Community Strategic Partnership Session: Health Care for the Homeless in NYC

U.S. Department of Health and Human Services (HHS)
Health Resources and Services Administration (HRSA)
Office of Regional Operations (OPO)
New York Regional Office (NYRO)

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Purpose & Goals Community Strategic Partnership Sessions

- **To improve the health of populations living within a "Community" (in this case Homeless persons in New York City) by....**

- **Support or build upon current health initiatives.**
  Identify synergistic practices across programs.
  Identify and spread best practices across programs.

- **Facilitate greater collaboration and partnerships among HRSA grantees in addressing priority health needs of that community, to improve performance and outcomes for the people we serve.**

- **Promoting partnerships and collaboration between HRSA grantees and other organizations that share or overlap in the mission to serve that community, to improve performance and outcomes for the people we serve.**

- **HRSA grantees and current partners, potential partners and other stakeholders will be convened to review and discuss a few key Priority Issues.**

- **Come up with a few doable actions steps, a group action plan, to improve the outcomes for those priority issues.**

Community Strategic Partnership Session

Community: Health care for all homeless persons in NYC.

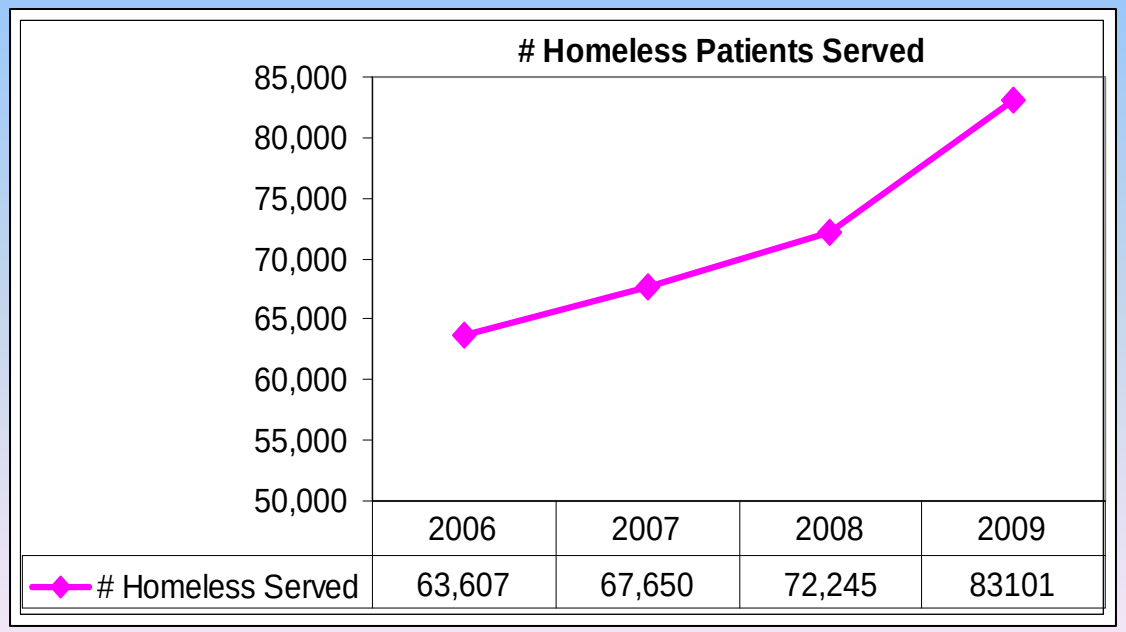
Strategic: Retreat to do short & medium term strategic planning.

Partnership: Can't do it alone, many organizations work together.

Session: Here we are; let's do it.
By the end of the day, you will have...
Written action plan with specific action steps,
timeline, organizations & individual responsible,
who is doing what with whom; when, where, how.

Homeless in NYC

- In 2008: ~100,000 New Yorkers experience homelessness annually.
  - NYC Shelter System ~35,000 homeless people per night.
  - More than 16,000 children and 8,000 single adults.
  - Thousands more sleep on streets and other public places.
- # of Homeless Patients Served by the 10 HCH Grantees:
- 2006=61,601; 07=65,643; 08=70,237 ⟹ 12% increase over 3 yrs.
- ...and now with "The Great Recession of 2009"...? 13% jump in one year.



Can't do it yourself... Partners, Cooperation, Collaboration

Who Else is Providing Health Care for the Homeless?

- **All 28 CHCs in NYC reported seeing 70,649 homeless users, of which 65,429 were under the 10 HCH grants.**
  - **The Primary Care CHC report seeing ~5,000 homeless persons; should they be seeing more? less?**

- **NYC DHS**
- **NYC HHC's hospitals, ERs, DTCs, Clinics**
- **DOHMH**
- **VA**
- **Other Hospitals**
- **Other CBOs**
- **Other …?**
- **Prison**

Can't do it yourself… Partners, Cooperation, Collaboration

Current Partners, Potential Future Partners &/or Other Stakeholders Might Include...

1. **NYC Jurisdictional entities such as the:**
   - **Dept of Homeless Services (DHS)**
   - **Dept of Health and Mental Hygiene (DOHMH)**
   - **Health & Hospital Corporation (HHC).**
2. **Maybe, the other HRSA supported community health centers and federally qualified health centers (FQHC look-alikes) that do not receive the homeless grant, but do see (or should be) seeing many homeless patients in NYC.**
3. **Other organizations that provide health services for homeless persons in NYC...?:**
   - **CMS-Medicaid; Fed, State, City-HRA**
   - **SAMHSA – Federal, State/Oasis, City-HRA/DHS/DOHMH/HHC**
   - **Jail/Prison/Corrections, Foster Care-ACS, PD, EMS-FD,**
   - **Homeless Service United, Common Ground, Community for the Underserved**
   - **VHA/VAMC**
   - **GNYHA – insofar as they represent the private/voluntary hospitals & EDs.**
   - **Other possible stakeholders or partners... You will decide!**

But remember: the HRSA HCH Grantees "own" the meeting

Who Was There?

HRSA HCH Grantees:

- Bowery Residents Committee
- Care for the Homeless
- Covenant House
- Damian/Samaritan
- Floating Hospital
- Harlem United
- Montefiore
- Project Renewal
- St Vincent's
- William F Ryan

Federal Partners:

- HRSA: NYRD & BPHC-Special Pop
- CMS: Region 2
- Veterans Health Administration

NY Partners:

- NYC DOHMH: Medicaid, Corrections, PCIP, etc...
- NYC Dept of Homeless Services
- NYC Health & Hospitals Corporation
- NYC Human Resources Administration – Medicaid
- NYC Dept of Corrections & Prison Health Services

- NYS DOH – Alcoholism & Substance Abuse Services
- NYS DOH–Health Systems Management (Facilities, Workforce)
- NYS DOH – Medicaid
- NYS DOH – Mental Health
- NYS DOH – Health Systems Management (PCO/Workforce)
- NYS Parole

- BronxWorks (CABNY)
- Children's Health Fund
- Coalition of Behavioral Health Agencies
- Common Ground
- Community Health Center Association of NY State (CHCANYS)
- Greater New York Hospital Association (GNYHA)
- Homeless Services United
- Partnership for the Homeless
- Primary Care Development Corporation (PCDC)
- Project Hospitality

Social Demographic of Users

Age 0-18	34%
Age 65 and older	2.7%
Female	48%
African-American/Black	54%
White	27%
Unknown or Refuse to Report Race	16%
Hispanic	33%

Selected Diagnoses & Services Rendered as % of all Clients

AIDS	0.8%
Asymptomatic HIV+	0.6%
TB	0.4%
Other STDs	0.5%
Asthma	13.4%
COPD/Emphysema	0.7%
Diabetes	3.8%
Heart Disase	2.0%
Hypertension	6.3%
Alcohol related	2.4%
Other Substance	2.8%
Depression	3.0%
Anxiety & PTSD	1.0%
Attention Deficit & Other Disruptive	0.9%
Other Mental	5.1%
Immunizations	13.2%
Pap	1.5%
Contraceptive management	1.3%
Otitis media	0.8%
Health Supervision ages 0-11	23.1%
Oral Exam	3.2%

Original Concept of Priority Health Issues

Development & Choice of Priorities Should:

- **Objective, data-driven, with trackable indicators of progress.**
- **Reflect population-level health indicators of a whole community's health status (in this homeless persons in NYC).**
- **Utilize Community health data and reflect key Community and HRSA public health goals and priorities.**
- **Not just relevant to one grantee or particular program or organization; relevant and trackable by all..**

Need to obtain early on in process, for Homeless in NYC:

- **Health and Health Service Indicators & Issues**
- **Population and Community Profiles**

At Different Levels:

- **Population-level: City-wide, All-homeless, borough, community, neighborhood, district, service-area**
- **Grantee-level, Program-specific, Service-level**

Original Concept of Priority Health Issues

- **Might be classical health conditions or disease category types of health issues such as to improve nutrition, tobacco cessation, alcohol, other substance use, mental health, HIV/AIDS, chronic diseases, etc.**

- **Might be health service related such as increasing access/number of patients taken care of, how to increase continuity of care, coordination of services across different providers the city, medical home, respite care, ER-diversion, etc.**

- **Chosen by HRSA HCH-Grantees**

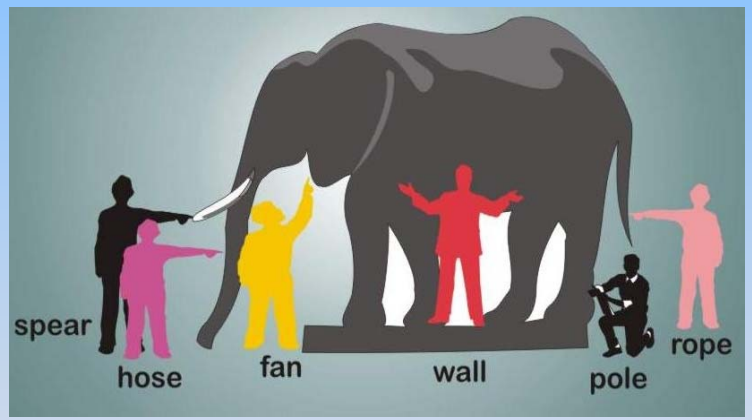
Original Health Priority Selection Factors

- **Is the issue of major importance?**
- **Is the issue one that that needs improvement?**
- **Is the issue one that is feasible to improve by the group of grantees, working together with the partners & other stakeholders?**
- **Is the issue one that is ripe to be improved by the group of grantees, working together with the partners & other stakeholders?**
- **Is the issue one that is better and more appropriately worked on by the group, and the partners and other stakeholders, rather than by each individual grantee separately?**
- **Is there grantee-level/program-specific/service-level data related to this health issue? If yes, what is it, who has it, what is its current value & trend? Do you have it for your organization, and if yes what is its current value and trend?**
- **Are there population-level all-homeless, service-area, community-wide &/*or* city-wide level data related to this issue?**
  - **If yes, what is it, who has it, what is its current value & trend?**

Some Suggestions

- **Don't spend time rehashing areas of disagreement.**
- **Don't spend time discussing what you CANNOT do.**

- **Find the areas of common agreement.**
- **Figure out what you CAN do together.**



See the whole elephant!

- **"What you see depends on where you stand"**
- **It is not that that they were all wrong**
- **They were all correct… and also all wrong**
- **Only by putting it all together can we get the job done**

Get to Yes!

- Two day small group brainstorming process
- Define and prioritize action items
- Defined specific action steps
- Which specific organizations making commitments
- Specific people assigned
- Timeframe and deadlines
- Process gets commitment and buy-in by all partners

Then

Just Do It!!!

- Can always find a reason to not do it

Pre-Meeting Surveying of Issues

- Access to care and services
- Limited vision and dental services
- Lack of service coordination and continuity of care
- Lack of information sharing among providers
- Substance abuse and mental health service needs
- Lack of immunization records for children
- Health Maintenance Organizations (HMO) restrictions
- Lack of client knowledge about insurance
- Scarcity of services tailored to youth
- Service delivery complications secondary to clients' criminal justice involvement
- Lack of data, e.g. no shows for appointments
- Lack of access to DHS and Medicaid data
- Lack of best practice model of care for the homeless

Priority Issue 1

"To increase access and number of homeless people receiving primary care health services in the most appropriate setting"

- **Challenge 1: Medicaid Issues**
- **Challenge 2: Bring People off the Streets into Care**
- **Challenge 3: Referrals Beyond Primary Care**

(have 4 page grid of specific action items with what & who)

Priority Issue 2

"To improve continuity of care, coordination of care, portability of clinical information, and increase cooperation between service systems and sites."

- **Challenge 1: Sharing Information**
- **Challenge 2: Medical Home**
- **Challenge 3: Communication Among PHCH & Partners**

(have 7 page grid of specific action items with what & who)

Example of Action Plan Worksheet

What	Who (in addition to PHCH-Doug Berman)
Refresher courses to HCH organizations and providers about Medicaid Managed Care: •Enrollment •Disenrollment •Recertification Patient education on their benefits	NYC HRA/MICSA/Managed Care; Renee Stout, ED T: 212-273-0034; E: stoutr@hra.nyc.gov NYC DOHMH/HCAI/Managed Care Operations; Wendy Negron, Executive Director: T: 212-341-2280; E: wnegron1@health.nyc.gov NYS DOH/OHIP/Bureau of NYC Compliance & Customer Service/Division of Coverage & Enrollment; Director: Anne Marie Costello, T: 212-417-6552; E: amc19@health.state.ny.us
Provide HHC access to eMedNY system.	NYS DOH Anne Marie Costello http://www.emedny.org T: 212-417-6552; E: amc19@health.state.ny.us
Onsite Facilitated Enrollment in shelters & other HCH sites: •Immediate: Co-locate facilitated enrollment staff from organizations that have them directly into shelters and other HCH sites. •Longer-term: Train HCH staff as Facilitated Enrollers.	Same – some mix of: NYC DOHMH: Wendy Negron, NYS DOH: Anne Marie Costello NYC HRA: Renee Stout NYC HHC
Connect HHC organization, providers and eligible individuals to VAMC	VAMC Julie Irwin – Network Coordinator, Homeless Outreach T: 718-584-9000; E: julie.irwin@va.gov

More Example of Action Plan Worksheet

What	Who(in addition to PHCH-Doug Berman)
DHS Street Outreach to link up with HCH and clinical providers at local level: Convene meetings of HCH grantees, HHC and other health resources/article 28 sites in each borough to link street outreach teams to primary care clinics and: ▪Explore maximum use of mobile vans; ▪Increased walk-in hours; and, ▪More flexible and/or open scheduling. Designate HCH liaison available to go out into the field to see clients with Street Outreach Teams.	NYC Department of Homeless Services (DHS) Dova Marder – Medical Director: T: 212-361-0584; E: dmarder@dhs.nyc.gov Jody Rudin – Asst Comm. Street Homelessness Solutions T: 212-361-0615; E jrudin@dhs.nyc.gov Danielle Minelli – Dir. Street Homelessness Solutions Unit BronxWorks (CABNY) & Montefiore Medical Center: In the Bronx, the Montefiore staff is embedded in the BronxWorks (CABNY) outreach team and drop-in center. Explore this as a best practice model to replicate citywide. GNYHA: help expand to other hospitals citywide Lloyd C. Bishop; V.P. Gov't Affairs & Community Health Initiatives T: 212-246-7100 x340; E: bishop@gnyha.org Alt GNYHA: John Murtha: Senior Director, Health Finance (Medicaid issues) T: 212-506-5514 jmurtha@gnyha.org HHC: help with other health resources/article 28 sites: LaRay Brown Senior VP Corporate Planning, Community Health & Intergovernmental Relations Tel. (212) 788-3448; E: laray.brown@nychhc.org Kathleen Whyte; Senior Dir, Corporate Planning, Community Health & Intergov. Relations T: 212-442-4064; E: kathleen.whyte@nychhc.org

Specific Achievements Accomplished As A Direct Result Of The CSPS

- Identified and disseminated information regarding DHS monthly roster of clients enrolled in Medicaid.
- Disseminated step by step procedures used by agencies to disenroll managed care enrollees and enroll in FFS Medicaid.
- DOHMH / HRA / SDOH/ Maximus workshop on Medicaid eligibility, enrollment and disenrollment.
  - –Identified issues with SRO, transitional residents being considered homeless;
  - –Process must be initiated by shelter staff (previously, providers could initiate process).
- OHIP training on eligibility determination; facilitated enrollment and other methods for enrolling homeless people.
  - –Informed attendees of streamlining enrollment, including data matching and birth certificate documentation.
- Report on why eligible adults do not enroll in Medicaid with recommendations for increasing enrollment.
- Workshop presentation by Health and Hospitals Corp on HHC Connectx.
  - –One agency received individualized additional training
  - –One agency is in process of scheduling an individualized training
- DHS convened workshop to link homeless health agencies with street outreach teams.
- Meeting with Seth Diamond, newly appointed commissioner of DHS and staff scheduled for July 15.
- Doctors Across NY: includes reference to special populations and expansion of mid-levels;
- Conference call with DOHMH re: applying for contracts in correctional facilities.
- Workshop with CHCANYS/PCDC re Medical Home accreditation.
  - –Several agencies applying for medical home certification with PCDC assistance.
- Participation in conference calls with National health Care for the Homeless Council re: Medical Homes
  - –(NHCHC using PCDC toolkits).
- Established PHCH as central repository of info on licensure of clinic sites and maximizing Medicaid reimbursement
- Agency directory and aggregated data collection .
- Expanded and enhanced “professionalized” annual conference .
- Increased information sharing, especially on patient centered medical home recognition .
- Use of facilitated enrollers at shelter sites.
- New Logo and Nascent website .
- Revised mission statement:
  - – The NYC Providers of Health Care for the Homeless is a member coalition made up of agencies that work collaboratively to ensure high quality, accessible, and comprehensive health care to homeless people in New York City.

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