Summary of strategies

On February 23, 2017, AmeriHealth Caritas hosted a strategy development summit titled Health Is More Than Health Care: Maximizing the Value of America’s Investment in Medicaid, where thought leaders and subject matter experts convened to discuss and develop strategies around a variety of individual and community-based health determinants including housing stabilization and violence intervention. Outlined here is a list of strategies that unfolded from each session at the summit, along with a special set of strategies to improve health care for the homeless, which was shared by one of the subject matter expert participants.
Session 1: The Social Determinants of Health

People served by Medicaid often face a variety of life challenges that make it difficult for them to focus on their health. Many have limited access to healthy foods and affordable housing, environmental and social issues in their homes and communities, and a host of other psychosocial determinants that stem from poverty and impact health and safety. To expand the use of Medicaid and address health from all aspects of a consumer’s situation, it is important for health care teams to focus on the social determinants of health rather than exclusively focusing on the provision of health care services.

STRATEGIES

1. Invest in community health resources that complement the personal health activities of members, such as supporting efforts to increase consumer access to healthy options (e.g., fresh food and exercise) and investing in preventive care, including school-based prevention models (e.g., asthma and smoking prevention).

2. Take a leadership role in establishing and building on multi-sector partnerships, including social services, housing, and health providers, to coordinate community health efforts; improve primary care delivery to individuals and family members; invest in opening family resource centers; and engage consumers where they are and learn from their lived experiences.

3. Develop and use community-based care management teams (e.g., nurses, social workers, and community health workers) to provide in-home care for high utilizers with physical and behavioral health needs. This team will help provide behavioral health workers with training in strengths-based, trauma-informed care; facilitate connections to primary care providers; provide consumers with a bridge to telephonic care to manage health care needs; and include a “health conductor” role to address the social determinants of health with a focus on interventions, awareness, and changes that improve member health outcomes.

4. Improve use of the Community Health Needs Assessment to identify and assess health needs of members, including the social determinants of health. This includes broadening the definition of health in the Community Health Needs Assessment to more successfully bridge gaps across sectors and bring various partners on board, and using funding from the Assessment to further invest in addressing social determinants of health.

5. Use a hub-and-spoke approach to address the social determinants of health, centralized around the mayor’s office, with spokes for community functions, such as the fire department, police department, Department of Education, and Housing Authority.

6. Expand use of Medicaid to encompass housing as a health need by leveraging Medicaid to pay for outreach and housing support services and maximizing the use of the State Innovation Models (SIM) initiative to address social determinants of health.

7. Identify data and common languages used across the health care system (e.g., hospitals, federally qualified health centers [FQHCs], and providers) and standardize data collection.

8. Build relationships with care providers and others who can intervene seamlessly and quickly to meet member behavioral health needs and other care needs as they emerge.

9. Use a standardized tool to assess the demographics of communities and needs of members by adopting the Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences (PRAPARE) to assess members for select social determinants of health and develop interventions for members based on assessment results.

10. Create more opportunities like AmeriHealth Caritas’ Health Is More Than Health Care summit for cross sector discussion and planning, supported by individual follow-up meetings to improve coordination of existing cross-sector forums, task forces, and work groups to continue identifying strategies, move forward on action steps, and track progress; bring in alternative partners who might be willing to give back to the communities they impact (e.g., developers and businesses); and partner with local leaders to give voice to community needs.
Session 2: Stabilizing Housing as a Health Care Initiative

Stable housing is an essential but often overlooked factor in health care. For example, people experiencing homelessness are at greater risk for poor health, are less likely to prioritize routine medical care, and are significant contributors to frequent hospitalizations and emergency room visits due to problems managing injuries and chronic conditions. By supporting, investing in, and increasing access to permanent supportive housing, we can reduce health system costs while increasing health outcomes for this vulnerable population.

STRATEGIES

1. Invest in improved data systems and increase the use of data to measure client health outcomes as related to housing availability and conditions.

2. Establish a timely referral and transportation process for members using the emergency room for nonemergent care needs to receive more immediate and appropriate care at nearby lower cost clinics; set up routing procedures with emergency services to provide this less costly alternative as a first option for members with nonemergent care needs; and increase awareness and utilization of preventive care as a first option.

3. Review the assessment tools in use in the District of Columbia’s coordinated entry system for connecting homeless or at-risk individuals to housing and services; consider the current weighting of health care issues, including primary care needs, and recommend changes to the tool as necessary; and identify opportunities for AmeriHealth Caritas to connect members to the coordinated entry system.

4. Work with Continuum of Care outreach teams, emergency shelters, Health Care for the Homeless clinics, food pantries, soup kitchens, and the entire spectrum of emergency services to have frontline health care workers on site to meet immediate medical needs and make connections for continued care.

5. Partner with local affordable housing providers and homeless housing programs to identify members with health care needs, provide access to immediate care options, and connect members to long-term care options including primary and preventive care.

6. Engage with researchers to pilot programs and investigate innovative health care and housing solutions for members, identify approaches that can be implemented nationwide, and work to create place-based solutions and respond to the needs of specific localities and populations.

7. Participate in housing, health, and service provider partnerships; focus partnerships around stabilizing the highest cost and highest use members; and utilize partnerships to coordinate treatment, training, navigation, and service delivery across systems of care.

8. Support efforts to increase local public and private investments in housing resources for individuals experiencing homelessness, including local housing trust fund programs, social impact bonds, and tax credits.

9. Invest in a spectrum of housing options for members whose health may be compromised by housing instability, including short-term rental subsidies, gap funding to access units and keep them affordable, longer term rent subsidies, and unit creation.

10. Work with stakeholders from the housing and health care systems, alongside local government officials and agencies, to create a consistent message that housing instability is a health crisis.

11. Incorporate community-based case management into service delivery and treatment options for members.

12. Support data sharing between homeless providers, housing advocates, and medical service providers; provide education around what and how data can be shared across providers and systems of care in compliance with various privacy laws; utilize cross-systems data to analyze gaps in resources available for members; and track progress in improving members’ health outcomes and housing stability.
Session 3: HIV, Health Care, and Housing Delivery

Homelessness and HIV/AIDS are intricately related. Homeless populations have higher rates of contracting HIV/AIDS, and people who reside in stable, permanent housing are more likely to face homelessness when they or someone in their family contracts HIV/AIDS. While the United States has made great strides in understanding and developing treatments for HIV, and while fewer people are being diagnosed, there are still prominent disparities in care, housing, education, and funding for people living with HIV/AIDS and those at high risk for the virus. Health care and community organizations can work collaboratively with state, county, and city health departments to implement new programs tailored to address the gaps and needs of the people and communities impacted by or at risk for HIV/AIDS.

**STRATEGIES**

1. Utilize local data to demonstrate the link between HIV, housing, and health care, and engage in cross-system advocacy efforts to improve health care and housing options for people living with HIV/AIDS.

2. Strengthen HIV treatment, prevention, and intervention services available at shelters and other emergency services locations; utilize mobile vans in the city for instant testing, supported by follow-up case management; and develop a resource map of HIV housing and health care resources in D.C. to assist health care providers in making connections and referrals.

3. Work with the D.C. Department of Health to identify where HIV is at its highest levels among members, non-members, and persons at risk of homelessness; heighten outreach and resource-directed housing and health care efforts; reduce HIV-related disparities in communities at high risk of infection by hiring staff from overrepresented communities; and partner with community-based organizations that specialize in serving overrepresented communities.

4. Conduct community outreach; promote trust so that more individuals get tested; and educate the community in overcoming stigma surrounding HIV testing, treatment, and services by increasing and enhancing the use of peer resource workers, investing in programs that promote early HIV screening to raise the percentage of individuals who are aware they have contracted HIV, and empowering community members to serve as mentors and representatives in providing education and reducing stigma around HIV.

5. Demonstrate strong support for the D.C. HIV continuum, Mayor Bowser’s 90/90/90/50 Plan, The Housing Opportunities for Persons with AIDS (HOPWA) program, and the Ryan White HIV/AIDS Program to maximize the benefits of existing resources and fill resource gaps.

6. Utilize a community support model to establish a network of providers for the provision of holistic primary care, housing, supportive services, and case management.

7. Invest in the full spectrum of housing and services for people living with HIV/AIDS, including subsidies, units, on-site services, and independent housing; create designated staff positions to foster treatment adherence and provide health care counseling and health classes for members with HIV/AIDS; and increase the number of housing navigators connected to health care providers.

8. Coordinate care with HIV-experienced primary care providers and treatment adherence services using state-of-the-art assessment tools and treatment protocols; improve mechanisms to monitor and report on consumer health outcomes, such as treatment adherence; and support data collection and data-sharing efforts to track utilization of housing and health care services for members living with HIV/AIDS (all in compliance with applicable privacy laws).

9. Develop a coordinated care system to support LGBTQ transition-age youth who have complex needs (e.g., HIV, housing, mental health, food security, medication management) through partnerships and expanded capacity (e.g., mental health services, group homes).

10. Facilitate a broader, deeper level of convening, specifically focused on people living with HIV/AIDS, with a focus on breaking down silos and improving discharge planning for this population.
Session 4: Housing and Health Care: Violence Interventions

Violence is a major public health issue. Homeless individuals, as well as other poverty-stricken populations, are at significantly higher risk for violence than those of a higher socioeconomic status. Like an epidemic, violence can spread from person to person, and it can expand across categories. For example, domestic violence can increase the risk of gang violence, and vice versa. Violence is complex and multidimensional, but it can be successfully contained with fast and appropriate treatment with multi-sector partnerships and coalitions encompassing health care professionals; academics; state, county, and city health departments; and the community members living in areas affected by violence.

STRATEGIES

1. Collect and utilize data on the effectiveness of anti-violence programs and on the cost savings to the health care system of treating and preventing violence by working with researchers to map violence in D.C. and demonstrate on a local level that violence behaves like an infectious disease.

2. Serve as an incubator for anti-violence community programs and investors in anti-violence initiatives; shift the focus of investment to violence prevention; work with medical schools to include violence interventions in their curricula; and connect with and support the National Network of Hospital-Based Violence Intervention Programs.

3. Invest in creating safe, violence-free spaces in the community by building on the example of wellness centers in AmeriHealth Caritas Pennsylvania and AmeriHealth Caritas District of Columbia; empower and train people from within the community, including faith-based partners, to run programs to address violence; and create centers in schools that target violence prevention and safety interventions for youth.

4. Create mediators and community health worker positions to de-escalate and prevent violence throughout the community, including in both housing and health care settings.

5. Collaborate with community organizations and residents to develop a multi-sectorial public health framework to prevent and treat violence by standardizing the best practice response to violence among related systems (hospitals, health centers, schools, law enforcement, etc.) and investing in school-based violence prevention programs.

6. Provide training for all staff positions in the health care system (receptionist, case manager, Care Coordinator, doctor, nurse, etc.) on addressing violence as a health issue, trauma-informed care and accountability metrics, mitigation and de-escalation tactics, and addressing stigma and discrimination when providing care to victims of violence.

7. Leverage Medicaid for helping prevent and cure violence by advocating with local Medicaid agencies to ensure violence prevention is a covered service; helping schools bill Medicaid for reimbursement of school-based health services; partnering with Medicaid outreach to conduct enrollment at jails, prisons, and youth corrections facilities; and working to ensure Medicaid and related benefits are seamlessly reinstated for recently released institutionalized or incarcerated members.

8. Partner with the new D.C. Office of Neighborhood Safety and Engagement (ONSE), with a focus on the health care needs of program participants, by ensuring hospitals, managed care organizations, and health care providers are connected to ONSE and to the Deputy Mayor’s violence prevention networks and crisis teams and work with a Community Crime Prevention Team to connect with members with unmet housing, health, and safety needs.

9. Start the conversation among partners about a standardized response to identifying, preventing, and curing violence; provide education to providers on available resources and methods to prevent and treat violence, establish safety interventions, and provide culturally-competent, trauma-informed care for patients affected by violence; develop standardized assessment tools and protocols to identify the type, severity, and amount of violence experienced by members; utilize the Adverse Childhood Experience (ACE) questionnaire as an assessment tool in schools, community centers, and among providers; code patient records consistently to track violence; and conduct individual member case reviews with a violence-conscious lens.
Barbara DiPietro, Senior Director of Policy at the National Health Care for the Homeless Council, spoke on the intersection of health, housing, and homelessness at the Health Is More Than Health Care summit. DiPietro highlighted six strategies for improving the delivery of health care to individuals experiencing homelessness:

### STRATEGIES

1. **Invest in support staff to engage members in systems of care.**
   Support staff, including outreach staff, case managers, behavioral health consultants, peer support specialists, and community health workers, are vital for engaging members in an appropriate venue of care. Roles for support staff include engaging members in the emergency room, providing documentation support, assisting in care coordination, helping schedule transportation and appointment arrangements, and facilitating referrals.

2. **Reimburse for medical respite services.**
   Medical respite reduces length of stay and readmission for individuals experiencing housing instability, resulting in better health outcomes.

3. **Reimburse for supportive housing services.**
   Managed care plans can invest in case management supports and wraparound services to ensure that housing solutions for members are stable and successful.

4. **Re-evaluate prior authorization policies.**
   To remove barriers to care, health care providers must re-evaluate how, when, and under what conditions prior authorizations are required. This includes taking steps to streamline referrals and re-evaluating the onus on providers to secure referrals.

5. **Incentivize health care providers to document homelessness using ICD-10 code Z.59.0.**
   The ICD-10 code for homelessness, Z.59.0, is currently under-utilized by health care providers. Incentivizing providers to document homelessness via ICD-10 code Z.59.0 would improve the ability of providers and managed care plans to identify and locate members experiencing homelessness and provide appropriate housing supports.

6. **Implement technology that facilitates expanded access to care.**
   Health care providers should engage with alternative methods of communication and service delivery for individuals experiencing homelessness. Mobile technologies, such as electronic consultation services with specialists, allow providers to serve vulnerable populations who are unlikely to self-present at a medical clinic.
AmeriHealth Caritas District of Columbia Priorities for 2017

Leveraging all of the hard work and critical thinking that emerged from the Health Is More Than Health Care summit, AmeriHealth Caritas District of Columbia has decided to pursue three key strategies in 2017 that we feel will be most impactful to our members.

1. **Improve assessment and identification of social determinants of health** — with special emphasis on homelessness — enabling health care providers to connect patients more quickly with appropriate housing supports and other services.

2. **Increase provider and community awareness about violence prevention and treatment resources**, because direct and indirect exposure to violence not only results in significant immediate health care costs, but also predisposes individuals to developing chronic illnesses such as cancer, heart disease, and diabetes.

3. **Leverage respite care facilities as a cost-effective way to meet the medical needs of people who are homeless** by providing acute and post-acute medical care for individuals who are too ill or frail to recover from an illness or physical injury on the streets, but are not ill enough to be in a hospital.