data sharing and exchange.

Information required

Whether the MCP has the ability to:

1. Receive timely alerts from their local HMIS when an MCP's member experiences a change in housing status; and
2. Match their member information with HMIS client information.

MCPs must also describe their process to translate the timely alerts into supporting referrals for CS from CoCs and other housing providers.

To meet the performance measurement

The first two elements are Pay for Performance. The MCP must answer yes to both. The element of translating timely alerts into CS referrals is a Pay for Reporting Metric; MCPs are awarded for reporting on their process.

How CoCs can assist

CoCs can work with their MCPs to provide direct access to HMIS that is more than read-only or enter into DSAs to facilitate both member matching and alerts of housing status changes for MCP members. See *Bi-lateral Data Sharing Agreement Between a Continuum of Care and Managed Care Plan* and *Sample Workflow for Continuums of Care and Managed Care Plans to Conduct a Client Data Match* in this Toolkit. See also: Breaking Down Silos: How to Share Data to Improve the Health of People Experiencing Homelessness and How to Share Data: A Practical Guide for Health and Homeless Systems of Care.

Metric 2.3: MCP process for tracking and managing referrals for the housing-related Community Supports it is offering during the measurement period

MCPs can elect to offer their members a variety of Community Supports (CS), several of which are housing-related: housing transition navigation, housing deposits, housing tenancy and sustaining services, recuperative care/medical respite, short-term hospitalization housing, and day habilitation programs. MCPs contract with providers to deliver CS services. When eligible members are referred for a Community Support, they are assigned a CS provider, who should then follow up with the member and ultimately deliver CS services.

Information required

The percentage of their contracted housing-related CS providers who electronically received, followed up, and closed a housing-related CS referral.

To meet the performance measurement

This is a Pay for Performance Metric. MCPs must report a 5% increase from their Measurement Period 1 submission. MCPs are evaluated based only on the Community Supports they offered during the measurement period.

How CoCs can assist

Work with MCPs to integrate housing-related CS referrals into CE or HMIS to help facilitate and track those referrals electronically. To read additional ways to ensure eligible MCP members are connected to available housing-related Community Supports, see *Maximizing CalAIM's Enhanced Care Management (ECM) Benefit and Community Supports (CS) Services* in this Toolkit.

Community Supports

The 5% increase must be in the proportion of contracted housing-related CS providers who electronically received, followed up, and closed a housing-related CS referral. For example: If during Measurement Period 1, an MCP had contracts with 20 organizations to provide housing-related CS services and 2 (or 10%) of them electronically received, followed up, and closed a housing-related CS referral, to meet this performance measurement for Period 2, at least 15% of the MCP's contracted housing-related CS providers would need to have done so.

Metric 3.1: Percent of MCP Members screened for homelessness/risk of homelessness

MCPs must know which of their members are experiencing or at risk of homelessness to ensure they are connecting people to needed housing-related services. This metric also encourages MCPs to connect their members in need of housing-related services directly to the CoC's CE to be assessed, prioritized, and connected to CoC resources.

Information required

The percentage of MCP members who were screened for homelessness or risk of homelessness during the measurement period.

To meet the performance measurement

This is a Pay for Performance Metric. MCPs must report a 5% increase from their Measurement Period 1 submission.

How CoCs can assist

Educate MCPs on effective and trauma-informed ways to screen their members for homelessness. CoCs can also have outreach teams or other CoC providers screen members they work with and can offer to train MCP staff on trauma-informed care.

Screened for Homelessness

The 5% increase must be in the proportion of MCP members screened. For example, if the MCP had 5,000 members during Measurement Period 1 and screened 200 (or 4%) during that time period, they would have to screen at least 9% of their members during Measurement Period 2.

Metric 3.2: MCP Members who were discharged from an inpatient setting or have been to the emergency department for services two or more times in a 4-month period who were screened for homelessness or risk of homelessness

This metric is a subset of Metric 3.1, specific to MCP members who are discharged from an inpatient setting or in the emergency department for services two or more times over four consecutive months.

Information required

The percentage of MCP members who were discharged from an inpatient setting or in the emergency department for services two or more times over four consecutive months who were screened for homelessness or risk of homelessness during Measurement Period 2.

To meet the performance measurement

This is a Pay for Performance Metric. MCPs must report a 5% increase from their Measurement Period 1 submission.

How CoCs can assist

Partner with MCPs to create hospital liaison positions within a homeless service provider. Liaisons can partner with local hospitals and provide support and education on treating, triaging, and identifying people experiencing homelessness who use emergency department services.

Metric 3.3: MCP members experiencing homelessness who were successfully engaged in ECM

An important goal of HHIP is to connect people experiencing homelessness who are eligible for Enhanced Care Management (ECM) to that benefit. This metric evaluates whether MCP members are successfully referred to and receiving the benefit.

Information required

The percentage of MCP members experiencing homelessness engaged in ECM during Measurement Period 2.

To meet the performance measurement

This is a Pay for Performance Metric. MCPs must report a 5% increase from their Measurement Period 1 submission.

How CoCs can assist

Educate CoC members about ECM. CoCs can collaborate with MCPs to provide information to homeless service providers that describe the process for making ECM referrals. See *Maximizing CalAIM's Enhanced Care Management (ECM) Benefit and Community Supports (CS) Services* in this Toolkit.

Metric 3.4: MCP members experiencing homelessness receiving at least one housing-related Community Support

Similar to Metric 3.3, this metric focuses on ensuring people experiencing homelessness who are eligible for housing-related Community Supports (CS) are successfully referred to and receiving at least one of the housing-related CS services.

Information required

The percentage of MCP members experiencing homelessness who received at least one of the MCP's offered housing-related CS services (housing transition navigation, housing deposits, housing tenancy and sustaining services, recuperative care/medical respite, short-term post-hospitalization housing, or day habilitation programs) during Measurement Period 2.

To meet the performance measurement

This is a Pay for Performance Metric. MCPs must demonstrate a 5% increase from Submission 1 or their LHP (whichever of the two reported a higher percentage).

How CoCs can assist

Educate their providers about the specific CS services offered by their local MCPs. CoCs can collaborate with MCPs to provide information to homeless service providers that describe the process for making CS referrals. They can encourage their housing service providers to apply to become CS providers. See *Maximizing CalAIM's Enhanced Care Management (ECM) Benefit and Community Supports (CS) Services* in this Toolkit.

Metric 3.5: MCP Members who were successfully housed

MCPs reported on the percentage of their members experiencing homelessness during the 8-month measurement period 1 (May-Dec. 2022) who were successfully housed during that time. For Measurement Period 2, MCPs must show an improvement in their ability to help successfully house their members.

Information required

The percentage of MCP members who experienced homelessness during the 10-month measurement period 2 (Jan.-Oct. 2023) who were successfully housed during that time; partial points will be awarded for significant improvement that is less than 25%.

To meet the performance measurement

This is a Pay for Performance Metric. MCPs must report at least 25% improvement from Submission 1 for full points; partial points will be awarded for significant improvement that is less than 25%.

DHCS provided MCPs with guidance on the definition of "successfully housed" for purposes of the metric. In brief, "successfully housed" includes situations in HMIS that CoCs typically designate as permanent housing, as well as community-based housing without a designated length of stay, permanent supportive housing (PSH) and other service-enriched affordable housing, and rapid rehousing (RRH). It does not include crisis housing, emergency shelter, transitional housing, bridge (reserved crisis) housing, or other living situations that CoCs do not consider permanent housing. For DHCS's full description of "successfully housed," see Measure 3.5 and 3.6 Defining Successfully Housed.

How CoCs can assist

CoCs can connect as many MCP members experiencing homelessness as possible to the community's CE, as well as referred to and connected to ECM, housing-related CS, and other resources and services that help people find and access stable housing. They can also share with the MCPs the lack of affordable housing in the area and discuss ways to leverage MCP funding to increase housing availability.

Metric 3.6: MCP Members who remained successfully housed

MCPs had to report on the percentage of their members experiencing homelessness who were successfully housed between Jan. 1-Apr. 30, 2022 who remained housed through December 31, 2022. For Measurement Period 2, DHCS wants to know how many of those same people are still housed as of October 31, 2023. They also want to know how many members who were housed in the latter eight months of 2022 are still housed as of October 31, 2023.

Information required:

- The percentage of MCP members experiencing homelessness who were successfully housed during the first four months of 2022 who remained housed through October 31, 2023.
- The percentage of their members experiencing homelessness who were successfully housed from May 1-Dec. 31, 2022 who remained housed through October 31, 2023.

MCPs must also describe the methods they used to keep members housed, including rental subsidies, direct financial assistance, housing matching, and other methods.

To meet the performance measurement

This is a Pay for Performance Metric. MCPs must report at least 85% for full points; partial points will be awarded for significant achievement that is less than 85%.

How CoCs can assist

Provide insight to MCPs on the strategies and supports most likely to help recently homeless individuals and families sustain their housing. CoCs can also provide MCPs information on prevention resources that exist in the community for any recently housed members who are at risk of experiencing homelessness again. They can also share with MCPs the lack of affordable housing in the area and discuss ways to leverage MCP funding to increase housing availability.

Successfully Housed

For example, if the MCP reported for Measurement Period 1 that 7% of their members who experienced homelessness between May 1, 2022 and December 31, 2022 were successfully housed during that time, to receive full points for Measurement Period 2, they will have to report that at least 32% of their members who experienced homelessness between January 1, 2023 and October 31, 2023 were successfully housed during that time.