Setting Indianapolis Up for Success

Best Practices in Health & Housing

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In 2017, Indianapolis moved forward to address some of the pressing housing needs that must be achieved to end homelessness. The City and advocates embraced a commitment to house 400 more people through the creation of additional affordable, supportive housing in the community. Housing First became more widely accepted as an effective approach to getting people off the streets and into homes of their own. And a partnership with the Indiana Housing and Community Development Authority and CSH resulted in four developer teams being selected to create a combined 125 permanent housing units for the homeless as part of new affordable-housing developments in the City.

Nonetheless, much more work remains to be done. The Coalition for Homelessness Intervention and Prevention in Indianapolis (CHIP) commissioned an analysis last April that found the city needs nearly 700 permanent supportive housing units available for move-in each year just to keep up with demand. Funding these new units and the services that must accompany them will require local leaders to adopt a strategy that looks beyond traditional sources of expertise and financing to tap into sectors historically absent from the table when housing is discussed. One such sector is health care and this paper outlines a general vision and approach to achieving a more meaningful partnership between housing and health care with the aim of finding new ways to create additional housing and services in Indianapolis.

Vision

Both the health care sector and the housing sector are increasingly recognizing the need for cross sector collaboration to achieve their vision and meet their goals. Additionally, both stakeholder groups continue a strong commitment to improving the quality of life for the people they serve. The health care sector has pressure to increase the quality and value of services received while decreasing costs simultaneously. The housing sector has pressure to serve more people with often more challenging needs and fewer resources. The homelessness systems have new data resources, to help them be a valuable system partner to the health care sector but are serving an increasingly vulnerable population with complex care needs and fewer specified resources for supportive services. These stakeholder groups work hard to improve the lives of low income Americans while documenting improved outcomes for people and the communities in which they live. All of these factors, with a significant increase in the portion of the population that has health insurance coverage, has come together to create a synergy between these systems in local communities. Pilot projects are happening in localities where local leaders are reaching across sectors to achieve the outcomes they desire for the people they serve. Lastly, these leaders recognize that population outcomes will only be achieved with these cross sector collaborations.

In this paper, we envision these sectors coming together. Historically, there has been limited collaboration and each sector has pursued their goals in siloes, with only the client/resident/member/tenant/patient as the point of intersection. In the current model, the onus for system collaboration lies with the person with the least resources, the person being served. The current best practice is for integrated services and supports that builds in program and systems collaboration to reduce the burden on the person being served. Unfortunately, this collaboration has proven notoriously challenging to operationalize and has needed strong leadership and often a respected outside entity to drive it. The most successful, enduring partnerships have begun with a basic understanding of the priorities of each partner, therefore those priorities for the health care sector are outlined below.

Why has this been so difficult? Both sectors speak different languages, have large goals and either limited means or significant regulations that limit collaboration. Both have seasoned leaders and experts who are being challenged to learn just enough about the other sector to be a valuable partner. The resources and funding streams are generally not aligned at the federal, state or local level, and there are structural disincentives for collaboration. Each system is generally being asked to "do more with less" and therefore has limited capacity to stay focused on the partnership. The paper will outline some of the best practices occurring nationally and make suggestions for how Indianapolis can capitalize on these pilots to move forward across sectors to achieve their goals of ending homelessness and creating healthier communities.

Priorities and Players in the Health Care Delivery System

Each sector conceptualizes their work differently and understanding the other sector's framework can be a starting place for partnerships. For the health care sector, the concepts of population health, social determinants of health (SDOH) and health equity are big ideas that engage their leaders. Population health is measuring not just the health of individuals, but the health of communities using community wide tools. Measures such as infant mortality, life expectancy and rates of chronic diseases can all be measured at a community level and even by zip code or census tract in many communities.[1] New tools have been developed to better measure population health goals and the health care sector is learning that those goals will not be achieved for the low income population, unless the social determinants of health are addressed. These measures, when analyzed and considered on a regular basis can inform the community about where progress is being made, where a community may be sliding backwards and where to target limited resources. SDOH are the health care sector's method for understanding that moving the needle on population health will only happen if health care can have an impact beyond the doors of the clinic or hospital. SDOH is the understanding that the health care system will need to effect change in the communities where people live.

In addition to SDOH, health equity is the broad goal to ensure that all people have equal access to the circumstances and resources that offer the opportunity for health. Health disparities analyses typically find that equal opportunity was not available for many groups such as racial and ethnic minorities, persons with disabilities and immigrants. Health equity work is focused on

[1] https://www.cdc.gov/500cities/

changing those population health outcomes so that all members of our community will have the opportunity to live healthy lives.

The health care sector can be a complex partner to collaborate with, as there are several key layers of players. If prospective housing sector partners understand those layers and which player to approach for a certain level of support, the process of collaboration should be smoother, take less resources to develop and be more productive.

- ✓ State Medicaid Offices

  State Medicaid offices are responsible for implementing the state Medicaid Plan. In Indiana, this is the Family and Social Services Administration or FSSA. The State Medicaid plan is a contract between the federal government and the state with a variety of requirements for offering certain services to certain populations. Commonly, the state Medicaid office collaborates with other state offices such as Aging or Behavioral Health or Intellectual Disabilities to implement services for the populations served by these offices. For example, Indiana's state Foundational Community Supports benefit will serve people with substance use disorders and therefore, it is expected that the state Division of Mental Health and Addiction (DMHA) will be closely involved in the roll out of this benefit. Commonly, the office that manages programs for a population collaborates with the state Medicaid office on services start up and maintenance. The program office focused on implementation with the Medicaid office supporting to ensure that the implementation follows all Medicaid administrative requirements.

  The state Medicaid office holds contracts with Managed Care Entities (MCEs) to maintain provider networks to deliver services. The state can highlight their priorities for the MCEs through requirements in the contract between the state and the MCE. Trends in health care indicate that increasingly states are entering into value based payment arrangements with MCEs where MCEs will have to meet certain performance based requirements. Furthermore, if MCEs meet these goals, the state will increase the payment (upside opportunity). If MCEs do not meet these goals, then the state will decrease their payments (downside risk). Most states fund MCEs using a Per Member, Per Month or PMPM payment method. As MCEs have more covered lives or people they serve, the MCE payment increases. The PMPM rate is calculated depending upon the services that are included in the benefit package for the members. To provide further context, a benefit package is the services that people will be required to receive if they meet Medical Necessity Criteria for qualifying for needing services.

- ✓ Managed Care Entities (MCEs)

  MCEs have a variety of functions they carry out for the state. The MCE is required to maintain a provider network of health care practitioners who can serve the people they cover, most commonly called members. The MCE is required to maintain departments that can collaborate with the people they serve to improve their health as well as ensure

that all members who receive care meet Medical Necessity Criteria[2]. MCEs have a strong leadership role to play in communities around maintaining the health of the community and implementing policies and practices that exemplify the vision of the state, for the health of the community. And it also should be noted housing providers can contract through MCEs to bill Medicaid.

✓ Hospitals and Health Systems

Hospitals are increasingly merging or integrating with primary care practices and other community health partners to create "Health Systems". The goals of these larger systems is to improve health outcomes for the whole community, while improving the patient experience of care and decreasing costs. These health systems are also community leaders and potential partners with the expertise and capacity to address health at the person, program and system levels. Visionary health systems are reaching beyond the hospital or clinic walls to determine the needs in their community and address those needs. Eskenazi Health System is just one example of such a partner and their Medical-Legal Partnership program is one example of a Health System moving beyond the hospital doors to help their community.[3]

✓ Primary Care Practices, Health Centers including Federally Qualified Health Centers (FQHCs)

Primary care practices, and health centers including FQHCs are being asked, as is much of the health care sector, to improve outcomes for the patients they serve. While some of that work will focus on evidence-based practices in clinical care, a large portion will focus on community-based efforts and partnerships with social services including homeless systems and supportive housing. Health centers have long standing history of community activities, which take a broader public health approach to improving those outcomes. Health centers also partner with schools to improve children's health, assist their neighbors to access health care coverage and partner to assist in other community priority activities. Health centers, particularly, the Health Care for the Homeless (HCH) community already provide services in shelters or housing programs. In many communities, primary care practices are learning about such activities and finding ways to participate. In Indianapolis, Health Net is a Health Care for the Homeless grantee.[4]

✓ Innovative Financing and Delivery models such as Accountable Care Organizations (ACOs), Value Based Payment arrangements (VBPs) and other Shared Savings models

Health Care is shifting from paying for volume (per visit, per procedure or per pill) to paying for value in which financial incentives are aligned to help people stay healthy. Such Value Based Payment (VBP) arrangements include models that offer supports and incentives to achieve population health outcomes. Accountable Care Organizations or ACOs are

[2] http://member.indianamedicaid.com/resource-center/member-education/glossary-of-terms.aspx#M1
[3] http://www.eskenazihealth.edu/programs/medical-legal-partnership
[4] https://www.nhchc.org/directory/healthnet/

networks of providers and practices that work together to assist people to maintain good health with data and analytic supports guiding much of their activity. These new payment models, when implemented successfully can create "shared savings" in which the savings can be used to implement SDOH initiatives, such as supportive housing. ACOs in Marion County include Franciscan Health and Indiana Care Organization. [5]

All of these systems are working together to achieve a shared vision of healthy communities, and this creates an exciting moment of possibilities. Each sector is working to ensure that all community members have the opportunity available to achieve health and well-being. Each sector is actively learning about the other sector. Each sector is building on their strengths to create a climate where they are 'partnership ready'. Finally, each sector is engaged with the other sector to sustain services and build a healthier community together.

Examples from the Field

Each sector, recognizing the need to partner, is reaching out to the other sector, offering the expertise and capacity in which they specialize. The examples and citations below are short synopses of what is possible in this space. What all these examples share is a local implementation based upon community need, community input and community collaboration. Only with those factors in place is success likely.

Housing reaching out to Health Care

The affordable and supportive housing community have long served individuals with significant services needs. That fact has created a priority for the housing sector to find ways to partner with health care to ensure that their residents receive the care they need to live healthier lives and contribute to their community. Partnerships examples include

- ✓ Housing funding increasing competitiveness for projects that serve those most in need. Examples include
  - All states and territories' Qualified Allocation Plan have incentives for projects that include some type of supportive housing. Seventeen states including Idaho and Iowa have set aside funding specifically for supportive housing. Indiana has a 10% set aside for developments that use a Housing First model and a 10% set aside for developments that serve special needs populations.[6] Indiana also offers additional points for integrated supportive housing and supports quality development and programs by requiring developers to participate in the Indiana Supportive Housing Institute to be eligible for the Housing First set aside or to receive the additional points.
- ✓ Qualified Health Centers located in or close by affordable or supportive housing developments. CSH has summarized how to move forward in this work in detail and the opportunities have only continued to grow.[7]

[5] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/ACOs-in-Your-State.html
[6] http://www.csh.org/wp-content/uploads/2017/03/2016-QAP-Report-Final-3-24-17.pdf
[7] http://www.csh.org/wp-content/uploads/2015/12/CSH-Health-Housing-Partnerships-Guide.pdf

- Developing supportive housing in close proximity to a health center and/or FQHC or developing a health center near supportive housing creates synergies in clients and services that can be built upon. Accessing services becomes easier, housing providers have quick consultative access when residents or communities face challenges, and the health center has a built-in clientele. Examples of such developments are in Denver (the Colorado Coalition for the Homeless' Stout Street Health Center[8]); Columbus Ohio, (the Columbus Area Integrated Health Services[9]); Portland Oregon, (Central City Concern's Richard Harris Building.[10]); and Walnut Commons, a partnership of UP Development LLC and Meridian Health Services, in Muncie, Indiana that leveraged low income housing tax credits awarded by the Indiana Housing and Community Development Authority to develop the supportive housing with a health care component on site.
- Health centers have also developed respite care, which is a step down option from acute care that allows people experiencing homelessness to continue their recovery in a supportive setting that helps prevent inpatient hospital recidivism. Anthem, through their Blue Triangle program, is currently supporting this model.[11]

✓ Housing developments including Health Impact Assessments (HIA) in their pre development activities.[12]

HIAs are decision making tools that can be utilized in the development process. An HIA will identify the potential effects of the development on the health of the community. Using data and analytics, public health expertise and a community input process, an HIA will assist the developers in considering the health implications of the project for residents and the community. A quality HIA will provide evidence-based recommendations on how to reduce risks, promote benefits and monitor health impact of the project. The Pew Charitable Trusts completed a report in 2016 that describes 40 HIAs conducted between 2002 and 2013.[13]

Health Care reaching out to Housing

✓ Setting the table - Accountable Health Communities (AHC)

The housing and health care sectors are large, stakeholder groups that have broad mandates for communities. Few organizations in either sector have capacity to create partnerships with no new resources. The Center for Medicare and Medicaid Services (CMS) has recognized this fact, by creating the Accountable Health Communities (AHC) Model. Capacity is needed to drive the partnership towards aligned goals and projects. The AHC model creates a group of people who are dedicated to the partnership and to the joint goals of multiple partners. The AHC's set the table so that community

[8] https://www.coloradocoalition.org/health-services
[9] https://www.columbus-area.com/copy-of-pathway
[10] http://www.centralcityconcern.org/properties/richard-l-harris-building
[11] https://marioncountyre-entrycoalition.ning.com/online-resources/anthem-s-blue-triangle-program
[12] https://www.nap.edu/read/13229/chapter/1
[13] http://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2016/03/guidance-for-housing-professionals

stakeholders in multiple sectors can build relationships, define a shared vision, analyze the health data from a community and develop joint projects that will assist in realizing that shared vision. The Community Health Network Foundation in Indianapolis is an AHC grantee in the Assistance track of CMS' AHC program.[14]

- ✓ For Profit MCEs as a Low Income Housing Tax Credit Investor and other supports to Homeless Systems

For Profit MCEs such as United and Anthem have both invested company profits in affordable housing developments. Using the Low Income Housing Tax Credit or LIHTC program, the financial arms of these large public companies have aligned their financial interests with the communities they serve by investing in affordable housing. United is working to determine how best to leverage these investments into housing options for their most vulnerable members, in projects such as Chicanos Por La Causa in Phoenix.[15] LA Cares, a county developed, nonprofit MCE is investing $20 million over 5 years to increase their members' access to Supportive Housing. [16] Since only for profit companies have a tax liability on company profits, it is important to note that not-for- Profit competitors will have other strategies to support housing related activities.

- ✓ Hospitals and Health Systems investing in Housing

Hospitals and health systems also are investing in Supportive Housing. From Florida Hospital in Orlando[17] to Kaiser Permanente and Legacy Health System in the Pacific Northwest[18], hospitals are finding that both their mission and their bottom line are best served by investing in supportive housing. Chicago's University of Illinois' "Better Health through Housing" is a great example of this type of investment.[19] A data matching project between the city of Chicago's Homelessness Management Information System or HMIS and the hospital's electronic health record helped them determine who was a priority for both systems to house. Using the hospital's Community Benefit Resources[20] to start for services and Continuum of Care resources for housing, this Housing First program has already served sixty-two people and shown a 27% cost reduction for the first twenty-four patients housed.

- ✓ Data and Analytic Strategies that include
  - Collecting data - using the ICD-10 codes for homelessness and housing instability

The International Classification of Diseases (ICD) is a medical classification list created with the leadership of the World Health Organization (WHO). The 10th iteration of their

[14] https://innovation.cms.gov/initiatives/map/index.html#model=accountable-health-communities-model
[15] https://careers.unitedhealthgroup.com/why-work-here/news-room/2016/unitedhealthcare-and-chicanos-por-la-causa-to-help-arizonans-access-quality-affordable-housing.aspx
[16] https://www.lacare.org/news/la-care-commits-unprecedented-20-million-to-tackle-homelessness-crisis
[17] http://www.csh.org/2014/11/florida-hospital-pledges-millions-to-end-homelessness/
[18] https://www.usnews.com/news/news/articles/2016-09-23/6-portland-health-providers-give-215m-for-homeless-housing
[19] http://hospital.uillinois.edu/about-ui-health/community-commitment/better-health-through-housing
[20] https://www.nhchc.org/wp-content/uploads/2016/06/policy-brief-hospital-community-benefit.pdf

system, commonly called, ICD-10 includes codes for both homelessness (Z59.0) and housing instability (Z59.9), and it also allows health care providers and payers to collect data regarding the housing status of the people they serve. Through this data collection, these organizations will hopefully better understand some of the SDOH that the people they serve are facing and be willing to serve as more engaged partners in the community to address these needs. Health settings such as Pedigo Health Center, a part of the Eskenazi Health System, prioritizes collecting this data and watches data quality closely. This priority stems from the clinics focus on serving those experiencing homelessness, but other health care partners can learn from their experience.

State Medicaid offices can require this data in their contract with MCEs and any Medicaid Management Information System (MMIS) changes, have an enhanced federal match rate if states need to modify their systems to capture more information regarding complex care populations, such as people experiencing homelessness. In implementing the Veterans Administration Supportive Housing Program or VASH, the VA created a two question screening for all veterans receiving outpatient services. This data served both at the person level to make appropriate referrals and at the system level to inform leadership about the extent of housing issues for the people they served. Still, attention will need to be paid to data quality and missing data that are common among HMIS systems. Homeless service providers and especially HMIS administrators and vendors will be in an excellent position to push this case.

- Data Integration Projects: Learning who is a priority for both sectors

Many of these projects and partnerships are born of data integration projects, similar to the University of Illinois project noted above. Another example of data being used to target and prioritize potential supportive housing residents can be found in Houston, Texas. In this project, HMIS data was shared with the local Managed Care Organization (MCO to determine priority persons, served by both the homeless system and the MCO. Two of three MCOs in the county performed the data match and used the results to recommend members for an upcoming supportive housing project. Resources from the state of Texas' 1115 Medicaid Wavier Delivery System Reform Incentive Payment, or DSRIP, program were used to fund Integrated Care teams that included community health workers, case management and nursing support. Clinical staff were employees of the Houston Health Care for the Homeless project, so that the care individuals received was from a clinic that understood their needs and offered integrated care between physical health and behavioral health. [21] Housing support came from the local Continuum of Care. Together the data matching has created a long term partnership between the COC, the MCEs and the HCH grantee in Houston. All are working together to fill in the service gaps that will be created when the waiver expires in December 2017 and the data matches continue in a regularly scheduled process. As new data matches show changes in the population, changes in services and the collaboration are to be expected, keeping the partners nimble in addressing the needs of their community.

[21] http://www.csh.org/wp-content/uploads/2016/01/HoustonFrequentUserInitiativeProfile_Jan16.pdf

- Tracking SDOH including Housing Status

Health care in the past decade has moved to Electronic Health Records (EHRs). These EHRs have a variety of data driven and analytic strategies to address the needs of the people they serve. One priority for health systems is to better track the SDOH and how those needs impact the people served by the health system. In Dallas, the Parkland Hospital System has used its technology resources to spin off a new nonprofit, PCCI. PCCI has created a referral and outcome network tool, that allows social service providers to sign on entering both their resources (for example shelters might note how many beds are available on a particular day) and their needs (housing, or food needs).[22] The Dallas Information Exchange portal directs resources to the people that need them and tracks outcomes to those referrals, allowing referring agencies to determine if they are making the right referrals that are assisting the people they serve. This accountable system is the basis of Dallas's new HMIS system and has opened the door to many collaborative possibilities between the Dallas COC and the Parkland Hospital system and the community at large. The 2017 National Medicaid Directors Survey found that by 2018, 21 states will be requiring MCOs to screen for social needs and the trend continues to grow.[23]

✓ The move to Managed Long Term Services and Supports or LTSS

As baby boomers age, more and more Americans will be in need of Long Term Services and Supports Services or LTSS. LTSS is comprised of two primary options, nursing home care and Home and Community Based Waiver Services (HCBWS). States, seeing the high costs, are turning to MCEs to integrate care and decrease costs. Most people would prefer to remain in their homes, rather than receive institutional care in a nursing home setting. And HCBWs are a fraction of the cost of a nursing home. The one challenge is the lack of affordable housing to transition people from institutional care. As more and more MCEs successfully bid for these contracts, the incentives for them to engage and support more supportive and affordable housing developments will only increase.

✓ Documenting Cost Savings

Supportive housing has a growing literature to document the increasing costs savings.[24] The Louisiana statewide supportive housing program decreased costs by 24% in the first year of transition from institutional care.[25] Massachusetts' Community Support Program for people Experiencing Chronic Homelessness or CSPECH program, showed cost a return on investment of between $1.61.to $2.43 for every dollar spent.[26] State budgets

[22] http://iep.pccipieces.org/
[23] https://www.kff.org/medicaid/report/medicaid-moving-ahead-in-uncertain-times-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2017-and-2018/
[24] http://www.csh.org/supportive-housing-facts/evidence/
[25] http://nashp.org/braiding-funds-to-house-complex-medicaid-beneficiaries-key-policy-lessons-from-louisiana/
[26] https://bluecrossmafoundation.org/sites/default/files/download/related/CSPECH%20Slides%20FINAL.pdf

are becoming increasingly tight, and the more supportive housing can demonstrate the Return on Investment or ROI for their activities, the more likely support they will receive from the state. As advocates work towards states making these investments, the business case and state specific ROI analysis will be essential for their success.

- ✓ Crosswalk between Supportive Housing Services and the State's Medicaid plan

  State Medicaid plans offer a variety of comprehensive, Person Centered services for people with disabilities. Supportive housing services overlap with a variety of these services. As each state Medicaid plan is different, a supportive services crosswalk can help a state or community determine what services are already offered in the state plan and what gaps might exist between services offered and populations served. A Crosswalk, done in collaboration with a state Medicaid office is an effective tool to ensure that persons who need supportive housing can access the services needed to maintain the lives in the community. CSH has completed full crosswalks for eight states and is working with the team in Indiana to fund an updated crosswalk for Indiana[27].

- ✓ Ensuring Quality in Supportive Housing and Supportive Housing Services

  In health care, the first question is always 'Access", can people access the services they need. When that question has been answered, the second question is always "Quality" and are the services they are accessing quality services. Communities and projects are working with CSH to ensure that their residents are offered quality supportive housing and services to maintain their community tenure and help residents live productive lives in the community.[28] When Medicaid is a payer for services, the state and MCEs will also have a vested interest in ensuring quality in the services that public resources are supporting.

- ✓ Long term partnerships between health care sector partners and Community-Based Organizations

  These partnerships between health and housing sector are only in their infancy stages. Over the years, the field is expected to grow and blossom into more efficient, effective program that impact communities and bend the needle on the health of people and communities. Two recent summaries of those partnerships, by the Nonprofit Finance Fund[29] and the Urban Institute[30] highlight the essential component of these partnerships- Relationships! These partnerships are not built in a day or in one funding cycle. Rather they are nurtured long term from project to project, administration to administration and through leadership changes. Only then can the fruit they have planted grow to feed whole communities.

[27] http://www.csh.org/medicaid-supportive-housing-crosswalks/
[28] http://www.csh.org/quality
[29] http://www.nonprofitfinancefund.org/news/report-human-services-healthcare-organizations-partner-improve-health-outcomes
[30] http://www.urban.org/sites/default/files/publication/91941/emerging_strategies_in_integrating_health_and_housing_final.pdf

Recommendations

As Indianapolis comes together as a community to address its housing needs, the health care sector remains a potent, largely untapped resource that, if brought in as a full partner, can significantly advance the community's ability to achieve its goals. The recommendations below are put forward to begin the process of building a more dynamic and successful partnership between the housing and health care sectors in Indianapolis.

I. Landscape Assessment to engage new health care sector partners

Locally more and more health and housing stakeholders are beginning to work together to address the needs in their community. Both sectors are learning that they cannot reach their goals of ending homelessness, or improving population health without the other sector. However, both sectors also need education around the possibilities for collaboration and to expand their networks of potential partners. A key, next step recommendation would be to expand upon the current engaged network of health care stakeholders and interview additional community leaders both to learn about their priorities and to educate them on the resources and priorities of their new potential partners. The Landscape Assessment should conclude in a cross sector convening to report results to all partners and develop next steps to address joint community priorities. Attention should be focused on, but not limited to hospital systems and health center partners.

II. Development of a public affordable and supportive housing list and development pipeline

For the healthcare and housing sectors to more effectively collaborate, each sector needs to learn more about the other. To this end, a publically available pipeline of affordable and supportive housing projects, can allow the health care sector to consider their geographic priorities and how to partner with these developing projects to add supportive services for their residents. A regularly maintained listing of projects will be a welcome resource to the health care sector, who is often stymied in their understanding of when, where and how housing is available or becomes available. This should be coupled with education on how Coordinated Entry operates. This recommendation will be most effective statewide and CHIP can collaborate with IHCDA to complete.

III. Statewide development of a supportive housing pipeline that aligns with supportive services funding

Indiana's Qualified Allocation Plan already prioritizes Supportive Housing. IHCDA, in partnership with CSH, has developed a robust pipeline of supportive housing through the Indiana Supportive Housing Institute and the Indianapolis Integrated Supportive Housing Initiative. The City of Indianapolis should align with IHCDA and

CSH to create a similar process that builds on cross sector partnerships to obtain needed services funding as units come on-line and create a viable pipeline for Indianapolis. This work should be guided by the "Mayor's Challenge" to ensure a coordinated approach with access to local resources.

IV. Build on findings from the data integration project to develop projects to address cross sector needs

Indiana is leading the way nationally in integrating data and using integrated data systems to build accountability for the public sector through the Governor's Initiatives on Transparency and the state's Management Performance Hub.[31] CHIP and their partners should use the results from initial cross sector data matches to determine

- What populations show the greatest need and the greatest opportunity for impact?
- What are the evidence-based interventions that will achieve that impact? An example may be a Frequent Users Systems Engagement or FUSE project for the designated community.
- What resources are needed to offer these interventions?
- What would be the necessary accountability measures regarding these interventions to ensure that the project's goals were met and shared with the broader community.

V. Update Medicaid Crosswalk and disseminate widely

In 2012, CSH had completed a crosswalk examining the relationship between the Mental Health Rehabilitation Option (MRO) benefits in Indiana and the services necessary for quality supportive housing. In 2016, the state of Indiana had updated that work with support from CMS's Innovator Accelerator Program or IAP. The work here should be combined and broadly shared with community stakeholders, so that each can be aware of the potential for efficiencies and collaboration between the two sectors. The combined crosswalk will give Indiana's Community Mental Health Centers (CMHCs) and its supportive housing providers, a level playing field, so that each understand the expertise and contributions of the other sector that is needed for community wide success. The goals of the long term collaboration and crosswalk will be for all partners to effectively collaborate for maximum impact for vulnerable residents of their community and their state.

The Crosswalk will be helpful in identifying what services are covered under Medicaid, what services are needed in supportive housing and where there is a gap in the types of services needed and populations served. The Crosswalk will identify services eligible in MRO and HIP 2.0 and tie those back to services needed

[31] http://www.in.gov/mph/

in supportive housing. Local partners should be educated regarding the crosswalk findings and ensure that any new services meet the Continuum of Care (CoC's) standards of care and best practices in supportive housing. This information can be used to guide possible private and public sector funders as they explore how to support system transformation.

VI. Collaborate with FSSA in the Tenancy Support Services Benefit Implementation

Indiana's Family and Social Services Administration's (FSSA) Office of Medicaid Policy and Planning (OMPP) is working towards implementing the foundational community support benefit for persons who are suffering from Addiction challenges. Their goal is to address the opioid crisis facing the state. Successful implementation of the benefit will require close collaboration between the state, the addiction treatment services provider community and the affordable and supportive housing community. Homeless Services and Affordable Housing providers should share their expertise in working with these populations, but also highlight the capacity building activities that will be needed in order to take advantage of the opportunities provided by these new billable services.

VII. Medicaid Academy for Supportive Housing providers to begin to bill Medicaid for services

Supportive housing and homeless services providers bring strong expertise in successfully engaging persons with multiple complicating disabilities; a growing priority for the health care sector. However, the administrative structures of these agencies often do not support billing of Medicaid. To capitalize on their expertise that is sorely needed by the health care sector, dedicated capacity building activities will need to occur. CSH has conducted Medicaid Academies in five states (CO, CT, IL, NH, & WA) that trains supportive housing providers on Medicaid Billing activities for their state as well as brokers needed relationships between Supportive Housing providers and Managed Care Entities (MCEs). The goal is to have Supportive Housing providers learn billing practices. This will help develop a business plan for their agency that includes Medicaid and begin relationships with MCEs, with the goal of contracting with the MCEs for the supportive services that they provide.

Timing and attendance at Medicaid Academy activities must consider a variety of factors including

- OMPP status of decisions regarding benefit implementation
- Administrative models that agencies are choosing. Agencies will need differing support depending upon if the agency is pursuing full Medicaid billing, the agency is partnering for the administrative support, or the agency is partnering for services support.

VIII. Partner with the growing Addiction treatment sector in Indiana

Indiana's leaders are committed to address the opioid crisis in their state. To that end, the addiction treatment field is growing quickly to address the need in Indiana's communities. The majority of people, with evidence-based supports are able to rejoin the workforce after treatment. A small minority however have extremely limited 'recovery capital' and will need longer term supports, including supportive housing. The addiction treatment sector and the supportive housing sector will need education regarding the perspectives of the other, as well as opportunities to grow relationships and collaborative partnerships to address the needs of vulnerable citizens of Indiana. Examples of collaboration include cross training of each sector for each sector of the other and system mapping activities, from a person centered design perspective that consider how people move back and forth between systems. When current cross sector activities are better understood, the team can make recommendations regarding recommended changes to system processes.

IX. Engage Hospital and Health Systems

A growing number of communities (Boston, Chicago, Portland, Los Angles) recognizing the impact of housing on health care outcomes have started pilot projects to support an increase in Supportive Housing opportunities for a community. In Chicago, the University of Illinois at Chicago, matched data and found a high incidence of chronic homelessness among persons who were frequent users of the emergency department. UIL partnered with the local COC to fund services and use leasing funding from the COC to increase PSH access. Boston Medical Center is investing over $6.5 million into a variety of housing functions including operating subsidies, zero interest capital loans and eviction prevention programs. Indianapolis, should begin a conversation with their hospital partners regarding what impact similar investments could have on both homelessness and health outcomes in their community.

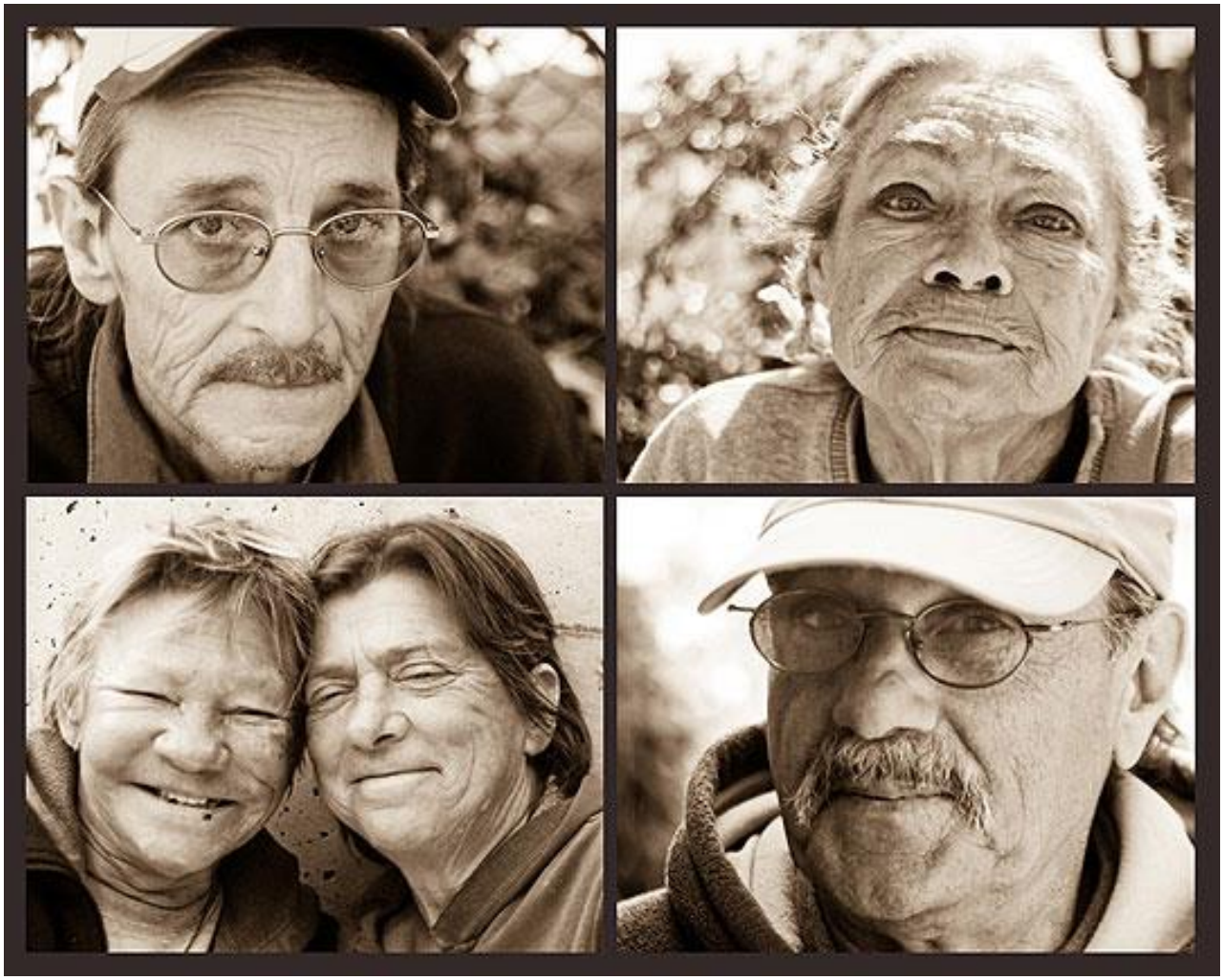
X. Quarterly Cross Sector convenings of the Health and Housing stakeholders to report on progress

To create the relationships and partnerships needed for long term cross sector projects, a regular forum needs to be developed to bring together stakeholders, review activities, analyze gaps and develop plans to address gaps. The group is proposed to meet quarterly, supported by the MCEs. The convening will update each sector on activities that can impact the other sector. A good initial example will be status on Coordinated Entry Systems start up and the ability of mainstream systems to support and engage with this system. Additionally, sharing an evolving housing development pipeline from the City of Indianapolis and Indiana Housing and Community Development Authority (IHCDA) that the MCEs can consider how

to offer supportive services to increase supportive housing capacity for the city and state.

Cross Sector convening activities can include

- Developing cross sector training for MCEs, Supportive Housing Providers, Hospital and Health Systems, CMHCs, Addiction Treatment providers and additional health care sector partners
- Developing a cross sector policy agenda that will increase supportive housing capacity and quality in Indianapolis and throughout the state.
- Developing cross sector pilot projects to address the need of populations that are priorities for multiple sectors. These projects will need to include an evaluation component as well as regular reporting to the stakeholders.



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