Healthcare x Homelessness Liaison Toolkit

Healthcare x Homelessness Pilot

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What is a liaison?

A liaison is an integral piece of coordination efforts between the homeless response system and healthcare system for a community. This position serves as a linkage between the two systems, building relationships between both organizations and designing processes that improve coordination, experiences, efficiencies, and outcomes for people experiencing homelessness.

There are two main types of liaisons:

1. A Healthcare Liaison embedded in the local CoC or homeless response system
2. A Homelessness Liaison embedded in the local hospital or healthcare system.

Healthcare Liaison Overview

A **Healthcare Liaison** is a role typically hired and managed by the local CoC or homeless response system with specific responsibilities related to engaging with the local healthcare system(s). This role works closely with other key CoC roles such as Coordinated Entry Lead or Outreach Manager, but is primarily focused on fostering and strengthening relationships with the local healthcare system or systems.

Value Statement

The **Healthcare Liaison** provides a dedicated lane for all population health and health equity work as it pertains to a local homeless population. This role's efforts center around individuals on both the chronic (or other sub-population) by-name list and the high-utilization list from the healthcare system. By focusing on this shared group of individuals, this role provides a clear path to reductions in care costs for the healthcare system (through coordination and linkages to housing), improved outcomes and a mechanism for prioritization within the homeless response system.

Benefits

- Strong understanding of the context of homelessness locally through management and role within the CoC.
- A clear lead for work with the healthcare system around patient discharge and referral processes, including collaborative support to review client eligibility and enrollment in relevant programs, public insurance offerings and services (Medicaid, Medicare, etc.).

- Dedicated connection point for all health system communication, planning, and outreach efforts.
- A strong demonstration to individuals in a community that the homeless response system views healthcare and access to care as a key component to health equity at large. By aligning with key healthcare partners, it allows for a more timely and personable referral.
- Builds trust between individuals experiencing homelessness and the healthcare system, while allowing for a clear avenue for advocacy within the healthcare system.

Challenges

- With the role embedded in the CoC, there are additional privacy and legal hurdles to clear before a Healthcare Liaison can access, edit, or read EHR records.
- Key staff within the healthcare system may not be aware of the liaison role since it is in a different organization. It requires additional coordination to improve visibility and awareness.
- Liaisons may be required to complete the healthcare system credentialing process before meeting with clients in the hospital. This can take up to 2 months or more. Meet early with the leader of case management at the hospital(s) you are partnering with to prepare for their process.

Monitoring and Evaluation

- **Possible key outcome measures include:**
    - Housing placements
    - 6-month retention in housing
    - Connection to primary care/"medical home"
    - Connection to community-based mental health or substance abuse care
    - Reduction in hospital visits, particularly inpatient days and readmissions within 30 days
    - Reduction in unnecessary emergency room visits
    - Increase in access to benefits, transportation, food security, and other health related social needs
- All metrics can be filtered to monitor access and outcomes among particular subgroups, such as racial or ethnic minorities and historically oppressed groups.
- To look at examples of an evaluation strategy in greater detail, please see the list of potential measures to consider in the Appendix.

Job Description Examples

LAHSA

Under the direction of the Adult Coordinated Entry System (CES) Senior Manager and in integral partnership with other members of key Los Angeles Homeless Services Authority (LAHSA) Departments, the Coordinator, **Healthcare Integration (Coordinator)** provides leadership for system integration activities between the healthcare sector and homeless services in Los Angeles County available through CES. The Coordinator builds bridges between systems with the goal of ensuring that persons experiencing homelessness can receive the appropriate resources and supports available through CES. The Coordinator represents LAHSA and its investment in CES to the community.

Full Job Description

HARTFORD, Connecticut

Under the direction of the Director of Strategy and in integral partnership with other members of key Journey Home staff, the liaison provides leadership for system integration activities between the healthcare sector and homeless services in Greater Hartford and Central Coordinated Access Networks available through the Coordinated Entry System (CES). The liaison builds bridges between systems with the goal of ensuring that persons experiencing homelessness and at risk of homelessness can receive the appropriate resources and support available through CES.

This position will serve as a linkage between hospitals and homeless service providers, fostering relationships between organizations and facilitating transitions of care for people experiencing homelessness. This position will assess and refer high utilizers to ensure a service connection is made to an appropriate CES Access Sites or Outreach Team. In addition, this position will work with internal departments and community partners to ensure that reconnections are made when necessary. The Hospital Liaison will provide technical assistance to hospital staff while ensuring that ongoing training and education on CES resources is provided.

Full Job Description

Homelessness Liaison Overview

A **Homelessness Liaison** is a role typically hired and managed by the local healthcare system or hospital with specific responsibilities related to engaging with patients at risk of or experiencing homelessness. This role works closely with other key social work roles such as case managers, discharge planners, coordinated care managers or community health workers but is primarily focused on fostering and strengthening relationships with the local homeless response system.

Value Statement

The **Homelessness Liaison** provides a dedicated role within a healthcare system for all patient and health equity work as it pertains to a local homeless population. This role's efforts center around individuals on the high-utilization list (typically from a particular department to start) and leverages a SDOH or Housing Screening tool to identify individuals at risk or experiencing homelessness. This role provides a clear path to reductions in care costs for the healthcare system (through coordination and linkages to the housing system and vouchers) and a referral mechanism to the homeless response system.

Benefits

- Strong understanding of the context of the healthcare system through management and role within the hospital or healthcare system.
- With the role embedded in the healthcare system, there are less privacy and legal hurdles to clear before Homelessness Liaison can access, edit, or read EHR records. However, there may still be HR-related issues to overcome.
- This role demonstrates a commitment and accountability within the healthcare system to generate solutions and commit resources for homeless populations, shifting the sole responsibility from homeless response.
- A clear lead for work with the homeless response system around patient discharge and referral process, including collaborative support to review client eligibility and enrollment in relevant programs (Medicaid, Medicare, etc), public insurance offerings and services.
- SDOH Screenings (recommended by The Joint Commission and required by CMS) allow for improved coordination and a richer needs assessment from which this role can focus their work, efforts, and process improvement protocols.
- A strong demonstration of commitment to health equity efforts within a community and local health system, often with a clear call to action for other community members to address homelessness as a crisis.

Challenges

- In a community with multiple healthcare systems, embedding one liaison in a singular system can be limiting in their impact and reach. However, this does provide a case study for other hospitals to understand the scope and benefits of the role and eventually sign on or support the work.
- Data-sharing agreements are still required for care coordination and release of patient information, even with this role in place. However, these agreements become simpler with this role in place.
- SDOH Screenings (recommended by The Joint Commission and required by CMS) must be delivered in a trauma-informed, sensitive manner for all individuals — which often requires time, focus, and training.
- Identification of individuals in the healthcare system that are at-risk of or experiencing homelessness does not directly streamline their access to secure housing, as there are still system processes on the HRS side to prioritize and serve those most in need.
- Connecting the day-to-day work of this role with the broader coordinated entry system and/or case conferencing leads of the CoC requires additional meetings, time, and coordination as well as clear processes and procedures for updating each other.

Monitoring and Evaluation

- **Possible key outcome measures include:**
  - Housing placements,
  - 6-month retention in housing
  - Connection to primary care/"medical home"
  - Connection to community-based mental health or substance abuse care
  - Hospital visits, particularly inpatient days and readmissions within 30 days
  - Reduction in unnecessary emergency room visits
  - Increase in access to benefits, transportation, food security, and other health related social needs
  - Referrals from the healthcare system to the homelessness response system
- All measures can be filtered to monitor access and outcomes among particular subgroups, such as racial or ethnic minorities and historically oppressed groups.
- To look at examples of an evaluation strategy in greater detail, please see the list of potential measures to consider in the Appendix.

Job Description Examples

LA Family Housing

The **liaison** will assess and refer high utilizers to ensure a service connection is made to an appropriate CES Access Site or Outreach Team. In addition, this position will work with internal departments and community partners to ensure that reconnections are made when necessary. The liaison will provide technical assistance to hospital staff while ensuring that ongoing training and education on CES resources is provided.

Job Description

More examples to come!

Funding your Liaison Role

For both liaison roles, **the source of funding will depend on the local population and the stakeholders that are invested in their needs**. There isn't a specific billing code or payment source for this type of role, but there may be in the future. Coordination between settings is highly valued the more we begin to understand the needs of underserved or complex populations.

States are testing innovation in payment for this kind of coordination through Medicaid 1115 waivers which may result in future opportunities for funding. Increasing focus on equity and health disparities is also driving interest in peer support and community health workers and some states or insurers are beginning to provide payment for these roles.

TIP: A helpful practice to consider is to start with funding for a one-year pilot and collect targeted outcome data that shows the impact of your program in a way that matters to stakeholders who will fund it for the long term. ***Most programs finance the role by showing reductions in cost, improved quality outcomes, improved revenue by connecting people to benefits (Medicaid and SSDI), and impact on equity for the population.***

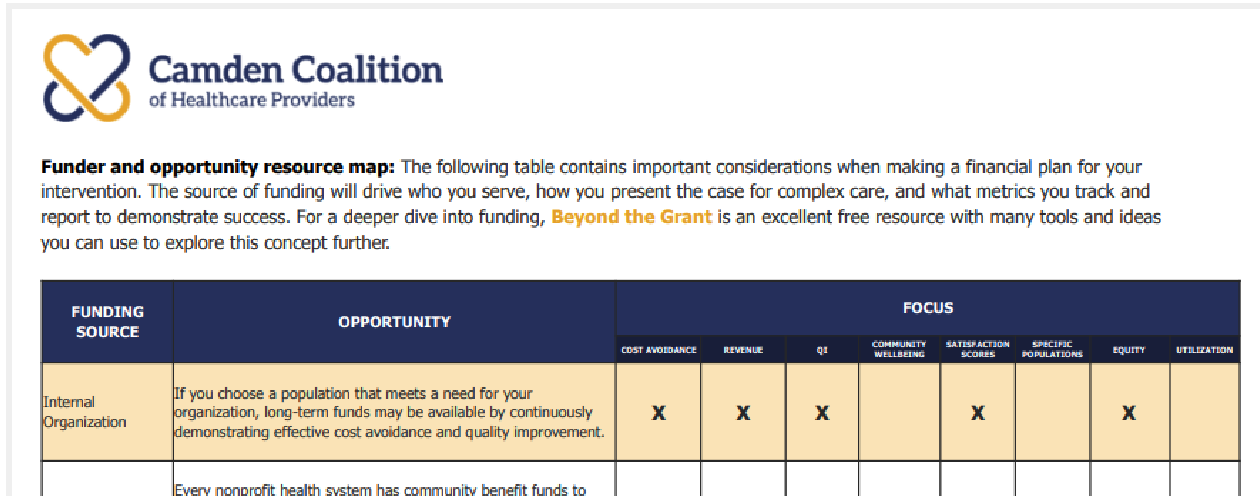
Potential sources of funding for a new liaison role include:

- Grant funding for a pilot
    - A few potential foundations that may align are payer foundations (i.e. Humana Foundation, IEHP Foundation) or local family foundations or city equity-based foundations.

    - Hartford, Connecticut, funded their role through a grant via CVS pharmacies.
- Community benefit funding from a hospital or healthcare system
- Investment from a value-based payment program like an ACO
- Investment from a payer like Medicaid/CMS.

The following table shows common drivers that motivate stakeholders to fund a liaison role:

Camden Coalition: Funder and Opportunity Resource Map



Funder and opportunity resource map: The following table contains important considerations when making a financial plan for your intervention. The source of funding will drive who you serve, how you present the case for complex care, and what metrics you track and report to demonstrate success. For a deeper dive into funding, **Beyond the Grant** is an excellent free resource with many tools and ideas you can use to explore this concept further.

FUNDING SOURCE	OPPORTUNITY	FOCUS							
		COST AVOIDANCE	REVENUE	QI	COMMUNITY WELLBEING	SATISFACTION SCORES	SPECIFIC POPULATIONS	EQUITY	UTILIZATION
Internal Organization	If you choose a population that meets a need for your organization, long-term funds may be available by continuously demonstrating effective cost avoidance and quality improvement.	X	X	X		X		X	
	Every nonprofit health system has community benefit funds to								

Additional resources to consider if you want to explore how to sustainably finance a liaison role and how to show the value case to potential funders for your program:

- ReThink Health Financing Workbook
- Value Case Summary
- Value Case Example

Scoping your Liaison Role and Program

Designing Your Program for Success

Identify Your Population

For both liaison roles, it will be important to consider the population you will be serving. Depending on the size of the homeless population in your community, you may need to start with a focused group, demonstrate success, and then advocate for more resources to serve all homeless clients. *For tips on how to identify your focal population, explore the Appendix.*

Assets in the System of Care

Understanding your community and the resources and partners to serve homeless populations will help you to build relationships that accelerate outcomes for your clients and rapidly serve their needs. Successful liaison practices include:

- Mapping the assets and resources in your community
- If you have time, visiting key resources so you have full awareness of the services and can build relationships with these partners

For more, explore the Asset Mapping Tool in the Appendix.

Creating a Workflow

Clearly identifying the actions in your intervention will help partners to understand the liaison role and support effective delivery for clients. Common elements in a workflow include:

- Inclusion and exclusion criteria for the population you will serve
- How you will receive referrals
- What actions you will take when receiving a referral
- What type of care coordination you will provide
- How you will connect and communicate with other providers
- How long your intervention will last and what constitutes "graduation" from the program

This website offers several examples of workflow charts to spark ideas for how you might want to document this for your program. In addition, you will find a simple workflow template in the appendix that you can customize (adapted from our Hartford team)

Identifying Assessment Tools

Developing standard tools for client assessment, prioritization of clients, definition of when your intervention will start and end, and documentation of the services you are providing will improve the impact of your program. In the appendix, you will find some examples to consider as you design your program including:

- Root Cause Assessment tool (Appendix)
- Triage Tool
- Triage Tool Example
- Example of a note to document your work with a client (Appendix)
- Arizona Self Sufficiency Matrix

Capture Outcome Data and Process Improvement Themes

Successful programs identify outcome metrics they will track and also capture themes in root causes or barriers for homeless clients. Identify metrics together with your stakeholders to ensure you capture outcomes that will continue to generate support of your program. In the appendix you will find suggested metrics to consider.

In addition, the following resources will provide an introduction to developing metrics for your program and a resource you could adapt to capture the themes in barriers your clients are experiencing. This information can be used to spark conversation across sectors about potential process improvements between systems to improve outcomes.

- Building the Value Case Toolkit
- Tool to Capture Themes in Root Causes

Practices to Accelerate Outcomes

Collaborating and communicating with partners is key to the success of the liaison role. A few practices to consider include:

- Take time to explain your role and the services you will provide to key partners.
  - ***Example:*** Present at a CoC meeting or at a hospital discharge planning meeting and share the criteria and contact information for your program.
- Set regular hours so partners know when they can count on you.
- Consider joining daily rounds at the hospital (if they have them) to support case managers in identifying potential clients and to educate providers about what services you can provide.
- Consider case conferencing across sectors to improve relationships between providers, accelerate outcomes for the client and develop shared plans of care.
- Document the actions you are taking so partners can see the difference the liaison role is making.
- Share the stories of success — many providers never get to hear how things turn out and would love to know that your efforts together are making a difference.

APPENDIX

Articles, webinars and free training to help you prepare for your role

Article on Nurse Liaisons
Article on Homeless Liaisons
Article Unmet Medical Needs of the Homeless
Discharge Planning for Homeless Clients Resources
Introduction for Discharge Planners
Example Toolkit for McKinney Vento Liaisons (school-based liaisons)
Free Healthcare for the Homeless Training
Free Webinar on Meeting Needs of Homeless in the Hospital

Identifying your focal population

A few tips for identifying your population:

- Identify the size of the homeless population needing healthcare support in the HRS through conversations with your local CoC and reviewing relevant data from HMIS.
- Identify the size of the homeless population needing support in the hospital through EHR reports, patient conversations, etc.
- If the potential population is larger than you can serve, consider which subset of the group would benefit most from your services to start with.
  - ***Example***: In the hospital — start by serving homeless clients who are inpatient and add homeless clients in the emergency department as your program grows.
  - ***Example***: consider starting with homeless clients who are high-utilizers (i.e. greater than three inpatient admits in a year or greater than five ED visits in six months) and prioritize them first for engagement.
- Think about which population is a high priority for your key stakeholders and start there.
- Consider your hours of service and match to meet the needs of the population.
  - ***Example***: If you are going to serve homeless clients accessing the emergency department (ED) — the turn around is quick and understanding what time of day clients typically access the ED will be important. ED liaisons typically reside in the ED and may work later hours or weekends to meet the needs of the population.

- Meet with your key partners from both systems (hospital and HRS) to identify together who is a priority to begin with for intervention. Develop the population criteria together.

Asset Mapping Tool

Below you will find a tool for **thinking about the assets in the homeless system of care for your community.** In addition to the homeless system of care, it can be helpful to also identify the following providers:

- Palliative care and hospice providers
- Primary care providers (who accept Medicaid or the uninsured)
- Behavioral health providers (who accept Medicaid or the uninsured)
- Substance use disorder providers (who accept Medicaid or the uninsured)
- Pain management providers (who accept Medicaid or the uninsured)
- Long-term care or residential facilities that are options for those experiencing homelessness

Potential Process and Outcome Measures

Below are two tables with potential measures to inform, monitor, and evaluate your liaison program and project. First, you'll want to install **process measures** to indicate the overall effectiveness and health of your system for this role. Next, you'll want to look at **outcome measures** to assess the effect of this intervention on your focal population and system.

Process Measure	Definition (Numerator/Denominator)
Percent of people with timely referral to homelessness response system (HRS)	# clients new this month who had initial referral to HRS within X days of their intake/ # clients new this month
Percent of ED admissions resulting in referral from health system to homelessness response system	# people experiencing chronic homelessness who visited the ED this month with referral to emergency, transitional or permanent housing/ # people experiencing chronic homelessness who visited the ED this month
Equitable access	# people enrolled in services this month of a specific demographic/ Total number of people enrolled this month *Then, compare to census: does % match?*
Commitment to diversity and inclusion	# people employed by the organization of a specific demographic or speaking a specific language/ Total number of people employed by the organization *Then, compare to census: does % match?* *Alternately: Total # languages spoken by people employed as service providers*
Connection to needed services … in a timely manner	# people enrolled in X service (eg., Medicaid waiver, Medicaid, Medicare, assisted living facility, person-centered medical home, community-based mental health or substance abuse services)/ # people referred to X service *Alternately: # people connected to (needed) service with X days of initial referral/* *# people connected to (needed) service*

Outcome Measure	**Definition (Numerator/Denominator)**
ED visits (cost, experience)	# ED visits by people served by liaison
Inpatient days	# hospital bed days by people served by liaison
Percent of people meeting goal (i.e., six months) for Permanent Supportive Housing (PSH) placement	# people placed in PSH this month that were referred to HRS less than 6 months ago/ # people placed in PSH this month
Housing retention	# people placed in PSH 7 months ago who retain PSH for at least 6 months/ # people placed in PSH 7 months ago
Equitable outcomes	For a given outcome measure, assess # people of a specific demographic achieving that outcome measure this month/ # people achieving that outcome measure this month *Then, compare to census: does the % match?*

Root Cause Assessment Tool

[Link to download tool]

Team Members:
Date:

Root Cause Assessment Tool

Using a standard process to understand your client and the issues they are facing can help to organize the care team, target where it is most important to focus and help drive the team to a successful action plan. The following framework has been helpful to teams addressing the needs of complex clients.

I. **4-quadrants of complexity (Root Cause Assessment)**

Client Initials:
Age:

Please fill in the boxes below based on any information you know about the individual you're working with:	
Medical Diagnoses	Behavioral Health and Substance Use Disorder
Social Issues impacting Care (ie transportation, lack of benefits)	Systems Barriers (i.e. inability to access services, lack of coordination amongst providers)

Sample Notes for Charting

Establishing a standard note can save you time and help your partners consistently see the value of the service you are providing.

Instructions:
Liaison Note
Pt followed by liaison for: Reason client was referred to service
Root Cause Assessment: Give a brief summary of the key medical, behavioral, social and system root causes affecting care.

Hx/Pattern of:

1. Important information that impacts care (i.e. has guardian, at risk of losing housing)
2. The obstacle that routinely causes the client to falter and return to the hospital (i.e. difficulty attending appointments d/t unreliable transportation)

Current Concerns/Considerations: List items in process such as applications, service referrals or messages out to others involved in care to verify client is active with their service.

Cross Continuum Team: Identify providers currently engaged with the client across the community and include their phone numbers. Indicate any information that will help the hospital or HRS team know who to link with to improve outcomes for the patient.

Case Conference: Identify date, attendees and shared plan of care from case conference

Closing Statement: Identify the contact information for liaison and the role the team will play.

Example:

Liaison Note

Pt followed by liaison for: frequent ED visits without access to primary care or pain management services

Root Cause Assessment: Patient is a 45 yr old male with COPD and chronic pain from a previous knee injury. He has a diagnosis of schizophrenia and can exhibit aggressive behavior when startled. He is chronically homeless and stays at xxxxx shelter. He has limited transportation and limited support system.

Hx/Pattern of:

1. Difficulty completing f/u appointments r/t inconsistent transportation
2. Hx of aggressive behavior when in unfamiliar environment

Current Concerns/Considerations:

1. Son is primary family contact but relationship is strained
2. Advancing clinical condition warrant need for additional treatment and support
3. Lack of housing exacerbates COPD, behavioral health and pain issues
4. In process: Referred to CES for accelerated access to housing. Application in process for Medicaid Waiver – filed by Melissa Tucker, DHS worker 616-867-5309 on 6/24/20. Connected to FQHC PCP xxxx with appointment scheduled for 7/5/20

Cross Continuum Team: Primary Care is Dr. Hicks PH:xxxxx, Case Manager is Debbie Antwoin PH:xxxxxx, HRS PH:xxxxx will be involved in the future.

Case Conference: Shared case conference held 9/20/20 with Medical unit CM, Psych/Med Unit CM, ED CM, HRS and PCP CM. Team will each address the need for DPOA and will follow up on Medicaid application and need for referral for additional services in the home.

Liaison will support discharge plan and facilitate cross continuum communication. Contact liaison at xxx for additional needs/ questions or concerns.

Workflow Tool

Link to download tool