



Trinity Health

Health Care for the Homeless (HCH) Scorecard Examples for FY18 Priorities

Based on FY17 Results

Table of Contents

Accessible Outpatient Services	0
Care Manager or Care Navigator Use.....	0
Operates in an Accessible Location.....	0
Street Outreach and/or Education.....	1
Supports Dental Care.....	2
Supports Housing First Model Financially.....	3
Supports Housing First Model w/ Staff.....	3
Staff Engagement in Meal Serving Externally.....	3
Staff Engagement in Meal Serving Internally.....	4
Provides Final Support to Community Clinics or Service Agencies.....	4
Provides Clinical Services to Shelters, Clinics, or Soup Kitchens.....	4
Provides and/or Funds Staff to Community Clinics or Service Agencies.....	5
Accepts Referrals from Community Clinics or Service Agencies.....	6
Provides Goods to Patients Internally.....	6
Provides Goods to Patients Externally.....	7
Financial Support for Patients Internally.....	7
Serves Patients in ED.....	7
Collaboration for Coordinated Care	8
Address Needs Upon Admission.....	8
Address Needs Upon Discharge.....	8
Trauma Informed.....	9
Continuing Education (e.g. training).....	9
Post-Acute/Respite Care Coordinated.....	9
Coordinated for ED.....	10
Coordination for Acute Care.....	10
Coordination for Inpatient.....	11
Conducts Follow Up.....	11
External Partnerships with Organizations.....	11
Community Outreach/Education.....	12
Addressing Specialty Health Concerns.....	12
Coordinates Connections to Community Agencies or Services.....	13
Care Manager, Navigator, or Planner (SW, RN, CHW, etc.).....	13

Complex Care Coordination Teams	14
Addressing Gaps in Care	15
CHNA Around Homeless Needs	15
Conducted Focus Groups	15
Support Medical Respite	16
Coordinated Care with Community Orgs.....	16
HCH Interdisciplinary Collaboration.....	17
Identified Homelessness as a Priority	17
Financially Supports Clinical Services.....	18
Financially Supports Community Agencies or Services	18
Organizational Member of National Health Care for the Homeless Council	19
Supports Expanding Behavioral Health Services	19

Examples

Accessible Outpatient Services

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

Care Manager or Care Navigator Use

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

Examples:

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

Operates in an Accessible Location

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

Examples:

- "Operates ...in neighborhoods where poverty is most concentrated...These locations are accessible by foot for the immediate neighborhoods served and by bus".*
- "The clinic is strategically located for easy access for community members in need".*

- "...Clinic is located in [an area] which has been identified as a primary area for the homeless".

- "All 3 of these clinics are operated in our most densely populated city in our service area with a high immigrant population."

- "Our clinics are accessible to all members of the community and several are located within our most vulnerable neighborhoods."

- "located...near...a Federally Qualified Health Center. Emergency health services are available through the Mercy ED 24 hours/7 days a week. The SCHC has extended hours for patients in need of routine medical services or chronic health care management. Mercy ED has pre-established appointment (blocked) times available at the SCHC for patients that need a follow-up visit with a primary care physician. "

- "...operates seven Mission Clinics in accessible community locations with vulnerable populations (homeless, migrant, undocumented) in diverse, impoverished communities in zip codes demonstrated with the highest need".

- "provides outpatient care to homeless individuals. This is inclusive of its primary care physician offices, wound care center, and specialty medical care in geographically dispersed areas throughout the community. ...Outreach team provides health services at (2) different homeless social service sites, and a (3rd) church-based location. In addition, a Mobile Unit provides access to screening services and special community based events such as a Homeless Foot Clinic are held throughout the year. These combined services provide access to our homeless population throughout the week; Saturdays, and events are often held on Sundays. [Our] County has a large geographic footprint and [Our RHM] has grown to meet the needs of its community. It strategically locates itself in high density areas making access convenient."

Street Outreach and/or Education

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

Examples:

- "Provide funds...to purchase a van for the newly formed Medical Respite Program of the Homeless".

- "Provides street outreach to engage and treat persons without homes, in rural communities, with multiethnic backgrounds, or persons with limited resources who may be affect by Social Determinants of Health."

- "Mobile clinic provides services to people who are 'housing insecure' (multiple families living in one home)".

- "Outreach RN is deployed to serve at designated locations where homeless individuals congregate".

-"...Provides mobile outreach through our Pediatric Van program. Our mobile unit serves homeless children in [the city] and the suburbs through their schools. We also respond on an as needed basis to new families in the area who are homeless and have relocated to a new community. In these circumstances, we meet them near their current location or see them on campus at the mobile unit."

-"[A homeless program started by the hospital] has regular clinics in addition to a mobile van that visits various sites throughout out the city."

-"Provides street outreach to engage and treat persons without homes, in rural communities, with multiethnic backgrounds, or persons with limited resources who may be affected by Social Determinants of Health".

-"Comprehensive Psychiatric Emergency Program (CPEP) operates a Mobile Crisis Outreach program, which serves individuals around the clock irrespective of housing status".

-"operates a mobile coach and a street medicine program offering healthcare services, items for daily living, referrals and connections to community resources".

-"Outreach team provides health services at (2) different homeless social service sites, and a (3rd) church-based location. In addition, a Mobile Unit provides access to screening services and special community based events such as a Homeless Foot Clinic are held throughout the year."

-"[We have] a mobile medical unit that provides basic primary care to the homeless and undocumented population...The van is deployed to several locations throughout [the area] five days per week without fees to its patients. In addition to medical services, the...Van gives out coats during the winter months and other basic necessities...OBGYN staff physicians and nurses provide prenatal education to [homeless shelter for pregnant women] and the CB manager provides professional development education to the ladies on a monthly or bi-monthly basis."

Supports Dental Care

Brief Definition: Increasing the accessibility of dental care and/or oral health services either through methods including but not limited to financial support, resource distribution, awareness raising, offering of direct services, coordination of care with local agencies and clinics, street outreach and/or education.

Examples: *-"...operates a free medical and dental 'safety net' clinic in the walls of a partner organization who feeds the poor and homeless".*

-"Provides financial support to...Dental Clinic for dental services for the underserved and those without homes".

-"worked through Project Homeless Connect to provide medical, dental and eye care to homeless individuals".

-"We offer free primary care medical and dental visits at no cost to those in need (homeless and poor)".

-"[Our RHM] also financially supports dental services that are available at the [the community health center/FQHC]."

- "CBMO has a portion [of] hours...allocated in kind to the...Free Dental Clinic".

- "Provides a patient advocate who visits area homeless camps daily (Monday-Friday) and documents services needed for daily living activities and helps make connections to other safety net providers (dental care etc.)"

Supports Housing First Model Financially

Brief Definition: Donating CHWB dollars to organizations that [support Housing First initiatives](#) or funding housing directly.

Examples:

- "Donates \$100K to...Housing First initiative".*
- "...funds 20 apartments for the homeless using Housing First Model and Permanent Supportive Housing, and including Diversion Case Management to prevent homeless".*
- "...subsidize rent for 15 families in low income housing".*
- "Funding Rapid Re-Housing for Adults program [a community housing organization]- \$45K".*
- "...awarded a grant to [a local organization] to provide permanent supportive housing and case management services for chronically homeless individuals and families".*

Supports Housing First Model w/ Staff

Brief Definition: RHM staff leading initiatives, collaborating with agency leaders, or serving on committees, etc. which focus on [Housing First initiatives](#).

Examples:

- "...serve on [Housing First initiative] Steering Committee to shape overall project as well as design of the supportive services component."*
- "...we support a local effort focused on the 'housing first' model for the homeless...we have staff donating time every week."*

Staff Engagement in Meal Serving Externally

Brief Definition: Staff volunteering to support local community agencies and/or organizations in their operations of serving meals to those experiencing homelessness.

Examples:

- "...provides one meal a month to Hope Ministries (over 3000 lunches)"*
- "...deploys staff on a weekly basis to the...soup kitchen".*
- "Mission council routinely provided people to help serve meals at the local homeless shelter."*

Staff Engagement in Meal Serving Internally

Brief Definition: Staff volunteering to support RHM initiated, direct serving of meals to those experiencing homelessness at hospitals, clinics, or any other facility affiliated with an RHM.

Examples: *"...provides a monthly meal at the Mission which is served by...staff".*

Provides Final Support to Community Clinics or Service Agencies

Brief Definition: Allocating CHWB dollars towards community clinics or local service agencies that are serving those experiencing homelessness. Support can be towards general operation costs, a specific service, an event, a needed resource, or anything else that is needed to serve the community.

Examples:

- "funded over \$950,000 to community partners to help meet the needs of the homeless".*
- "provided funds to the Interfaith Partnership for the Homeless to purchase a van for the newly formed Medical Respite Program of the Homeless."*
- "...financially support to two FQHC's"*
- "works with our local free clinics...to enhance the work that they do... Provides a large annual financial contribution to [a local free clinic] each year for general operation".*
- "Provides financial support to community based homeless clinic or services agency".*
- "...funds (\$25,000 annually) to a medical respite center located at the [local] Rescue Mission (a partner organization). [Our] Medical Center will also be supporting the homeless "point-in-time" count (\$5,000) this fiscal year."*
- "Provides financial support to [a local dental clinic] for dental services for the underserved and those without homes."*

Provides Clinical Services to Shelters, Clinics, or Soup Kitchens

Brief Definition: Offering and administering clinical services such as screenings, immunizations, physicals, pharmaceutical needs, lab services, counseling, or any other form of care delivery to advance health, to community clinics or local agencies that serve those experiencing homelessness.

Examples:

- "...conducts multi-functional clinic at homeless shelter (to include financial assistance, foot care, etc.)"*
- "Provides in-kind goods **or services** to community based homeless clinics and services"*
- "Operates a free medical and dental "safety net" clinic in the walls of a partner organization who feeds the poor and homeless".*
- "We also work [with local free clinics] on many wellness programs by providing staff hours and space. We have a contract in place...to provide lab work for their patients at no cost....There is a program in place to provide [local] Nurses Clinic patients with free mammograms".*

- "provide RNs to soup kitchens...provides staffing at clinics... Outreach RN is deployed to serve at designated locations where homeless individuals congregate".

- "provides...the charitable pharmacy... staff provide care at community homeless shelters and soup kitchens."

- "provide lab services for patients from [local free clinic]"

Provides and/or Funds Staff to Community Clinics or Service Agencies

Brief Definition: Offering and administering clinical services such as screenings, immunizations, physicals, pharmaceutical needs, lab services, counseling, or any other form of care delivery to advance health, to community clinics or local agencies that serve those experiencing homelessness.

Examples:

- "...clinical staff offer blood pressure screenings and education at [soup kitchen events]"*
- "Deploys staff to community-based homeless clinics or service agencies..."*
- "...awards a grant...to support a full-time Medical Case Manager, an RN, and a Mental Health Care Manager to serve those diagnosed with a chronic disease and to connect them to long-term services"*
- "- "Mercy's HCH is the clinical sub-contractor for [the City's Health Services for the Homeless] and has been providing clinical, street and shelter services since 1983. Staff provide services at 23 sites in [3 different cities/counties] area and has a strong street outreach program consisting of a nurse, case manager and outreach volunteer person".*
- "... a Program Counselor and a Psychiatric Nurse Practitioner...interfaces with the Salvation Army and Rescue Mission accepting referrals for assessment and follow up care. She schedules weekly appointment times at the Salvation Army's Women Shelter and Emergency Shelter as well as the Rescue Mission. If time is available, she and the NPP also provide services to [3 different agencies which also serve the homeless population]. Both staff work with...Inpatient Psychiatric Units as well to connect/reconnect with anyone who is in inpatient care and are known to be homeless."*
- "Several...OBGYN staff physicians and nurses provide prenatal education to [homeless shelter for pregnant women] and the CB manager provides professional development education to the ladies on a monthly or bi-monthly basis."*
- "...provides in kind service to community based homeless agencies, such as vaccines for children and Reach Out and Read. [RHM] deploys staff to community based services. Recently we did a program for over 100 uninsured women patients to complete their women's health exam".*

Accepts Referrals from Community Clinics or Service Agencies

Brief Definition: Either from a formal or informal relationship with local organizations allows those referred to be seen by RHM. Referrals could be for specialty, inpatient, outpatient, and any other service needed along the continuum of care.

Examples:

- "Accepts referrals for patient or specialty care from community based homeless clinic according to a written agreement"*.
- "...accept patients from homeless clinics as appropriate"*.
- "...accepts all in-patient or specialty care referrals from area agencies that provide services for the homeless..."*.
- "As a community hospital, [we] accept referrals for inpatient and specialty care of homeless individuals from social service providers, homeless shelters, and day centers."*
- "...accepts all in-patient or specialty care referrals from area agencies [that] provide services for the homeless – for example, the Rescue Mission, the American Red Cross and Catholic Charities...currently working with the Catholic Charities local organization to participate in a federally funded program that will provide care through SAMSHA to set up area local clinics to provide care for all individuals with serious mental illness and substance use disorders."*
- "[a Psychiatric NP] interfaces with the Salvation Army and Rescue Mission accepting referrals for assessment and follow up care. She schedules weekly appointment times at the Salvation Army's Women Shelter and Emergency Shelter as well as the Rescue Mission."*
- "Accepts referrals for inpatient or specialty care from community-based homeless clinics according to a written agreement with [an agency that works with] "Border Kids" and refugees who are abandoned at the United States borders."*

Provides Goods to Patients Internally

Brief Definition: Tangible goods are given to those experiencing homelessness that seek services at an RHM.

Examples:

- "...provides Blessing Bags to homeless patients that come through our system or other organizations in the community that deal with the homeless. Specific contents of the bags include: Blanket, hat, scarf, gloves, socks, bag of food containing at least one protein item, raisins, applesauce, energy bar, bottle of water, and miscellaneous extras, bag of toiletries containing first aid kit, flashlight, soap, shampoo, conditioner, lotion, etc., local resource list, and card reflecting our love and concern for the recipient."*

Provides Goods to Patients Externally

Brief Definition: Tangible goods are donated to, and distributed by, organizations that serve those experiencing homelessness.

Examples:

- "Donations of food, clothing, and other goods have been donated...to area homeless shelters through clothing and food drives".*
- "Donates hygiene items to shelter..."*
- "Provides fresh produce, canned goods, and bath blankets to the homeless shelters in our area".*
- "...provides food, clothes, diapers etc. to several community based homeless agencies".*
- "[has] backpack drives, flu shot clinics, Reach Out & Read events, "Mom" events for new and expecting mothers, free exercise classes, food trucks, and other community events".*
- "...provides meals, housing, clothing and household items to individuals and families in need of assistance at no cost".*

Financial Support for Patients Internally

Brief Definition: Financial assistance is provided to patients that are seen at RHM facilities regarding needs that they may have impacting their ability to receive reliable care, address personal maintenance or health needs, or be eligible for additional support services. This can include things such as documentation, clothing, transportation, medication, and more.

Examples:

- "...provides financial support to patients in need of acquiring ID documentation, clothing, transportation, and medication to individuals in need...bus passes for transportation to medical appointments, goodwill pass, money for clothing, and assistance in obtaining identification for financial aid".*

Serves Patients in ED

Brief Definition: Meeting the needs of those experiencing homelessness through ER visits.

Examples:

- "...serves the homeless and uninsured population in our ER..."*
- "Emergency health services are available through the ED 24 hours/7 days a week...ED has pre-established appointment (blocked) times available at the [local FQHC] for patients that need a follow-up visit with a primary care physician"*

Collaboration for Coordinated Care

Q3: RHM collaborates with internal and external parties to coordinate care for persons without homes

Address Needs Upon Admission

Brief Definition: Housing status is collected and acknowledged during admission. This information is used to inform the steps of care provided during the visit. The patient is connected with individuals during admission that can provide supportive, informed, and coordinated care based on their specific needs as someone experiencing homelessness.

Examples:

- "Assigns navigator, care coordinator, social worker, community health worker, or similar staff member to each homeless inpatient or emergency department admission..."*
- " All patients are assessed for living situation/arrangements during the initial assessment. Social Workers are involved if patients are homeless - unless they are secure in a shelter and will be returning back to prior living arrangements."*
- "Housing arrangements are discussed with the patient and the nurse case manager and/or social worker collectively complete the initial assessment of all patients and document the information in the medical record".*
- "Clinical Care Managers identify housing vulnerability during their assessment process. If patient has complex needs, efforts to coordinate post-discharge care also involve a social worker in the development of a safe transition plan."*

Address Needs Upon Discharge

Brief Definition: Housing status is revisited during discharge for those who have been identified as experiencing homelessness. This information is used to inform the discharge process and care plan. The patient is connected with individuals during discharge that can provide supportive, informed, and coordinated care based on their specific needs as someone experiencing homelessness.

Examples:

- "In the acute care setting, housing arrangements are addressed as part of the discharge plan".*
- "A social worker...will engage homeless individuals to help address their housing needs upon discharge".*
- "Addresses housing arrangements in every discharge plan."*
- "Clinical Care Managers identify housing vulnerability during their assessment process. If patient has complex needs, efforts to coordinate post-discharge care also involve a social worker in the development of a safe transition plan."*

- "has a social worker who floats through the Emergency Department and will engage homeless individuals to help address their housing needs upon discharge"*.
- "addresses housing arrangements in every discharge plan by executing discharge planning assessments between 24 to 48 hours"*.
- "Care Management staff addresses housing arrangement in discharge plans in order to ensure a safe discharge."*
- "...assessment identifies the specific patient needs or concerns for the interdisciplinary team members to use as appropriate in developing the discharge plan."*

Trauma Informed

Brief Definition: Having the incorporation of [trauma informed care](#) practices, principles, and approaches embedded into the care structure and protocol for working with those experiencing homelessness.

Examples: *-"Trains teams and individual staff members in trauma-informed care".*

Continuing Education (e.g. training)

Brief Definition: Having opportunities for staff to obtain additional training around understanding and meeting the needs of those experiencing homelessness, through trainings, workshops, webinars, guest speakers, online modules, or any other form of engagement. This can include, but is not limited to, [trauma-informed care](#).

Examples: *-"Social workers frequently attend trainings on trauma-informed care".*
-"ER orientation and continuing educations curriculum includes training in 'trauma-informed care' for staff and physician".
-"In partnership with the National Health Care for the Homeless Council...sponsored a day long trauma informed care workshop for homeless service providers and also partnered with the Western Mass Network to End Homelessness in providing 3 days of training in the areas of trauma informed care/motivational interviewing".

Post-Acute/Respite Care Coordinated

Brief Definition: The ability for patients experiencing homelessness to recover and heal in a safe environment is coordinated prior to discharge. Coordination can be done with services the RHM itself offers or through partnerships/connections with local organizations that can also meet this need.

Examples: *-"Beginning in 2017, a Medical Respite site opened at [our] Hospital, which will be operated by Interfaith Partnership for the Homeless. This 10-bed unit will be an option for homeless patients who are appropriate for hospital"*

discharge, but are too frail or ill to recover from a physical illness or injury on the street or in a traditional shelter."

-"Coordinates care with and makes referrals to [Recuperative Center] in [the] County, 3 medical respite beds available".

-"Because [our] County has fewer than 20 medical respite beds, oftentimes homeless patients remain as an inpatient to receive necessary on-going medical treatment vs. discharging them to the street. On occasion, the administrative team has provided motel nights for discharged patients to ensure a safe healing process and transition into shelter care."

-"Has access to Medical Respite Care beds or equivalent safe discharge location as discharge option for appropriate patients".

-"Social workers utilize the Mission Shelters and medical care beds in those shelters for respite care as discharge options for appropriate patients. We also have put patients up in hotels for a period of time to aid in their recovery."

-"Respite care is given on an as needed basis to HCH patients and is supported through donation resources with the HCH program".

-"Ensures affordability and accessibility of post-acute care of persons without homes."

-"...staff at both clinics include case management and the ER departments (both) have social workers assigned to assist, care management teams provides options for post-acute care including a Zip doc program".

Coordinated for ED

Brief Definition: Housing status is taken into consideration in the care coordination, delivery, resource identification, and overall care via explicit protocol, roles, or structure in the emergency department for patients.

Examples: *-"...has a social worker who floats through the Emergency Department and will engage homeless individuals to help address their housing needs upon discharge".*

-"...employs a social worker to each homeless inpatient or ER patient".

-"The team consists of 4 case managers that address homelessness and housing status both off-site and in the acute care/emergency department setting".

-"Assigns CHW to each homeless...emergency department admission".

Coordination for Acute Care

Brief Definition: Housing status is taken into consideration in the care coordination, delivery, resource identification, and overall care via explicit protocol, roles, or structure in acute care (including post-acute) for patients.

Examples: *-"Internally, a 'Difficult to Discharge' meeting is held once a week to discuss and coordinate complex cases, within all of our acute care hospitals"*

-"Post-acute care/rehab needs for persons without homes are assessed with individuals [and] placed in appropriate medical settings as needed".

- "Both RN and Social Workers ask Housing Status for patients; this has to be documented every 12 hours in Meditech and/or Care Management Software. Care Coordination Workflow was developed for each point of care with each area factoring living situation into overall plan of care: (1) PCP, (2) ED/Community-Based Care Manager, (3) Acute Care Hospitalization/Community Based Care Manager, (4) Home Care/Community Based Care Manager, (5) Nursing Facility/Senior Facility/Community Based Care Manager, (6) Urgent Care Work Flow, (7) LIFE Workflow".

Coordination for Inpatient

Brief Definition: Housing status is taken into consideration in the care coordination, delivery, resource identification, and overall care via explicit protocol, roles, or structure for inpatient care.

Examples:

- "Assigns navigator, care coordinator, social worker, community health worker, or similar staff member to each homeless inpatient..."*
- "Assigns CHW to each homeless inpatient...admission."*
- "employs a social worker to each homeless inpatient...This social worker then offers resources (housing opportunities) and tools (available social services) to the patient."*

Conducts Follow Up

Brief Definition: After discharge, there are procedures in place that are executed in order to contact or locate patient experiencing homelessness to follow up in a way that is considerate of their housing status and needs.

Examples:

- "The discharge planners are assigned to follow up on all homeless patients even after discharge"*
- "The discharge planner and case manager work to ensure follow up appropriate follow up after hospitalization".*
- "Health Home assigned patients discharged to the local shelters from the hospital are followed by the Health Home Care manager who will attempt to engage in a face-to-face within 2 days of discharge".*

External Partnerships with Organizations

Brief Definition: Collaboration, care coordination, resource sharing, referral arrangements, and other forms of engaging with local agencies or organizations that also serves those experiencing homelessness. Can be informal or formal.

Examples:

- "Yes, we have a dedicated social worker that is active on the Continuum of Care, community group for homeless services".*
- "We remain engaged in interagency care conferences with community partners...also launched a Health Resource Hub with two CHW's that have the ability to work on homelessness with clients in need".*

- " To ensure persons discharged have access to affordable post-acute care, Mercy as arrangements with a local pharmacy...and the local...Community Health Center."

- "The program has a long history of collaborating with numerous community providers in both a formal and informal setting. Some examples of external partnerships are: HUD Continuum of Care meetings; HUD Continuum Board of Directors; Shelter Case Management meetings; Co-Leadership of the [Network to End Homelessness]; Police Outreach meetings; Pont-in Time HUD counts; [School Department] meetings, etc."

Community Outreach/Education

Brief Definition: Utilizing RHM staff to enter the community both in spaces of advocacy as well as in direct service and contact with those experiencing homelessness, to educate, offer care, and/or connect with services. This role can be fulfilled by a designated outreach person or team, a social worker, RN, community health worker, or anyone else that your RHM sees fit.

Examples: *- "Community Outreach leadership staff participate actively in the...County Homeless Continuum of Care meetings in the community, providing leadership, advocacy, and as a liaison between the hospital and homeless provider arena."*
- "The registered nurse who is employed as a community outreach educator has recently been assigned to this Chronic Care Committee".

Addressing Specialty Health Concerns

Brief Definition: In the development of resources, care coordination, organizational partnerships, support services, or donations the need for specialty care and services is taken into consideration and incorporated in order to meet those needs. Examples could include specific diagnoses such as AIDS/HIV or Cancer; or specialist care providers such as connections to offer ophthalmology or OBGYN services.

Examples: *- "We also work with the Ministry of Hope for homeless patients with AIDS/HIV. We have made several referrals to the Sacred Heart Home...which provides hospice for cancer patients who are homeless and/or uninsured."*
- "We also engage in interagency case conferencing with community partners such as [local AIDS organizations], Specialty Care, and Advantage Behavioral Health for the homeless population."

Coordinates Connections to Community Agencies or Services

Brief Definition: Leverages partnerships or awareness of community agencies or services when coordinating care for patients experiencing homelessness. Facilitates the connections to organizations through either a protocol that can be executed by any staff person, or through the support of a care navigator/support person designated to coordinate connections.

Examples:

- "...partners with social service agencies to assist those experiencing a housing crisis and to connect them to primary care services..."*
- "Links patients with appropriate community resources and outside agencies".*
- "We do not have an assigned staff liaison for community-based providers of homeless health care, but all of our social workers have relationships and work closely with these providers but not as a formal liaison. Yes, we have a dedicated social worker that is active on the Continuum of Care, community group for homeless services. And they contact collateral agencies all the time for care plans on patients."*
- "[we partner] with social service agencies to assist those experiencing a housing crisis and to connect them to primary care services provided by [our clinics]"*.

Care Manager, Navigator, or Planner

Brief Definition: Utilization of a designated role that works to support those experiencing homelessness (does not have to be exclusively) that seek care at an RHM. This can be a social worker, RN, community health worker, or otherwise designated care coordinator.

Examples:

- "Clinical Care Coordination Staff (RN discharge planners & social workers) within the hospital work with all patients to address needs, including homelessness"*
- "Assigns navigator, care coordinator, social worker, community health worker or similar staff member to each homeless inpatient or emergency department admission".*
- "Assigns CHW to each homeless inpatient or emergency department admission".*
- "To the best of their ability, Clinical Care Coordinators ensure affordability and accessibility of post-acute care to homeless individuals, this may include referrals for public assistance (food stamps and TANF (temporary aid to needy families), health insurance (Medicaid, Medicare, NYS Health Exchange), or SPHP Financial Assistance."*
- "Social work at Saint Francis is consulted if the discharge plan or medical needs are complex for homeless or housing insecure patient. If a homeless patient has medical needs which require home care, Social Work will coordinate with home care liaison, usually Home Care, to meet with patient either at the Sunday Breakfast Mission or at day program at [a local organization]. Social Work will also coordinate with other transitional housing programs...for which persons must apply, interview and be accepted".*

Complex Care Coordination Teams

Brief Definition: Internal interdisciplinary and or/interagency coordination to collaborate on problem solving, resource identification, care plan development, or general strategy to best serve those experiencing homelessness that have presented as complex care cases.

Examples:

- "Engages in interagency case conferencing with community partners: Through the community-wide Case Manger's Committee".*
- "Weekly, there is a multi-disciplinary Discharge Planning meeting for complex cases and frequent visitors that takes place to discuss complex cases and strategize for best outcomes. Holy Cross works with its community partners and at times engages in interagency case conferencing with community partners to coordinate patient care and outcome planning."*
- "Assigns navigator, care coordinator, social worker, community health worker or similar staff member to each homeless inpatient or emergency department admission—Identified homeless inpatients are linked to care manager and identified homeless senior's emergency center patients are linked to a social worker".*
- "On a weekly basis, a meeting of [our] discharge planning team, community based care coordinators, and [a local mental health agency] is held to discuss 'complex care patients' that frequently visit Mercy and the other local hospital."*
- "An internal team, the Complex Care Committee, has been formed to develop care mapping and cost-saving initiatives for the care of complex patients. This coordination is also afforded to all homeless patients. This committee consists of clinical leaders from acute medical care, managers from the ER and clinic areas, the VP of the medical staff, physicians in charge of the residency program, quality personnel and social workers."*
- "Social Workers and Case Managers arrange care conferences on complex cases that include the medical team to develop a comprehensive plan to address medical and mental health needs."*

Addressing Gaps in Care

Q5: RHM develops, shares and analyzes data on population health with providers such as community health centers, HCH programs, other safety net providers.

CHNA Around Homeless Needs

Brief Definition: Contain a component of asking about housing status and homelessness in the Community Health Needs Assessment. It is not necessary for the CHNA to surface homelessness as a priority.

Examples:

- "[our RHM] explicitly includes homeless population in Community Health Needs Assessment. We do have a section in our CHNA that looks at the homeless population in our counties however it is not included in our Top 10 health needs that we based our implementation strategy on."*
- "As an active participant in the Annual Point in Time Survey, providing direct homeless healthcare services in the community, and attending to the inpatient needs of the homeless, Holy Cross is acutely aware of the insufficiencies and gaps in care for homeless individuals in [our] County. This situation is accurately portrayed in our needs assessment both in the narrative and prioritized needs; housing and food insecurity amongst the highest."*

Conducted Focus Groups

Brief Definition: Utilize a focus group of individuals who either serve those who experience homelessness, are experiencing homelessness, or formerly were, to gain an understanding of community health needs or service gaps in the community.

Examples:

- "[Our] Medical Center did 2 Focus Group[s] where we engaged clients who in the...Transitional Housing Program. One focus group was done in English and the other in Spanish. Results of both focus groups was added to our 2016 CHNA."*
- "In past CHNA efforts, our system has included homeless individuals in both focus groups and survey opportunities. Also, leaders in the area of homeless services have been included as part of key leader focus group interviews for the CHNA. "*
- "The CHNA included a focus group with unstably housed individuals."*
- "During the CHNA focus groups in [the] county, homeless population was specially brought up and in our action plans it is listed as an item."*

Support Medical Respite

Brief Definition: Through financial support to organizations or directly to patients funding options for patients experiencing homelessness to have a safe place to recover and heal. Alternatively, support medical respite through care coordination and partnership with organizations that have beds available or offering beds that are available within RHM facilities such as permitting extended stay or having emergency beds available.

Examples:

- "As far as respite care is concerned, we utilize the swing beds at [at one of our hospitals] for patients needing IV therapies in the event that there is a need."*
- "[Our RHM has] worked with partner institutions and safety net hospitals to advocate and write for funding to increase our medical respite programs to defray inpatient costs and unnecessary prolonged lengths of stay."*
- "Invests \$25,000 into a Medical Respite Care program that is free for participants and has the mission to serve the homeless."*
- "Medical Respite Discharge planners work through a variety of players including area nursing homes, homeless shelters and DHS for designated respite beds."*
- "Provide emergency beds for homeless in transition of care episode."*
- "Medical Respite Care, [RHM] has engage primary one a local FQHC and OSU about the need for respite care for homeless individuals in [our city]. [a local organization] has 6 beds but would like to expand. [RHM is] continuing to hold discussions on this need through our Urban Management Department."*
- "Medical Respite Care / services for homeless families – Several years ago, [Our RHM] initiated the Welcome Home Project with several local agencies. A small nursing home was converted into apartments for families to use on a temporary basis while they were homeless as a result of various personal transitions and/or hardship. Now the facility is managed by [a local community agency]. The agency is a private, nonprofit human services organization composed of local public officials, business leaders and representatives of the low-income community. [We support] the agency and continue to provided supplies and donations to furnish the apartments. Monthly activity reports for the Welcome Home Project are shared with [our] Diversity and Inclusion Committee of the Board."*

Coordinated Care with Community Orgs

Brief Definition: Informal or formal partnerships with local agencies or organizations that serve those experiencing homelessness are established and utilized when care coordination is being planned, in order to best serve the community.

Examples:

- "has worked with partner institutions and safety net hospitals to advocate and write for funding to increase our medical respite programs to defray inpatient costs and unnecessary prolonged lengths of stay."*

-" worked through Project Homeless Connect to provide medical, dental and eye care to homeless individuals. Over the past two years, [we have] developed relationships with the [a local] CEED organization and the [local] Commission for the Blind to coordinate care for the underserved and homeless in our community with annual events offering eye exams, diabetic screenings, mental health screenings, foot screenings, depression screenings, influenza shots and lipid screenings to over 100 community members."

-"...partners with local behavioral health provider to support Mental Health treatment at all 3 clinics..."

-"...many of the partnerships and programs that have been developed by [our Ministry] contemplate service specifically for the homeless as a subset of the broader poor and underserved population served if the program is not designed specifically for homeless individuals".

HCH Interdisciplinary Collaboration

Brief Definition: Partnership across departments, professions, and disciplines interagency or intra-agency in order to address the needs of those experiencing homelessness in the community.

Examples:

- "Through the...Hospital Collaborative social work and community benefit staff have participated on several workgroups focusing on transitional housing."*
- "involve our community benefit team, our resident physicians and our nursing school students".*
- "Additionally, staff take it further to not only address the need for services but also assess actual access of these services. Working within our own system for substance abuse services, HCH staff work with the Vice President of addiction services to insure transitions from hospitalization/detox services into long term treatment program. A significant amount of community benefit funding is used to support and compliment the clinical services provided under the auspices of [our RHM] and contracts with the City."*

Identified Homelessness as a Priority

Brief Definition: Either in the CHNA or through the RHMs own decision or identification process, homelessness is stated, and explicitly known, to be a priority.

Examples:

- "The initial CHNA and CHIP done in 2011 addressed Homelessness as one of our top priorities."*
- "The City ... has made healthcare for the homeless a priority and this topic remains an item of discussion for the collaborative."*
- "Homeless individuals are identified as a "priority population" in our most recent Community Health Needs Assessment and the Implementation Plan."*
- "Both Behavioral Health and Homelessness were amongst our top 8 priority community needs in 2016 CHNA".*

- "As an active participant in the Annual Point in Time Survey, providing direct homeless healthcare services in the community, and attending to the inpatient needs of the homeless, Holy Cross is acutely aware of the insufficiencies and gaps in care for homeless individuals in Broward County. This situation is accurately portrayed in our needs assessment both in the narrative and prioritized needs; housing and food insecurity amongst the highest."

Financially Supports Clinical Services

Brief Definition: Allocates CHWB dollars towards supporting community clinics, federally qualified health centers, or other organizations that deliver clinical services for people experiencing homelessness.

Examples:

- "[We are] a financial backer of the federally qualified community health center in town."*
- "...routinely makes financial contributions to many of the agencies providing homeless assistance and housing and is supportive of associate efforts to improve the lives of the homeless"*
- "...provides grant support for 2 Detox Centers in our service area; funds embedded Mental Health Case Manager at Shelter; partners with local behavioral health provider to support Mental Health treatment at all 3 clinics; and has also piloted the addition of a Crisis Manager in our ED 24/7".*
- "...provides financial support for two FQHC's. MCHS has also partnered with Concord Counseling to provide services to the homeless."*

Financially Supports Community Agencies or Services

Brief Definition: Allocates CHWB dollars towards supporting community agencies or services that meet social, non-clinical, needs for people experiencing homelessness.

Examples:

- "...provides support to Interfaith Partnership for the Homeless, which is housed on [our hospital] Campus. Our support includes providing laundry and food services as well as homecare services to patients residing at Medical Respite. In FY17, [our RHM] gave funds to purchase a van for use in the transportation of patients from hospital discharge to the medical respite. The van will also be used to transport patients to and from medical and social service appointments. [Our RHM] operates a transitional housing program for patients who are with or without homes and/or are in treatment for addiction: a Shelter Plus Care (housing assistance for persons in recovery) and an emergency shelter. [Our RHM] absorbs the cost of any uncompensated/unreimbursed service associated with these programs & reports them as community benefit."*
- " provided \$285,000 grants YTD to local non-profit behavioral health service providers to address gaps in services for this vulnerable patient population... Close to \$1 Million in grants is awarded each year to fund local non-profit social service providers serving the homeless in our service area."*

- "donates in-kind and financial resources to organizations in our community that specifically target the homeless population".*
- "Provide funding to organizations that serve homeless populations and seek to fill gaps in care."*
- "Directs Community Benefit spending to organization filling gaps in care for persons without homes. [Our RHM] provides financial support to the YWCA for its battered women's shelter. "*

Organizational Member of National Health Care for the Homeless Council

Brief Definition: Is an official organizational member of the National Health Care for the Homeless Council. Has paid the membership fee and registered.

Examples: *None available

Supports Expanding Behavioral Health Services

Brief Definition: Financially, with staff, resource connection, care coordination, or advocacy supports the increase of accessibility and utilization of services for those who support people experiencing homelessness that also struggle with substance abuse and/or mental health.

- Examples:**
- "...operates a transitional housing program for patients who are with or without homes and/or are in treatment for addiction: a Shelter Plus Care (housing assistance for persons in recovery)".*
 - " Additional resources (\$125,000) have been granted to expand substance abuse mental health services through our local partner organization..."*
 - "...provides grant support for 2 Detox Centers in our service area; funds embedded Mental Health Case Manager at Shelter; partners with local behavioral health provider to support Mental Health treatment at all 3 clinics; and has also piloted the addition of a Crisis Manager in our ED 24/7. In FY17, [Our RHM] provided \$285,000 grants YTD to local non-profit behavioral health service providers to address gaps in services for this vulnerable patient population. [Our RHM] funds 20 apartments for homeless, as well as, 2 Diversion Case Managers."*
 - "...directs community benefit spending to organizations filling gaps in care for persons without homes by providing the SOAR (Supplemental Security Income/Social Security Disability Insurance Outreach Access and Recovery) program to eligible adults who are experiencing or at-risk of homelessness and are struggling with a disability or substance use disorder."*
 - " HCH staff work with the Vice President of addiction services to insure transitions from hospitalization/detox services into long term treatment program".*
 - " [Our RHM works] to coordinate care for the underserved and homeless in our community with annual events offering eye exams, diabetic screenings, **mental health screenings**, foot screenings, **depression screenings**, influenza shots and lipid screenings to over 100 community members."*