Health Care Sector Participation in Coordinated Entry

September 22, 2021

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California Health Care Foundation

Today's Agenda

- Welcome by California Health Care Foundation
  - Michelle Schneidermann, Director of Advancing People-Centered Care
- Presentation by Homebase: Examples of Health Care Programs Participating in Coordinated Entry
  - Gillian Morshedi, Directing Attorney
- Provider Spotlight: Valley Homeless Healthcare Program's Involvement in Santa Clara County's Coordinated Entry System
  - Libby Echeverria, LCSW
- Q&A

California Health Care Foundation

CHCF is an independent, nonprofit philanthropy. We work to improve the health care system for Californians with low incomes and those not well-served by the status quo.

Our big priorities:

1. Get everyone covered
2. Deliver care better
3. Make care just

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ADVANCING SOLUTIONS TO HOMELESSNESS

- Subject matter expertise in homelessness and cross-system coordination
- Work at the federal, state, and local levels with an emphasis in California
- Assist communities and agencies to establish systems and programs needed to help people experiencing homelessness achieve housing stability and improve health and wellness

Innovative Thinking & Solutions

Transformational | Strategic | Practical

The Case for Collaboration

- Connection between housing & health care needs
- Disconnect between needs and access
- Disconnect between systems

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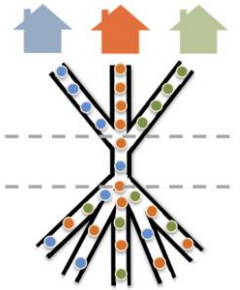
Coordinated Entry Refresher

- Fundamentals & Key Components
- Opportunities for Health Care Stakeholders

What is Coordinated Entry?

- Process each CoC sets up to ensure people experiencing or at risk of homelessness are:
  - prioritized for resources based on severity of need, and
  - matched to available resources most suited to them.
- Primary purpose is to allocate housing resources equitably and appropriately.



VS

Key Components: System Entry

System Entry

Clients seeking housing or services make contact with the community's homeless response system.

Key Components: Assessment

System Entry

Assessment

All individuals and families who enter the system are assessed in a consistent manner, using a uniform decision-making process and standardized assessment tools.

Key Components: Prioritization

System Entry

Assessment

1
2

Prioritization

Clients are prioritized for housing and community resources based on need-based factors agreed upon by the CoC.

Key Components: Matching

System Entry

Assessment

Prioritization

Matching

As housing resources become available, clients at the top of the priority list are given a choice to accept resources for which they are eligible.

Key Components: Referral

System Entry

Assessment

Prioritization

Matching

Referral

Clients matched with a resource are referred to the program holding that resource.

Key Components: Placement

Placement

Clients are placed into the program and ultimately into housing.

Participation Opportunities

- Help connect potentially eligible patients to CE entry points
- Serve as a CE entry point
- Help review, select, and/or develop assessment tool(s)
- Provide space for assessments to take place
- Administer assessments
- Work with CE system to ensure health considerations are factored into prioritization

System Entry

Assessment

Prioritization

Participation Opportunities (cont'd)

- Participate in matching case conferences
- Help clients understand their options and potential impacts on health care access
- Offer support like health care or other services to increase likelihood that referred patients are accepted and successful in housing
- Help clients procure necessary eligibility documentation and provide transportation help to get clients to appointments
- Follow up with housed clients to ensure continued connections to health care

Matching

Referral

Placement

Health Care Participation in Coordinated Entry

- Examples of Successful CoC-Health Care Partnerships
- Provider Spotlight: Valley Homeless Healthcare Program

Examples of Successful Partnerships

Yakima Neighborhood Health Services (Washington) and **Heartland Health Outreach** (Chicago) serve as CE access points. They identify and complete the CE intake process for people who may be eligible for homeless services.

Managed care plans can work with CoCs to ensure plan members connect to the CE system to be assessed and prioritized for housing resources.

Examples: **L.A. Care and United HealthCare**

Washington state provided CoC/CE training to state psychiatric hospital discharge planning staff so staff could better identify patients who were eligible for homeless assistance and connect them to the relevant CE systems.

Hospital, clinic, and community health center staff are often part of homeless outreach or street medicine teams, which can serve as CE system entry points for people experiencing unsheltered homelessness.

Examples of Successful Partnerships

Baltimore Health Care for the Homeless assisted in building and testing the CoC's locally-created CE assessment tool and provided training for CoC staff to use the tool.

Albuquerque Health Care for the Homeless is an assessment location for the CE system. Trained Engagement Specialists complete CE assessments for clients.

Daily Planet Health Services (Richmond, VA) and **Hennepin County Care for the Homeless** (Minn) participate in case conferences to help match prioritized households to resources and support progress toward housing.

Houston's CE system partners with three Health Care for the Homeless programs to refer clients to health clinics, dental services, mental health services, HIV services, and housing.

COVID-19 as a Partnership Catalyst

- People experiencing homelessness are among those most vulnerable to severe COVID-19 illness and death for multiple reasons
- Many CoCs across the country adjusted their CE prioritization schemes to incorporate COVID-19 risk factors
- Public health departments, local Health Care for the Homeless programs, and other health system stakeholders were key partners

Provider Spotlight

VALLEY HOMELESS HEALTHCARE PROGRAM (VHHP)

https://www.scvmc.org/hospitals-clinics/valley-homeless-health-care-program-vhhp

Questions?

Upcoming Webinars + Resources

- Join us next week for the final webinar of this 3-part series on cross-system collaboration and data exchange between health and homeless systems of care: **Sharing Data Across Health and Homeless Systems of Care**
    - September 29, 2021, 11:30 – 12:30 PST
    - Register
- Supporting resources:
    - Homelessness Response 101 for Health Care Providers and Stakeholders
    - Breaking Down Silos: How to Share Data to Improve the Health of People Experiencing Homelessness
    - Homebase: Resources for Building Health Care-Homeless Response System Partnerships

Thank You!

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