Recommendations to Improve Implementation of ECM & Community Supports for People Experiencing Homelessness

The introduction of CalAIM's housing-related services through Enhanced Care Management (ECM) and Community Supports (CS) has brought tremendous potential to support people experiencing homelessness as they transition to permanent housing and stable health. Over the first year of the Initiative, the homeless system of care has embraced the opportunities presented by CalAIM. At the same time, counties, Continuums of Care (CoCs), and service providers have become intimately aware of the many ways the cross-sector partnerships and processes needed to maximize these resources could be more effective.

A group of CoC representatives from across the state has been meeting monthly with Homebase focused on implementation of the Housing and Homelessness Incentive Program (HHIP). All 44 CoCs are invited to attend the monthly roundtable convenings. Most CoCs participate in some fashion, with attendance by staff who lead the CoCs' health care work or implementation of CalAIM.

Since May, the group has focused on ECM and CS, sharing what processes have been working and ways in which they can be improved. They identified a list of enhancements that would strengthen communication and collaboration across the health and homeless systems of care to ensure people experiencing homelessness are better able to access and utilize these critical CalAIM programs.

The recommendations fall into three broad categories:

- Streamlined referrals and coordination;
- Enhanced education, awareness, and training; and
- Improved data, metrics, and evaluation.

Below is a list of the recommendations developed by Homebase, the CoC representatives, and some of their key provider partners. These are intended to facilitate improved collaboration toward full and effective ECM and Community Supports implementation and can be shared with local Managed Care Plans (MCPs) and ECM/Community Supports providers as the community invests more deeply to ensure CalAIM maximizes the potential for Medi-Cal members to thrive.

Homeless system providers are making referrals to ECM and housing-related Community Supports (CS) for many of their clients. They follow the processes outlined by the different managed care plans serving their counties and frequently hear nothing back. They continue to serve their clients but are often wholly unaware of the services or care their clients are receiving under CalAIM, which makes it challenging to coordinate care and avoid duplication. Some homeless system providers would be excellent ECM and CS referral partners but are unaware of or confused by the differing referral processes and required documentation across MCPs and types of Community Supports.

Recommendations:

Reduce Barriers to Initiating Referrals.

- Minimize and simplify eligibility requirements for both ECM and Community Supports (especially housing-related CS). Consider:
  - Offer presumed eligibility for ECM and relevant Community Supports to people with certain conditions or life circumstances (similar to when a student is homeless, they are categorically eligible for free school meals and other programs).
  - Remove or reduce barriers relating to the Housing Deposit Community Support.
    - Allow members to access housing deposits when they receive housing navigation services from another trusted provider in the homeless system of care.
    - Permit CoC agencies who provide housing navigation services to refer members for Housing Deposits without requiring housing navigation to come from a CS contracted provider (e.g., by sending a developed housing plan along with a referral).
    - Remove prerequisite time-period requirements before Housing Deposits can be provided.
    - Require expedited turnaround time for Housing Deposit providers (e.g., same or next day, not weeks).
  - Relax requirements for documentation/verification for eligibility criteria.
  - Simplify or expedite diagnoses and/or prescriptions where required (e.g., pre-identified doctors, clinics, street medicine programs; connect certain diagnosis codes to automatic verification; etc.).
- Map out the local homeless response system/Coordinated Entry System to identify appropriate places for screenings/referrals to take place (i.e., specific system access points and/or providers).
  - Leverage Coordinated Entry intake points/hubs to get referrals and to facilitate follow-up with MCPs about referral outcomes.
  - Hire or support CalAIM coordinators to participate in the local Coordinated Entry System processes (e.g., manage ECM/CS referrals and follow ups, attend or coordinate case conferencing, etc.).

- Simplify referral processes and required documentation to allow for more efficient and effective referrals for members experiencing homelessness, including:
    o Streamlined referral forms.
    o Universal/standardized referral forms across MCPs and Community Supports that include fields for referring agency/CoC case worker(s) to contact for follow up.
    o Designated points of contact at each MCP for referrals from CoCs and homeless service providers.
- Develop a streamlined application/referral protocol for street outreach/street medicine teams to facilitate simplified, efficient direct referrals and follow-up.
    o Develop/utilize an app for street outreach/street medicine teams to make referrals from the field.

Improve Referral Follow Up Process.

- Coordinate with the CoC to identify ways CoC providers can help ECM and CS providers make initial contact with Medi-Cal members who may be living unsheltered, especially for ECM or CS providers with little to no familiarity with people experiencing homelessness. For example: to help assigned ECM or CS provider connect with member to confirm enrollment and begin delivering services.
- Encourage and require assigned ECM and CS providers to connect with CoC/Coordinated Entry System to identify and coordinate with case workers to ensure warm hand-offs.
- Institute protocols (including timelines) that apply after referrals are submitted to, at minimum:
    o Update the CoC (or provider who submitted the referral) on referral status and to notify them about any missing documentation or issues with the form or authorization request;
    o Confirm authorization, enrollment, and whether member has accepted enrollment; and
    o Provide name and contact information of ECM or Community Supports provider and/or ensure proactive outreach by that provider to the CoC or referring provider.
- Ensure referral follow up process includes a consistent and reliable way ECM and CS providers can connect with CoC providers who already work with members who were referred and enrolled.
- Develop or support a dashboard or other system to allow the CoC to track the clients/members who have been referred for services, as well as utilization of services. This is especially vital for CS benefits with one-time lifetime limits.

Facilitate Additional Cross-System Coordination to Improve Referral Outcomes.

- Designate MCP staff in each community to coordinate with CoCs about ECM and CS.
- Require contracted ECM and CS providers to get to know their local CoC/homeless service providers, such as through:
    o Virtual or in-person "meet and greets."
    o Introductions/updates when staff turns over.

- Encourage or require ECM and CS providers working with members experiencing homelessness to participate in the CoC (e.g., attend CoC membership or relevant working group meetings) to better understand dynamics and structures and to integrate into the local homeless response system.
- Encourage or require ECM and CS providers working with people experiencing homelessness to participate in relevant case conferences/case management/Coordinated Entry prioritization meetings.
- Provide clarity around the process to assign ECM and CS providers to members experiencing homelessness, including:
  o Timelines.
  o How decisions are made about assigning a provider to a member once eligibility is confirmed/benefit or service is authorized.
  o Protocols and expectations for ECM and CS providers to outreach and engage with members, confirm enrollment, begin to provide services, report back to MCPs, follow-up with referring entity, etc.
- Improve the process to assign ECM and CS providers to members experiencing homelessness to ensure providers with experience or specialized capacity to serve people experiencing homelessness are assigned to those members (and, where possible, providers who already have a connection with the members through the CoC).
- Participate in strategic conversations about braiding funds/coordinated investment planning that takes into account the community's existing homeless response strategic plans and MCP priorities.
- Host or participate in in-person conferences with community-based organizations/CoC agencies and MCPs/ECM/CS providers.

Enhanced Education, Awareness, and Training

Homeless system providers have found that many of the contracted ECM and CS providers listed by MCPs for referrals are new to their local communities, have no familiarity serving people experiencing homelessness, or in some cases are based out-of-state. At the same time, homeless service providers may only know a limited amount about Medi-Cal or CalAIM's new housing-related services. Greater education and training to both groups could enhance their collective abilities to provide streamlined and effective services to their shared clients. Moreover, Medi-Cal members experiencing homelessness often know they have health care coverage, but are wholly unaware of how the system works, let alone know that there are new benefits that could help them access stable housing.

Recommendations:

Educate and train homeless service providers and people experiencing homelessness.

- Distribute educational and marketing materials (aimed at both providers and members experiencing homelessness) about ECM and CS that include descriptions of the benefits and services and who is eligible for each. Information should explain both the resources available and the value in accessing them, as many people experiencing homelessness and providers who work with them may be hesitant to engage with a new program or

provider without specific information about how the resource will actually help when previously offered resources have often failed to help them successfully access and maintain housing.

- Provide clarity and informational materials to providers (especially those who might become contracted ECM or CS providers) regarding eligibility, reimbursable activities, and restrictions/limitations for ECM and each type of Community Support (e.g. one-time only benefits, limits on the number of providers who can serve a client on a single day, etc.) so that providers understand the reasons a person might be found ineligible and/or what reasons a provider might end up not getting reimbursed fully for activities related to ECM and CS.
- Differentiate the requirements or processes that are internal MCP requirements/processes vs. state- or federally-required.
- Hold informational and enrollment fairs with all local MCPs, specifically designed to help people experiencing homelessness apply for Medi-Cal if they are not already enrolled and/or screen and enroll them in ECM and CS if they are enrolled in Medi-Cal and have a health plan.
- Offer trainings for CoC/homeless system staff on managed care plans/Medi-Cal managed care and ECM/CS, as well as general information about how to help clients access and utilize the health system.
- Provide a list of contracted ECM and CS providers in each county that is updated regularly and includes:
  - Contact information for each provider (ideally a point of contact for people experiencing homelessness).
  - Counties/states in which the provider operates and where the provider is based.
  - Whether the provider has experience working with people experiencing homelessness or specializes in working with any other particular populations (e.g., certain age groups, people with behavioral health needs, etc.).
  - For CS providers, which Community Supports they are contracted to provide.
- Facilitate or support coordination among counties for purposes of sharing knowledge and resources (e.g., regarding strategies for reducing administrative burden on ECM/CS providers).
- Provide or help to secure technical assistance and fiscal support, especially to help CoC agencies become ECM and CS providers or help counties or providers develop capacity to serve as intermediaries for administration.

Educate and train MCP and ECM/CS provider staff.

- Provide trainings for MCP staff at all levels on housing and homelessness, including:
  - What CoCs are, what they do, funding available to them, resources they provide, etc.
  - Realities of homelessness and working with people experiencing homelessness (especially people who are unsheltered or have been homeless for a long time).
  - Local CoC structure, resources, critical gaps/needs, etc.
- Require trainings for ECM and CS care managers and case workers who have little to no familiarity with people experiencing homelessness that cover the following topics:

- o The community's homeless response system (Coordinated Entry System, HMIS, etc.).
  - o Realities of homelessness (especially unsheltered homelessness), how those impact a member's ability to engage with providers in the same way people not experiencing homelessness do, and adjustments providers need to make to expectations and the "usual course of business" as a result.
  - o Critical approaches and best practices for working with people experiencing homelessness such as Housing as Health Care, Housing First, Harm Reduction, Trauma-Informed Care, and Motivational Interviewing.
- Engage and support more ECM and CS providers who are 1) local,[1] 2) part of the CoC, and/or 3) have experience working with people experiencing homelessness.
  - o Support CoC providers to become ECM and CS providers by reducing the burdensome process and increase the reimbursement rate offered by MCPs.

Improved Data, Metrics, and Evaluation

Data collection, data sharing, and data analysis in the homeless response system can be constrained by the infrastructure that exists and is required by HUD. Yet CalAIM and other California initiatives have incentivized health and homeless systems of care to acknowledge that they work with the same clients and would benefit from greater data sharing and collective metrics and evaluation that look at both health and housing outcomes. To create the ideal conditions for the collective use of data required to create metrics and evaluate the success of cross-sector efforts, more resources need to be invested in bi-lateral data sharing.

Recommendations:

- Provide mandated trainings for MCP IT staff to better understand HMIS, including the history, the funding, the requirements (or lack thereof), and privacy considerations.
- Mandate that ECM and CS providers who serve members experiencing homelessness use HMIS.
- Provide financial and other support to enable more HMIS users and/or increase functionality of HMIS to enable easier data sharing (e.g., ability to export CSV file with client information to share with MCPs and receive matched member information back again directly into HMIS).
- Institute feedback protocols to understand member experiences (e.g., satisfaction surveys).
- Track utilization metrics by ECM and CS providers (e.g., length of time from authorization to enrollment, percentage of members who accept service) and provide support to or end contracts with providers with low success rates.

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[1] Many ECM and CS providers who are not located in the county in their members reside (especially those 2-3 counties away or out of state) depend on telehealth, which creates challenges to meaningful access for members experiencing homelessness.