THE HEALTH CARE AND HOMELESSNESS PILOT INITIATIVE

Exploring A Catalytic Role for Health Systems

A Two-Year Initiative Convened by Community Solutions and the Institute for Healthcare Improvement

PROSPECTUS: SEPTEMBER 2020

COMMUNITY SOLUTIONS

Why Now, Why You?

BE ON THE LEADING EDGE OF DEFINING AND PIONEERING THE ROLE OF HEALTH SYSTEMS IN ENDING CHRONIC HOMELESSNESS

It is well documented that social factors, such as racism, social isolation and inadequate housing, and diet have a 60 percent higher contribution to poor health outcomes and premature death than health care access alone. Given the impact of social determinants on health outcomes, leaders in both homelessness and healthcare have been working on fruitful ways to collaborate. An example of this is data matching across systems to help coordinate services outside clinical walls and experimenting with health system investments in housing subsidies, transportation, fresh food and other supports for individuals whose frequent use of health care services is influenced by the social conditions of their lives.

Despite these important efforts, no clear model yet exists to guide health systems in optimizing their resources to drive reductions in homelessness across a community. Health systems that recognize the need for a clearer role in the overall health of their communities have in places embraced an "anchor" mission. This concept, developed by The Democracy Collaborative[1], emphasizes the commitment to deploying long-term, place-based economic power, people-power, and other resources to better the long-term welfare of the community in which the institution is anchored. However, if we are going to improve population health and realize the positive impact of the social determinants in our communities, the anchor mission should not be only within the purview of innovative health systems. **Rather, we must develop new, scalable models that maximize the role that healthcare can have as a partner in solving communities' toughest cross-sector issues.**

1. *"Can Hospitals Heal America's Communities? - Democracy Collaborative - 20 Nov. 2015* https://democracycollaborative.org/sites/default/files/downloads/CanHospitalsHealAmericasCommunities.pdf

PILOTING A CATALYTIC ROLE FOR HEALTH SYSTEMS

What are the most meaningful, measurable, and transformative contributions healthcare can make toward ending chronic homelessness in a community?

Community Solutions and the Institute for Healthcare Improvement (IHI) are working together to design and implement a two-year pilot seeking to answer this question and lay the groundwork to spread and scale solutions nationally.

To do this successfully, we are actively seeking community pilot sites prepared to forge the path forward by bringing together the local health system(s) and the cross-sector stakeholders actively working to end chronic homelessness in that community. This initial stage of pilot testing will draw from communities currently involved in the **Built for Zero** initiative that have achieved quality, real-time, person-specific data on people experiencing chronic homelessness and are working to reduce chronic homelessness. As part of working together, the healthcare system(s) in each chosen Built for Zero community will focus on improving its role as an anchor institution to affect population-level outcomes for this target population (including reductions in homelessness, lower health care costs, and improved population health).

BUILDING A FOUNDATION FOR GOING FULL SCALE

In addition to the Pilot work in a selected community, Community Solutions and IHI will also support participating health systems in setting a foundation for going to full scale by establishing integrated, quality, real time data on homelessness across every market of the health systems participating in the Healthcare and Homelessness Pilot. This upfront work on establishing quality, real time data across all markets will allow leaders and implementers to:

- Target limited housing resources to the most vulnerable individuals and families
- Understand disproportionality across race for service delivery and outcomes to spotlight areas for targeted equity work
- Stretch resources further by connecting people to the most cost effective support to meet their needs
- Use aggregate data to see trends, flag bottlenecks, and identify improvement opportunities across the system
- Test new strategies and know quickly whether efforts are reducing homelessness
- Ground advocacy in concrete data
- Use monthly data trends to make stable projections and quantify projected resource gaps
- Partner and share data with upstream institutional players to reduce inflow and expedite housing placements

Community Solutions and IHI will be working participating health systems to co-design the details of this specific strategy and its implementation.

Overall Aim & Strategy

Our goal is that, by the end of this two-year pilot initiative, participating communities will have made measurable progress toward ending chronic homelessness, with a focus on building racially equitable systems. We believe that starting with chronic homelessness is just the first step and will intentionally hold space for conversations and co-design around the right population focus, especially since COVID-19 has brought forward the question of who is most vulnerable in both the homelessness and health care sectors. Additionally, health systems and their partner communities will have a clear understanding of what is (and is not) working to:

- Prevent, reduce and end chronic homelessness through collaboration with healthcare;
- Adopt shared accountability for racial inequities in both the local homelessness response systems and the upstream systems that plunge people into them;
- Identify interventions/ways of working that have the greatest impact;
- Make the business case for both the health system and the overall community;
- Understand the effects of housing for the health of the chronically homeless population and the impact on healthcare institutions operationally, including the morale of staff as a result of actively participating in problem solving; and
- Achieve cost reductions or greater value for funds spent.

LEARNING QUESTIONS

This work will also be guided by the following learning and evaluation questions to drive our ability to see improvement efforts around the social determinants of health. These questions are specific to health care's role in ending homelessness, and we may choose to add additional learning questions that come up as part of the pilot effort.

- What is the convening potential and influence that health care can have?
- What learnings are specific to ending chronic homelessness, and what can be applied to other populations experiencing homelessness?
- What learnings can be applied to any population health or equity goal across a community?
- What learnings can be applied to the homelessness system's work with other mainstream systems and sectors (e.g., education, business, etc.)?

FIVE COMPONENTS TO SUPPORT STRUCTURAL CHANGE AND ONGOING IMPROVEMENT

The work of the initiative will be guided by a Theory of Change (ToC) for health care's role in reducing and/or ending chronic homelessness in five "pillar" areas that together will lead to a comprehensive, meaningful role for a health system in their community. Each of these five Pillars in isolation is necessary but not sufficient in reducing or ending chronic homelessness in a community. While many of these approaches are relevant to other sectors, this ToC is focused on health care specifically.

Each of the five Pillar areas in the ToC contains a set of strategies for planning and executing the work with suggested specific actions and steps health systems can take, divided into work within the health system, and work done *together with* the community.

Each community pilot site will identify specific priorities and chart their path to transformation. There are many possible paths depending on your starting point and your health system and community priorities. Thus, the ToC is meant to be used as a toolbox - a menu of strategies and actions without a specific sequence. However, we know some health systems will want to prioritize or sequence work and we will offer a starting set of changes for the first six months, focusing on commitment, governance, data and equity.. Additionally, we believe the ToC can be used to facilitate a conversation within the health system and in the community.

The Details

Community Solutions and IHI will mobilize experts in the areas of improvement, homelessness, and health system change management to work in close partnership with participating sites. The Community Solutions and IHI team will provide strategic guidance, improvement coaching and support, capability building, and systematic tracking, documentation, and reflection on the teams' testing. Through both virtual and in-person learning activities, Community Solutions and IHI will:

- **Build a learning community** in which all participating sites are committed to actively testing changes, sharing what does and does not work, tracking their progress, adapting ideas, joining affinity groups to learn from each other on specific topics, and building relationships.
- **Bring leading subject matter experts in homelessness and health systems, as well as those who have tested and demonstrated promising results,** to discuss case-based ideas to apply systems improvement methods to chronic homelessness.
- **Bring leading subject matter experts in the area of health equity** to share strategies that create more equitable outcomes for people experiencing homelessness and coach teams to identify specific solutions within their community.
- **Provide each participating site with a multi-disciplinary coaching team,** including:
  - An improvement coach from the housing and homelessness sector to support ongoing application of state-of-the-art tools and methods for improvement;
  - Faculty with expertise supporting change management/population-focused transformation in health systems.
- **Engage in up to two site visits with each participating site** over the course of the pilot initiative for ongoing intensive coaching, collecting key learning, and providing tailored support.
- **Develop an information infrastructure to support data-driven testing and learning** from all participating sites.
- **Develop a communication system among participants** that supports rapid learning, connections, and relationship building with like-minded organizations and partners.
- **Design and implement a messaging and dissemination plan** to publicly highlight the learning and successes of the participating sites.
- **Use evaluation techniques** to continue to improve the delivery of Community Solutions and IHI's support to sites' work and advance the ToC and strategy.

SPECIFIC PROGRAMMATIC ACTIVITIES

The structure of the two-year, intensive pilot initiative is as follows:

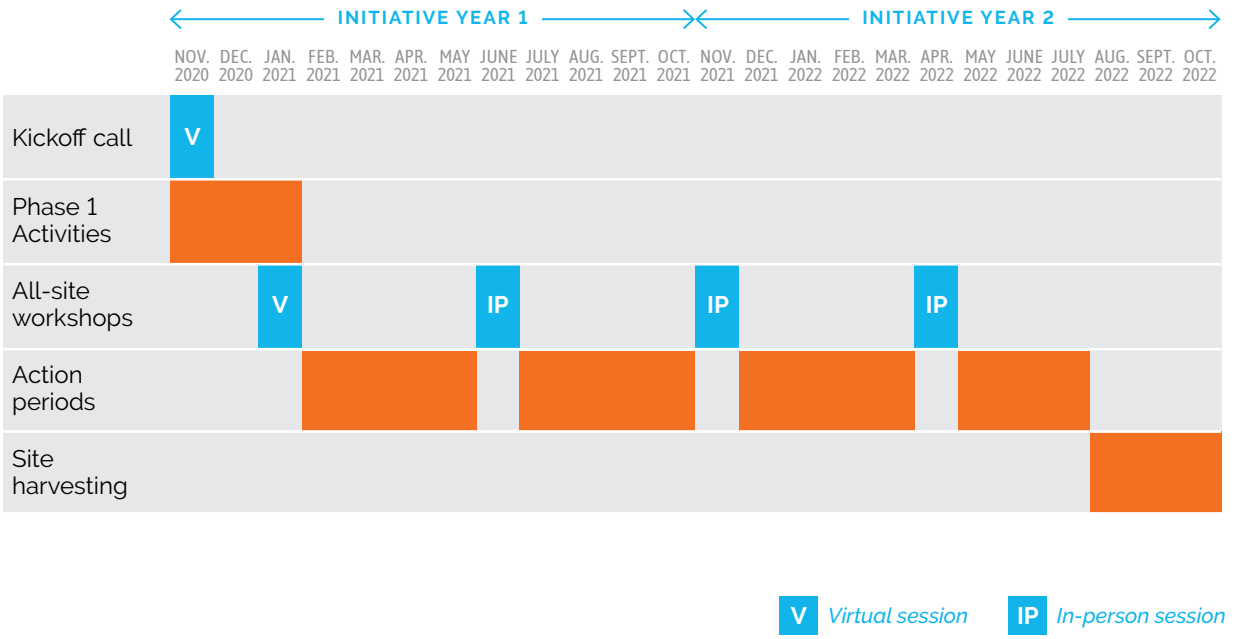
Phase 1 Activities: Participating sites will engage in a kickoff call and complete a series of activities that will orient participants to the overall Learning Community, faculty and staff, and communications methods. During this time, participants will organize their teams, gather data on the current state, map the Learning Community activities to strategic priorities and equity goals, identify partners and assets in their communities, and assess their teams' current capabilities in improvement methods and project management.

Four (4) Piloting Workshops over two years. Each Piloting Workshop will focus on building relationships across the learning network and advancing the learning and application of improvement methods for each community. The first workshop will be held virtually in 2021 with the goal of convening in person for the remaining workshops. (Note: Community Solutions and IHI will closely monitor and evaluate the state of the Covid 19 pandemic to determine the safety of meeting in person).

Intensive Action Periods. The months between Workshops are designed for intensive learning and action. Within each Action Period, participating sites will engage in:

- **Monthly All-Site Calls:** Community Solutions and IHI will host monthly calls to facilitate shared-learning across communities and learn from case studies and stories from the field.
- **90-Minutes of Private Coaching Per Month:** Each team will work with faculty and improvement coaches for individualized coaching up to 90 minutes a month to support: the learning needs and pacing of tests of change, reflection, and action; reviewing data collected; and addressing challenges and successes.
- **Ongoing Reporting of Data and Activity:** Ongoing reporting of progress and testing throughout the initiative to gather learning and see real-time data on results.
- **Site Visits to Participating Sites:** Visit participating sites up to once per year to provide deeper coaching and strategy support. This could include presence at coalition or C-Suite meetings, strategy sessions, deep measurement review, etc.
- **Emergent Activities as Needed:** Given that this is a pilot and that we will be iterating on our ToC, it is likely that this structure described above may be adapted. For example, in similar programs, we've found that there has been a desire to form affinity groups to support targeted learning in areas such a measurement, will-building, forming community partnerships, or program leadership.

PROGRAMMATIC ACTIVITY TIMELINE



V *Virtual session* IP *In-person session*

Partnering Sites: Time and Energy Commitment

EXPECTATIONS OF HEALTH SYSTEM PARTNERS INVOLVED IN A PARTICIPATING SITE

Health systems of any size may join this pilot initiative. Expectations for health systems interested in joining the pilot initiative follow:

- **Senior Leadership Support:** Because of the strategic and system-level focus of this work, participating health systems must have the explicit support of their senior leadership and these leaders must stay actively connected to their team's work. To maximize results, addressing the social determinants of health of both patients and the community should be a recognized priority supported by each organization's senior governing board, along with a commitment to addressing equity gaps in their pursuit of outcomes. The Community Solutions and IHI team will convene the senior leaders periodically through a series of calls and dedicated time during learning sessions to discuss leadership and governance. *To demonstrate this level of commitment, a letter of support from the CEO of the health system is required for participation.*
- **Dedicated Interdisciplinary Project Resources:** The senior leader should appoint a high-level project leader to orchestrate overall participation and to drive day-to-day progress on the site's portfolio of work within the health system and together with the community. Because of the challenges in securing population-level data, we also strongly recommend designating a data expert to the team. Additionally, we expect that the team will be a partnership between health system Community Benefit/Engagement efforts and clinical leaders. A strong link between the organizational strategy and this work should facilitate the fulfillment of these roles.
- **Improvement Skills and a Record of Successful Improvement:** Succeeding in this work requires strong quality improvement (QI) capabilities. Participating organizations will already have a high level of QI knowledge and capability as evidenced by measurable results from previous QI initiatives.
- **Commitment to Equity and Addressing Social Determinants of Health:** Health Systems participating in this initiative should have a documented commitment to address inequities within their system as well as *experience* addressing social determinants of health at both the strategic and operational levels.

- **Participation in All Pilot Initiative Activities:** This includes engaging in all meetings over a two-year period, including: one-on-one team coaching, monthly virtual all-site calls, in-person site visits, and four in-person Piloting Workshops each year with other participating sites. Additionally, the health system should be prepared to submit monthly reports on changes tested, process data, and outcome data (some of which will be reported in collaboration with community partners).
- **Willingness to Share Learning, Challenges, and Data Transparently and Publicly:** This includes knowledge sharing with fellow pilot sites, as well as in efforts to share stories of learning and progress (e.g. publications, speaking engagements, coaching teams in future phases of work).

EXPECTATIONS OF HOMELESS SYSTEM PARTNERS INVOLVED IN A PARTICIPATING SITE

Current Built for Zero communities of any size may join this pilot initiative. Participating Built for Zero teams must currently be working to end chronic homelessness and reporting monthly data from their quality by name list. Leadership must be willing and able to partner in earnest with one or more local healthcare organizations. Additionally, current Built for Zero communities must be willing and able to continue to receive regular improvement coaching from their Built for Zero Improvement Advisor. Coaching will focus solely on reducing chronic homelessness through partnership and collaboration with the aforementioned healthcare organization(s). Expectations for Built for Zero homelessness systems interested in joining the pilot initiative follow:

- **Senior Leadership Support:** Because of the strategic and system-level focus of this work, participating homelessness systems must have the explicit support of their Continuum of Care (COC) senior leadership and these leaders must stay actively connected to the team's work. *To demonstrate this level of commitment, a letter of support from the appropriate CoC leader(s) is required for participation.*
- **Dedicated Project Resources:** The CoC leader(s) should appoint a project leader to orchestrate overall participation and to drive progress in partnership with the health system. Because of the reliance of data across systems, we expect a skilled data expert will be part of the project team. Strategically, we expect a strong link in approach with the existing ToC for ending chronic homelessness across the community. Given this, the project lead will be responsible for bringing in appropriate team members from across multiple agencies as needed to drive reductions in chronic homelessness through a collaborative effort.

- **Participation in All Pilot Initiative Activities:** This includes engaging in all meetings over a two-year period, including: one-on-one team coaching, monthly virtual all site calls, in-person site visits, and four in-person Piloting Workshops each year with other participating sites. Additionally, Built for Zero teams should be prepared to submit data monthly on changes tested, process data, and outcome data (some of which will be reported in collaboration with health system partners).
- **Willingness to Share Learning, Challenges, and Data Transparently and Publicly:** This includes knowledge sharing with fellow pilot sites, as well as in efforts to share stories of learning and progress (e.g., such as publications, or speaking engagements, coaching teams in future phases of work).

Partnering Sites: Financial Commitment

Community Solutions and IHI recognize that resource availability varies across organizations dedicated to improving health and housing outcomes across our communities. Given the scope and ambition of this plan, we propose using a consortium approach to leverage available resources from a range of sources, including foundation funders as well as sponsorship from participating health systems.

PIONEER SPONSORSHIP FROM PARTICIPATING HEALTH SYSTEMS

The community pilot sites chosen to participate in the initiative will be those prepared to forge the path forward by bringing together the local health system(s) and the cross-sector stakeholders actively working to end chronic homelessness in that community.

The select group of participating health systems will also help set a direction for all US-based health systems and will be seen as Pioneers in developing new, scalable models that can maximize the role that healthcare can have as a partner in solving their communities' toughest cross-sector challenges. Pioneer Sponsors will commit to using their place-based economic power and other resources to measurably reduce chronic homelessness in their community, serving as national models for what is possible when it comes to eliminating chronic homelessness.

In addition to the time and energy commitment needed to drive this work, CS and IHI ask that each health system invest financially via a sponsorship commitment of $75,000 per year to participate in the initiative.

This financial investment will:

- **Demonstrate the strategic importance of the work within the health system** and to the community and build the conditions for sustainability after the conclusion of the two-year Pilot;
- **Provide partial funding to cover the cost** of supporting the programmatic activities and coaching provided through the Pilot;
- **Support the capability and capacity building of those leading work in the health system and in the community** to engage in quality improvement and transformation efforts; and
- **Cover travel and logistics costs for a small number of community stakeholders from the Pilot site to attend the face-to-face Piloting Workshops.** (The health system will be responsible for also covering the cost of their own travel and logistics separate from the $75,000/year fee).

Pioneer Sponsor health systems can consider mobilizing needed funding through locally-based philanthropic resources in their area and their own foundations, including, where applicable, community benefit dollars.

FOUNDATION SPONSORSHIP

Our hope and expectation is that one or more leading national foundations will provide an initial funding "stake" which will augment the direct sponsorship from participating health care systems. Financial support from regional and national philanthropic funders will be combined to support a Pilot that generates results for the participating sites and communities, and shapes the course of population level health and housing outcomes health and housing nationwide for people experiencing homelessness.

Conclusion & **Next Steps**

We are grateful for the work you are committed to doing to end chronic homelessness in your community and look forward to working with you to make this vital network a reality. If you have further questions or are interested in joining the pilot initiative, please contact Andi Broffman at Community Solutions at **abroffman@community.solutions.**

COMMUNITY SOLUTIONS works to create a lasting end to homelessness that leaves no one behind. Since 2010, our work has helped communities find homes for more than 200,000 homeless Americans and, in 14 instances, end homelessness outright for key populations. Our Built for Zero team has worked with a vanguard group of over 80 US communities to reach and sustain an end to veteran and chronic homelessness. We have now helped 73 of these communities achieve comprehensive, real-time, person-level data on homelessness. Eleven of these have used that data to drive a measurable end to veteran homelessness and three have done so for chronic homelessness.

IHI is a leading innovator in health and health care improvement worldwide. An independent not-for-profit organization, IHI partners with visionaries, leaders, and front-line practitioners around the globe to spark bold, inventive ways to improve the health of individuals and populations. Recognized as an innovator, convener, trustworthy partner, and driver of results, IHI is the first place to turn for expertise, help, and encouragement for anyone, anywhere who wants to change health and health care profoundly for the better. Based in Boston, MA with a staff of more than 200 people around the world, IHI mobilizes teams, organizations, and nations to envision and achieve a better health and health care future.