National Human Services Data Consortium

2019 Spring Conference

Nashville, TN

April 15-17, 2019

Integrating Healthcare and Homeless Systems

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Increasing Capacity &
Building Connections:
Bridging to the Future

What will you learn from this presentation?

- Building on existing structure
- Lessons learned from a small pilot
- Preparing for large scale integration
- Being dynamic in constant change

Tucson/Pima County

- Medium size community; geographical size- 9,189 square miles
- Tucson population: 525,796
- Pima County population (outside Tucson): 496,973
- Goals of healthcare integration in Tucson/Pima County
- Discharge planning & coordination

Tucson/Pima County HMIS & Coordinated Entry

- HMIS operations since 2008
- 34 Participating agencies
- 256 HMIS Users
- Full data sharing on 7/1/2016
- Written client Release of Information (ROI)

Tucson/Pima County HMIS & Coordinated Entry

- Coordinated Entry Model
  - No Wrong Door
  - Uses VI SPDAT, F VI SPDAT, & TAY VI SDPAT (SPDAT & Prevention tools)
  - By Name List
  - Bi-weekly Case Conferencing
  - Monthly Dashboard tracking all population: Inflow (new, returning) and Outflow (housed, Missing/No Contact, Not Homeless)

Behavioral Health Integration

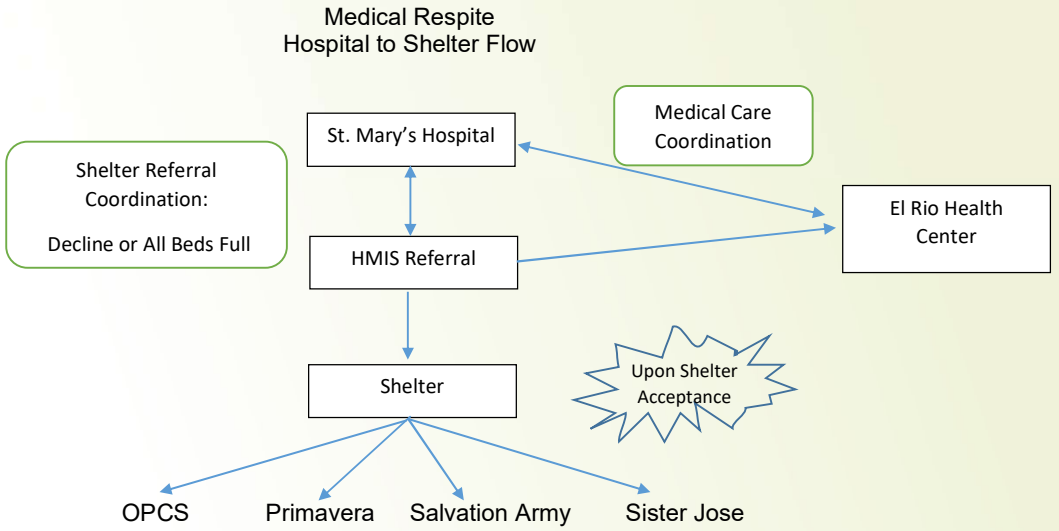
- Behavioral health CoC participating agencies (7)
- Regional behavioral health authority transitions
- Integrated Health Care Home Model
- Medicaid housing Coordinated Entry & housing system- Launched December 2017
  - Prioritizes frequent utilizers
  - Risk score
  - Community Health Center participation (2 of 3)

Medicaid Housing Coordindation

- 179 Referrals to Medicaid housing in 2018
- 415 Households with a total 740 people being served
- Housing follows HUD data collection requirements
- Added accountability

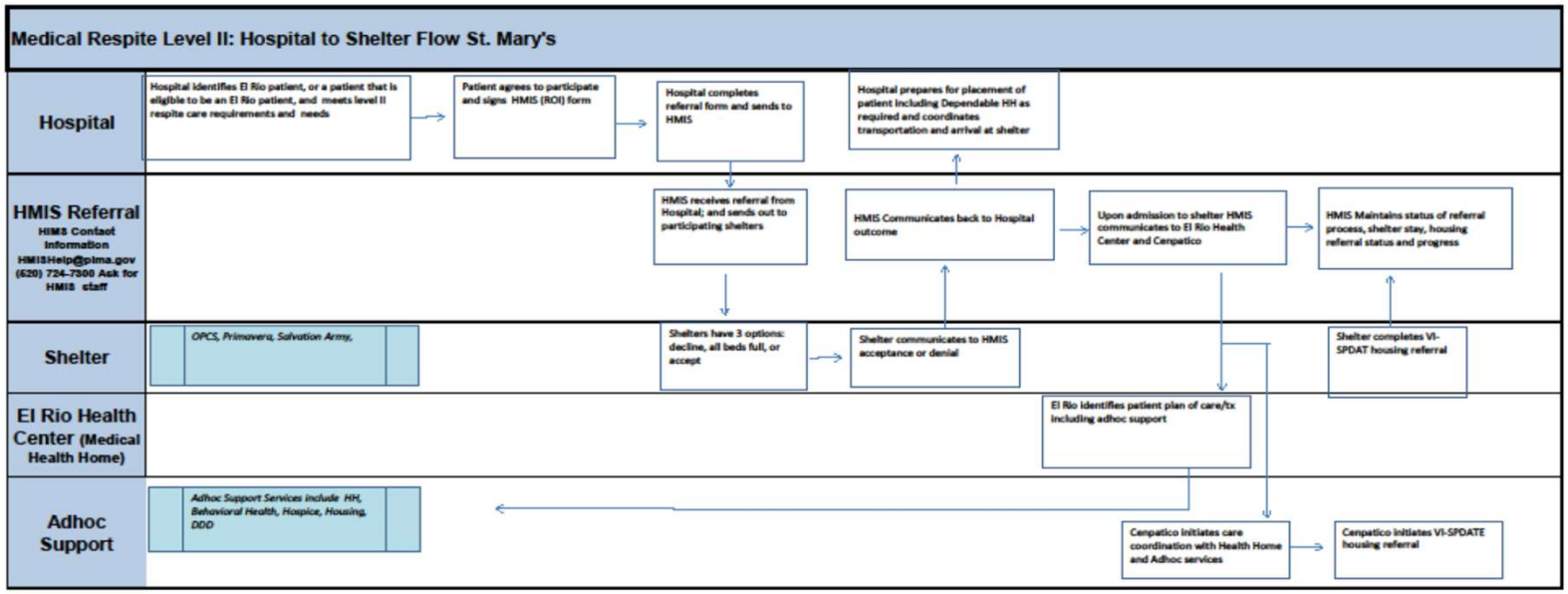
Hospital Discharge Coordination

- Lead by St Mary's hospital, Catholic Community Services, & El Rio Community Health Center
- Research and review data
- Level 1 and Level 2
- Large scale plan modeled after Phoenix's Circle the City program
- El Rio Community Health Center medical respite building in process



HMIS Data Sharing following the HMIS Release of Information and will allow visibility for all partners to see the status of Respite client in shelter referral process, shelter stay, housing referral status and progress.

HMIS Contact Information:
HMISHelp@pima.gov
(520) 724-7300
Ask for HMIS Coordinated Entry staff


Medical Respite Level II: Hospital to Shelter Flow St. Mary's
Hospital
Hospital identifies El Rio patient, or a patient that is eligible to be an El Rio patient, and meets level II respite care requirements and needs
Patient agrees to participate and signs HMIS (ROI) form
Hospital completes referral form and sends to HMIS
Hospital prepares for placement of patient including Dependable HH as required and coordinates transportation and arrival at shelter
HMIS Referral
HMIS Contact Information
HMISHelp@pima.gov
(520) 724-7300 Ask for HMIS staff
HMIS receives referral from Hospital; and sends out to participating shelters
HMIS Communicates back to Hospital outcome
Upon admission to shelter HMIS communicates to El Rio Health Center and Cenpatico
HMIS Maintains status of referral process, shelter stay, housing referral status and progress
Shelter
OPCS, Primavera, Salvation Army,
Shelters have 3 options: decline, all beds full, or accept
Shelter communicates to HMIS acceptance or denial
Shelter completes VI-SPDAT housing referral
El Rio Health Center (Medical Health Home)
El Rio identifies patient plan of care/tx including adhoc support
Adhoc Support
Adhoc Support Services include HH, Behavioral Health, Hospice, Housing, DDD
Cenpatico initiates care coordination with Health Home and Adhoc services
Cenpatico initiates VI-SPDATE housing referral
8/30/2018

What we now know:

- Hospitals are currently discharging with and without coordination directly with shelters (many times, people are dropped off by taxi)
- Shelters need help – coordinating clients medical care is limited at best
- Hospitals want better coordination – some patients can't go to rehabilitation or receive oxygen because they lack a fixed residence
- HMIS is an excellent central coordination point
- Referrals made in HMIS to support providers allow everyone to see how client is being supported
- Housing is healthcare, so Coordinated Entry is vital to connect clients with permanent housing options
- Additional hospitals want both post hospital support for care AND ER/hospital discharge options for patients with no housing

What we now know (cont)

- Referrals made in HMIS to support providers allow everyone to see how client is being supported
- Housing is healthcare, so Coordinated Entry is vital to connect clients with permanent housing options
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Current Process

- Hospital is now HMIS and VI SPDAT trained to make Medical Respite and CE referrals
- Each shelter has a medical respite project in HMIS to track clients
- HMIS follows up with shelters to identify openings for hospital discharge possibility
- Shelter reviews patient need directly with hospital to determine shelter appropriateness
- Client enters shelter = post care coordination with Medicaid plan and community health center

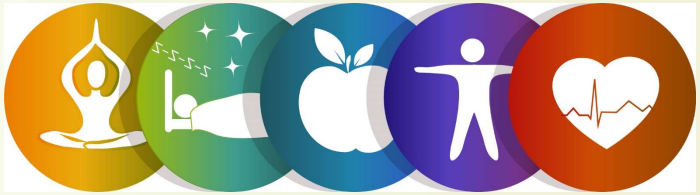
Next Steps:

- Getting additional hospitals in HMIS
- Expanding shelter options
- Solutions for challenging cases (i.e. clients who don't show up at shelter, IV therapy, open wound care, contagious illness/diseases)

Medical Respite/Chronic Health Coordination

TH-RRH Project

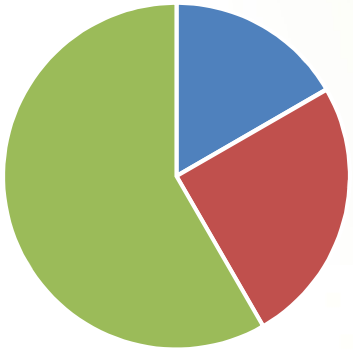
- Began July 1, 2018
- Referrals using TH/RRH VI SPDAT scoring range
- Chronic Health Condition as defined by HHS (ie. Cancer, Cardiovascular diseases, Chronic Respiratory diseases, Diabetes, Blindness, Chronic Pain syndromes, Thyroid Disease, etc.
- HUD requires separate project for each project and entries are made into both projects for each client



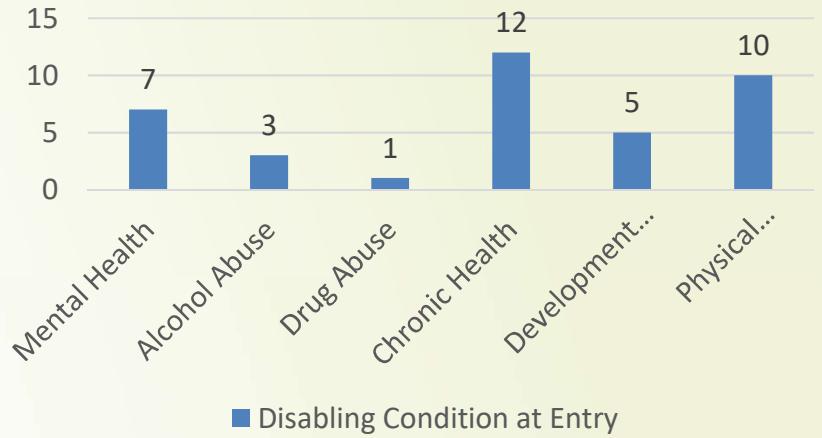
Year-to-Date Progress

- 12 Individuals served in Transitional Housing
- 11 males and 1 female
- All aged 45+
- 67% with 3+ disabling conditions at entry
- Current average LOS 125 days

Participant Ages



Disabling Condition at Entry



Jail Discharge Coordination

- Pima County Administration launching new project
- Jail & health care frequent utilizers
- Partnership with PHA (City of Tucson)
- Modeled similar to Pay for Success
- RFP used select community partners (OPCS & Intermountain)

Jail Discharge (cont)

- Uses County general funds
- Mainstream resource coordination (SSDI, Food Stamps, etc.)
- Includes budget with special considerations (i.e. transportation, document retrieval, toiletries, furniture)
- Referral directly from Criminal Justice stakeholders (Sheriff, police department, adult probation & pre-trial services)
- First housing expected by May 1, 2019

CoC Next Steps:

- Review data regarding client medical need in community
- Continue work with area hospitals, doctors, community health centers, rehab centers, etc. to explore care options
- Interview formerly homeless and/or current homeless to understand challenges and explore solutions
- Formalize discharge coordination through CoC policies & procedures

Questions?

TPCH
Tucson Pima Collaboration To End Homelessness

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Pamela.Moseley@pima.gov

PIMA COUNTY
COMMUNITY SERVICES