West Virginia

Housing-Healthcare Integration (H²)

Action Plan

This Action Framework emerged from the West Virginia Housing – Healthcare (H²) Action Planning Session held on August 12th and 13th, 2015 in Charleston. It represents a concise presentation of the recommended actions put forth by the session’s participants and reviewed and revised by West Virginia’s H² Leadership Team (page 14).
West Virginia H² Target Populations
1. People experiencing homelessness; and
2. Low-income people living with HIV/AIDS

This plan encompasses 4 primary objectives:
I. Collect, Organize, and Use Cross-System Data to Evaluate Need, Expand Awareness, and Demonstrate Cost Savings and Program Effectiveness to Improve Health Outcomes and Housing Stability.
II. Foster Ongoing Collaboration Between CoC Housing and Health Systems, Integrating Care to Improve Lives.
III. Transform Access and Delivery of Health Care and Housing as an Open System to Meet Client Needs, Conditions, and Abilities.
IV. Maximize Use of Medicaid and Other Existing Resources to Increase Access to Health Care and Other Services That Support Housing Stability.

Overarching Implementation Plan
• H² Leadership team will forge strong partnerships for H² Plan implementation, working with the Rural Health Association, Behavioral Health Association, Primary Care Association, Hospital Association, colleges and universities in the state, State Medicaid, State Behavioral Health and Hospital Facilities.
• H² Leadership team will report out to WV Interagency Council on Homelessness at their periodic meetings.
• H² Leadership team will provide input into statewide planning processes and other larger efforts, including those meeting health and housing needs of homeless population.
  o Bureau of Senior Services planning now underway
  o State Medicaid Office work on waivers
  o Substance abuse and behavioral health groups
  o Preparation of CMS rural housing toolkit (Evie Williams, HUD, will help identify a point of contact).
• Engage higher education institutions to assist with research tasks, including:
  o Review service delivery models for people experiencing homelessness and persons living with HIV/AIDS, including housing stability and crisis stabilization services.
  o Develop feasibility study for long term sustainability of health and housing providers.
  o Consider using Masters students, local housing association interns, etc. WVCEH is willing to task its MSW intern with specific projects.
  o Reach out to schools of social work at Marshall University, West Virginia State University, and University of Charleston.
  o Note: Interns/students would be good for projects that can be completed within a school year. Longer term research or trend analysis projects may be less well suited, at least for undergraduate interns.
I. Using Data Driven Decision-Making

Objective: Collect, Organize, and Use Cross-System Data to Evaluate Need, Expand Awareness, and Demonstrate Cost Savings and Program Effectiveness to Improve Health Outcomes and Housing Stability

Strategy I-1. Conduct a statewide service needs analysis.

Leadership Team Lead: Zach Brown
Timeline: Q4 2016 first 2 bullets; 2017 for the remainder

- Monitor and support ongoing data study by West Virginia University (WVU) and West Virginia Coalition to End Homelessness (WVCEH).
  - Current: Analysis of “static” data. Comparison of 3 years of statewide HMIS data with various other data systems (hospital data, veterans, Medicaid, etc.)
    - Phase 1: Develop baseline universe of services being provided and what it costs → i.e. What does homelessness currently cost the state?
    - Phase 2: Compare VI-SPDAT assessments with actual occurrences (i.e. compare self-reporting acuity with reality, as shown by data analysis). This will likely be done by county.
  - Upcoming: Examination of how to present and analyze real-time data to identify gaps in needed services.
- If not revealed by WVU/WVCEH study, compare Medicaid data against HMIS data to:
  - Identify who in HMIS is enrolled in Medicaid, their assigned Managed Care Organizations, and most recent housing/service provider.
  - Identify who in HMIS has applied for Medicaid and was denied, to determine whether enrollment assistance would result in approval.
- Following study, determine what other data, if any, is needed, and where improved coordination could reduce duplication of data collection and/or analysis.
  - For any CoC not already engaged in this, create a CoC subcommittee to handle this and data consolidation strategy. Each subcommittee will report to CoC.
  - Look into various existing regional divisions (e.g. Mental Health catchment areas; behavioral health councils, etc.) to see if they would make sense as geo divisions to create various Health-Housing coalitions.
  - Convene regular phone meetings of representatives from each CoC participating in this to share information/lessons learned/obstacles faced.
- Coordinate systems’ data collection and analysis going forward to ensure ongoing awareness of target populations’ needs, any service gaps, and performance.
  - Investigate coordination of Rural Health Association’s data collection and data portal with HMIS.
  - Talk to WV Primary Care Association, which may be creating a new data system to ensure housing data is part of it. [this could be new data warehouse]
  - Continue to broaden HMIS to include non-HEARTH Act-funded agencies (including health care providers (FQHCs, free clinics, etc.) Start with basic information, such as who treated the client, rather than requiring all HMIS fields. Involve HRSA and PCA to push participation by FQHCs if necessary. Northern Panhandle, Cabell/Huntington, and Balance of State CoCs HMIS systems include some such agencies already.
  - For VA providers, use new guidance which encourages (though does not mandate) each individual VAMC to participate in HMIS

January 14, 2016
Revisit possibility of using Skan Point Auxiliary (a Service Point module where each client is issued an HMIS card and scans the card at points of service) at future state HMIS committee meetings.

- Determine better way to get a comprehensive count of people experiencing homelessness, taking into account various definitions of “homelessness” and systems that have “counts.”
  - First step: Determine what we want to know; how we want to use the count information. Do we want to focus first on literally homeless, then chronically homeless, etc. and ultimately unstably housed so we can target resources to highest need populations first?
  - Partners/databases to consider in determining how to create a comprehensive count: Dept. of Education; Rural Health Clinics database; APS, CPS; DHHR; HMIS/PIT counts; hospitals (using ICD10 codes); Criminal Justice System; Non-CoC providers (e.g. faith-based organizations, food pantries).
  - Determine how to avoid duplication of counts (data warehouse, for example).

**Strategy I-2. Ensure housing stability of people presenting to health care providers repeatedly for the same health issue.**

*Leadership Team Lead: Zach Brown*

*Timeline: Q2 2016*

- Ongoing WVU/WVCEH data study includes sufficient information to produce a list of people.
- Conduct outreach to people on list to determine whether they need to be connected to homeless assistance services.

**Strategy I-3. Use data on cost savings to non-housing systems to get buy-in for coordination and ultimately data collection/sharing. Health care providers are currently hesitant.**

*Leadership Team Lead: Zach Brown*

*Timeline: 2016 (except as noted)*

- Monitor WVU/WVCEH Data Study that is currently underway. The final phase of data should show cost savings.
- Continue current communications with State Hospital Association and/or Health Authority (which licenses hospitals) to help encourage resistant hospitals.
- Ruby Memorial in Morgantown has conducted a cost study; use that to share with other hospitals. (See session materials for other cost studies.)
- After WVU/WVCEH study is completed, Leadership Team will review data/results and make a plan going forward. Discussion will include whether legislation would help. If so, create lobbying strategy. Consider lobbying legislators. **Timeline: 2017**
II. Integrating Housing, Health Care, and Other Services for Housing Retention and Ongoing Wellness

Objective: Foster Ongoing Collaboration Between CoC Housing and Health Systems, Integrating Care to Improve Lives

Strategy II-1. Improve discharge planning by strengthening cross-system linkages.

*Leadership Team Lead: Amanda Coleman*

*Timeline: 2016 (and ongoing)*

- Educate hospitals and other institutions on how proper discharge planning can lead to much lower readmissions/recidivism rate and how to properly discharge someone experiencing or at risk of homelessness. Need administrative buy-in at a few hospitals to incentivize discharge planning staff to begin planning at admission. WVU/WVCEH data study results will hopefully help to show cost-savings.
- Create discharge protocols that link clients at risk of homelessness to housing and appropriate treatment and services.
- Advocate for each hospital (or other institution) to have at least one discharge staff member trained to identify homeless or at-risk patients and how to properly link any such patients to housing system.
- Explore use of VI-SPDAT during discharge process, or other means by which to link clients to CoC Coordinated Entry Systems.
  - Research other states doing this already (e.g. Homeless Health Care Los Angeles (hhcla.org/hospital-discharge-planning) and various places in Canada).
  - Expand efforts to link health care providers to Coordinated Entry System.
  - Involve health care providers in local housing prioritization process so health care providers can learn what health needs are prevalent among people being prioritized for housing.
- Create recuperative care program if deemed necessary to assist discharge from hospitals for patients that no longer need hospitalization but are not stable or healed enough to be released into homelessness or unstable housing.

Strategy II-2. Create patient-centered medical homes linked to CoC agencies to promote and maintain overall wellness of people experiencing homelessness (including those recently housed).

*Leadership Team Leads: Zach Brown; Eric Pulice*

*Timeline: 2016*

- Support and monitor ongoing efforts by Balance of State CoC (WVCEH) and MVA.
  - Medical homes to include behavioral health treatment and primary care.
  - Consider working with MCOs to embed this activity.
- MVA and WVCEH to create performance metrics for housing, health, and other outcomes.
- When current WVCEH/MVA effort has progressed sufficiently to extract “lessons learned,” evaluate model for potential replication in key homeless population centers throughout state.
- Create program(s) specifically intended to serve the homeless, including those recently re-housed by the homeless assistance system.
  - Link to behavioral health treatment and primary care programs.
  - Work with MCOs to embed this activity.
III. Improving Enrollment, Engagement, and Access

Objective: Transform access and delivery of health care and housing as an open system to meet client needs, conditions, and abilities

Strategy III-1. Identify and address issues and obstacles in the provision of care to people experiencing homelessness.

*Leadership Team Lead: Eric Pulice*

*Timeline: 2016*

- **H² Leadership team to meet with health care associations (e.g., Primary Care Association, West Virginia Hospital Association) to discuss. Meet separately with various associations. MVA’s Executive Director will present H² at PCA Board of Directors Q1 2016 meeting. The Board is made up of the majority of FQHC CEOs.**
- **Educate/train health care providers on working with homeless populations.**
- **Engage state regulators/funders/licensing agencies.**
- **Examine the Community Health Needs Assessments conducted by public hospitals (as required by the Affordable Care Act) for issues and/or findings relating to homelessness or unstable housing. Review existing Community Health Needs Assessments and engage with public hospitals in advance of next round.**
- **Consider out-stationing medical staff at homeless housing programs (which would likely result in cost-savings to hospitals and other health care providers) and/or housing-focused medical outreach teams.**

Strategy III-2. Increase behavioral health services capacity and improve delivery of behavioral health services, specifically focusing on improving crisis response system.

*Leadership Team Lead:*

*Timeline: Q1 2016 for first two bullets*

- **Determine appropriate people to involve in this discussion (e.g. Steve Canterbury at State Supreme Court; Linda Artemis).**
- **Approach on county-by-county basis. Because problems exist throughout the state, it sometimes appears to be a system issue. But issues and severity of problems vary from county to county.**
  - Start in Kanawha County. Examine what works well about the system and why. What is the structure that allows it to work well relative to other counties?
  - After Kanawha County analysis is complete, work on applying similar structure to counties where system does not work as well (e.g. Cabell County).
- **Work with behavioral health centers to improve crisis response system.**
  - Mental health commissioner process needs to be instantaneously responsive to CoC calls for care.
- **CoCs to partner with existing mental health and crisis intervention teams to divert clients from needing mental health hygiene process. The teams should be integral to mainstream agencies, such as law enforcement and behavioral health.**
- **H² Leadership Team will work with Beacon to determine feasibility of replicating Massachusetts Behavioral Health partnership. [See H² worksheet 4-A, pg.7.]**
Strategy III-3. Incorporate comprehensive health exams and behavioral health assessments into CoC Coordinated Entry System.

Leadership Team Lead: $H^2$ Leadership Team

Timeline: 2016

- Start with Balance of State in limited capacity. Remaining CoCs to monitor the progress and evaluate.
- Examine where in the Coordinated Entry process is the most appropriate point at which to conduct any such exams or assessments (i.e. not necessarily at intake point; perhaps after client is housed).
- Explore whether information from the VI-SPDAT, which is currently used for coordinated entry in 3 of West Virginia’s 4 CoCs, could be used to recommend health/mental health interventions at the outset.
- Consider including primary/behavioral health providers in CoC prioritization process and/or incorporating health care providers into HMIS.
- Provide client supports (e.g. case management, transportation, immediate appointments) as needed.
- As barriers are identified to accomplishing this, review potential solutions with $H^2$ Leadership Team.
- Involve state and federal partners at regional level in sorting out pathways to solutions and colleges and universities for research and analysis.
IV. Maximizing Resources

Objective: Maximize Use of Medicaid and Other Existing Resources to Increase Access to Health Care and Other Services That Support Housing Stability

**Strategy IV-1. Increase capacity to bill Medicaid for services that support housing stability.**
*Leadership Team Lead: Esther Hupp*
*Timeline: Ongoing (2016)*
- Research process/feasibility of housing agencies becoming Medicaid providers.
  - Monitor technical assistance opportunities (e.g. by HUD/CMS) and relevant toolkits.
  - Learn from ongoing efforts in the state. For example, Huntington has started meeting with DHHR regarding this.
- Once requirements are understood, determine which, if any, agencies should pursue the option.
- In the meantime (and as an alternative), consider partnerships (formal or informal) between housing agencies and health care and service providers that are already Medicaid providers (e.g. FQHCs).
  - For example, a housing provider may provide an administrative fee to FQHC in exchange for a portion of reimbursement. MVA would be amenable to these types of partnerships.

**Strategy IV-2. Explore additional funding sources for health care and supportive services.**
*Leadership Team Lead: Zach Brown*
*Timeline: Q2 2016*
- Explore using TANF for housing, and any opportunities to provide additional tenant-based rental assistance (TBRA). Look to other states for models.
- Analyze SAMHSA and HRSA funding opportunities.
  - Develop program pipeline aimed at funding targets.
  - Examine the use of block grants and seek discretionary awards.
- Explore possibility of recouping state grant funds that have been cut from free medical clinics.
- Expand CoC funding base to include non-HUD funds.
- Explore possibility of shifting focus of West Virginia’s HOME funds to tenant-based rental assistance (TBRA)

**Strategy IV-3. Build capacity in clinic system (including free clinics, FQHCs, rural health clinics, indigent care clinics) as patient centered medical homes (PCMH) within federal reimbursement system.**
*Leadership Team Lead: Eric Pulice*
*Timeline: Q2 2016*
- Research existing PCMHs in West Virginia to determine locations throughout the state and identify where additional ones are most needed.
- H² Leadership team to meet with WV Association of Free clinics and primary care association to expand capacity within all clinics of patient centered medical homes.
• Seek designated funding source to pay for practice transformation of clinics and expedite approval process.
• All CoCs participate in forging pathways for clients to less expensive but more comprehensive medical care.
• All CoCs need to document housing services that provide cost savings to health care system. Ideally, need information from health care providers on the cost of medical care provided to homeless patients. [linked to data strategies]
• All CoCs should strengthen capacity of homeless service providers to retain connection to clients as means of providing continuity of care.
• All CoCs should strengthen housing stability services on community wide basis to support housing retention over period of years.
  o Connect with State Take Me Home money follows the person program as they develop transition and post-placement models.

H² Federal Partners will work to support and inform the state effort. The H² TA Team will provide support and function as liaison for a minimum of 90 days post action-planning session. TA Team Point of Contact: Gillian Morshedi, HomeBase, 415-788-7961 x301, gillian@homebaseccc.org.
Appendix

The following ideas were discussed at the planning session, considered by the Leadership Team, and validated as useful and necessary, but are not being prioritized for action under West Virginia’s H² initiative at this time. The Leadership Team hopes these ideas will find traction in other planning and program development arenas, while H² attention focuses the key strategies enumerated above.

Data

Strategy A-1. Determine what else needs to be asked, or what needs to be asked differently, by health care entities to collect information needed to know whether someone is “homeless” for any given program (e.g. “Where did you sleep last night” rather than “Are you homeless?”

- Educate front-line staff and outreach workers regarding what questions should be asked.
- Ensure hospitals are using existing housing-related ICD10 codes for any patient identified as homeless or unstably housed.
- Explore having hospitals and clinics administered VI-SPDAT during discharge process; and then linking appropriate people/VI-SPDAT score to homeless assistance system.

Strategy A-2. Collect data to evaluate effectiveness (including improved health outcomes, housing stability, utilization of crisis services, cost-savings) of various programs and interventions.

- Programs to evaluate:
  - Housing First and Permanent Supportive Housing programs
    - Identify current Housing First and PSH programs in West Virginia.
    - Create relationships with hospital and criminal justice systems within geographic areas (start with visits back and forth).
    - Collect information on hospital and criminal justice visits before and after Housing First.
    - Reach out to Helping Heroes, which has good relationships with all the jails in the area.
    - Each out to “Health Statistics” Department at DHHR, which has many kinds of data.
  - Examine data to determine whether any positive outcomes would have potential for replicating models in homeless community.
  - Create a frequent user pilot program
    - Within each CoC, identify CoC/hospital or hospital system to start with
      - WVU or other university (David Parker) could be a host for program
      - Marshall (which has an informatics program)
    - In North Central part of the state, could do this directly with MVA and the HCH program they are now receiving.
  - Determine what larger effects helping one problem (lack of housing) has on other outcomes/systems. Show cost savings and other positive outcomes in health care, EMS, criminal justice systems resulting from stable housing.

Strategy A-3. Create a data warehouse (or expand upon an appropriate existing one).

Strategy A-4. Address privacy concerns (HIPAA, etc.) regarding data sharing.

- Create release forms with new language about sharing certain types of data for the purposes of linking/coordinating care and services (this would be particularly useful for providing names of homeless system clients to hospitals to do a data match). WVCEH can provide examples; has done this for research study with WVU and is working on it for HMIS.
- Use aggregate data where possible (for cost studies; needs assessment; identifying successful or unsuccessful interventions).

Strategy A-5. Monitor HHS for release of Community Interoperability and Health Formation Exchange Cooperative Agreement Program funding opportunity. (Previous application deadline was June 15, 2015.) Stated goal of program is to “move the nation toward a more standardized, interoperable health IT infrastructure.”
Service System Integration

Strategy A-6. Develop a seamless system of care between health care and housing systems to adopt common goals for serving the target populations, and to monitor outcomes in each system.
- In each community, hold joint meetings and focused health summits among providers from both systems to understand client pathways and improve service delivery. Each CoC to identify all providers that need to be brought to the table to discuss these issues/do this work (e.g. Criminal justice, health care, housing, etc.)
- Educate across systems on various definitions of homelessness.
- Collect ongoing information on costs outcomes to document savings and better delivery. [linked to Data Section]
  - Standardization in data collection (such as HMIS) would solve linkage issues while simultaneously collecting data on outcomes.

Strategy A-7. Consider adding indicators in Medicaid contract that Behavioral Health and Primary Care MCOs should meet. For example: Include health indicators that are prevalent for people experiencing chronic homelessness and housing stability indicators similar to CoC performance measures.

Strategy A-8. Expand health care coverage and treatment opportunities by exploring and engaging with Accountable Care Organizations in West Virginia and service delivery to Medicaid population to determine inclusion of homeless people. [See Worksheet 4-B.]

- Convene meetings with State HMIS, CoCs, and MCOs (statewide or by geographic area).
  - Focus on how homeless population is identified for connection to care and how case management is reimbursed to housing providers.
  - Consider written agreement to connect people to health care at point of CoC intake/assessment.
  - Consider Behavioral Health MCOs committing assessment slots for persons referred from CoC intake/assessment.
  - Seek out “nuts and bolts” training on how precisely to bill Medicaid for supportive services and/or case management.

Enrollment and Access

Strategy A-10. Increase capacity of behavioral health services.
- Build a full continuum of housing and behavioral health care that is seamless and responsive on demand to client needs.
  - H² Leadership team will meet with Behavioral Health Association, State Behavioral Health and Health Facilities, and First Choice Health Systems.
  - Present profiles of homeless population with substance abuse and mental health needs, supported by data.
  - Identify detox and treatment recovery beds available for homeless and persons living with HIV/AIDS population, including those with serious medical issues.
  - Identify partners for federal grants applications (e.g. SAMHSA).
  - Identify state resources to fund needed opportunities for care.
- Propose to Federal Partners, including SAMHSA, a rural community behavioral health pilot project in West Virginia, with Planning Grant as Phase I and Implementation Grant as Phase II, to demonstrate how to redesign existing state behavioral health, health and housing resources into a fully new system for homeless and HIV populations.

Strategy A-11. Transform health care entry portals to meet client perceptions, needs and abilities.
- Add mobile outreach, “in community”, and “on street” participation by medical team.
- Design interventions and treatment to be delivered “in crisis mode” for population living in crisis. (e.g. a WVCEH staff person is a Mental Health First Aid trainer)
- Have emergency room triage capacity to provide basic care on parallel route. (i.e. ER diversion)
- Increase access and use of health care by developing comprehensive case staffing and community engagement specialists to connect clients to actual care and treatment, including transportation support.
**Strategy A-12.** H² Leadership Team will meet with Ryan White Program and review system of care and program design elements.

- Consider replicating model for homeless population without HIV, i.e. explore possibility of creating a Ryan White-style program targeted to people experiencing homelessness (regardless of HIV status). Ryan White Program includes: co-pays required, funds for prescriptions, insurance premium, housing supports, preventative care and wellness checks.
- Meet with Public Health Departments and Schools of Public Health at West Virginia University and Marshall University to conduct analysis. (Note: WVU School of Public Health was recently announced as a new recipient of HOPWA funds in West Virginia.)
- Examine Medicaid and other funding sources.

**Strategy A-13.** Increase number of people reaching out to jails to do Medicaid enrollment. Currently, there is only one responsible for this in the state.

**Strategy A-14.** Increase capacity to provide ancillary programs (e.g. smoking cessation, diabetes screening/prevention, recovery programs for substance abuse, gambling addiction) for target populations.

- Determine data sources (starting with what can be accessed through HMIS).
- DHHR has tobacco cessation program in public health; they have lots of data. It would include heart disease, diabetes, and other health risks associated with smoking.
- Pre-diabetes program conducted a few years ago (it was a Master’s Degree program), established some diabetes workshops. Look into those.
- Each County Health Department should have these types of programs.
- Each free clinic should have programs (e.g. Health Right has one).

**Strategy A-15.** Create case and treatment plans, using motivational techniques, providing wellness checks, nutritional education and prevention, smoking cessation, exercise, healthy lifestyle behaviors, etc.

**Strategy A-16.** Focus on increasing/improving housing access and retention for people experiencing homelessness who have substance use disorders.

- Create protocols for intervening with landlords to prevent loss of tenancy.
- Work with PHAs to encourage vendor payment of utility subsidy.

**Resource Maximization**

**Strategy A-17.** Ensure all Medicaid-eligible individuals/families experiencing homelessness are enrolled and stay enrolled.

- Educate population about Medicaid eligibility and resources available to assist with enrollment/recertification (Get list of enrollment assisters from HRSA.)
- Address various reasons for gaps in rural vs. urban areas
  - Lack of education/awareness.
  - Lack of transportation to get to Medicaid office to enroll. Facilitate use of telephone meeting option for Medicaid agency meetings for people who don’t have access to phones, perhaps by designating a phone at an agency to be used for this purpose certain times/days.
- Increase number and geographic diversity of in-person assisters – Identify programs/locations/areas that have greatest need for in-person assisters/would benefit the most number of eligible non-enrolled people.
  - DHHR currently sends people to hospitals. Expand that program.
- Maximize use of enrollment specialists:
  - Increase awareness and use of SOAR program, including opportunities to get trained as SOAR case manager.
  - Use Aging and Disability Resource Center counselors at 866-987-2372.
  - Identify ADRC local office for each CoC and each CoC develops MOU to maximize use of counselors.
  - Each CoC will engage FQHC to identify outreach and enrollment staff, especially who can travel outside region, and develop operating agreement.
Each CoC should convene street outreach workers and identify annual pathway to enrollment, not dependent on appointment slots.

- Address needs of sub-populations that require additional help (e.g. people who aren’t able to read; non-English speakers; deaf/blind).
- Flag client files with dates on which additional enrollment or re-enrollment steps must be taken. Engage in outreach at appropriate times to make sure those steps are being taken.

**Strategy A-18.** Educate community and providers in housing and health care systems on existing resources to assist clients. Create resource directory (expanding on 211 and/or ResourcePoint) that includes various programs offered throughout community and expand awareness of 211.

**Strategy A-19.** Explore additional funding sources to increase housing resources

- Launch H² grants work group to oversee this and next strategy.
- Explore funding to expand permanent supportive housing stock in state.
  - Form a flexible subsidy pool that supports rent, rehabilitation, new construction, and operating costs for PSH.
  - Review WV Housing Development Fund and statewide housing needs assessment underway.
  - Lobby for tenant-based rental assistance (TBRA) utilizing HOME funds.
- Change priorities of CDBG funds to focus on homeless services.
  - See Louisiana example in Worksheet 4B.
  - Identify projects that could use the funds quickly (since CDBG funds are meant to be used on quick turnaround projects).
  - Lobby representatives regarding need for reprioritization.
  - See “recruitable communities project” that operates out of Division of Rural Health and Recruitment. They evaluate community and make recommendations for improvements to community to incentivize doctors to come.
  - Explore recently passed Land Bank legislation for rehabbing old buildings.
  - Explore conversion of old school buildings or other empty buildings.
  - Review re-starting the SHAPE program model for replication. H² Leadership Team should lead an all-CoC conversation to review.

**Strategy A-20.** Expand use of health homes to every CoC [See Worksheet 4-B].

- Examine WV Health Right’s program as model to expand/replicate.

**Strategy A-21.** Increase capacity to bill Medicaid for services that support housing stability.

- Develop an 18-month program to clearly identify and implement a program within each CoC for PSH providers to focus on delivering Medicaid eligible health care and other services to target Medicaid eligible people experiencing homelessness and PLWHA.
  - Review partnering with health clinics.
  - Look at capacity to become Medicaid billers.
  - Identify current housing stability services and health care supports that could be billed to Medicaid.
  - Include targeted case management (which can be billed to Medicaid).
  - Develop systematic training program, protocols, quality assurance review and other infrastructure to sustain more formal practice.
  - Match activities to Medicaid billing code and language.
  - Note: WVCEH will be working with MVA to also do this with RRH.
- Review existing Medicaid waivers to expand use for homeless population [Note: the age and disabled waiver is so clustered already (waitlists are very long) that this might not be very feasible.] [WV Advocates is constantly involved in looking at the IID waiver; they could be involved in this. Also involve Medicaid Review Team.]
- Work with WV Medicaid office to implement CMS Bulletin on using Medicaid funds for housing supports (work with Esther Hupp at Medicaid. Currently have housing program.)
  - Identify sustainable funding mechanism for a statewide housing navigator program.
    - Key role of navigators is to identify housing and support housing stability and prevent recycling into crisis response system.
- Could be in conjunction with Take Me Home program.
- Consider linkage of housing navigators to access resources from Affordable Housing Trust Fund and Housing Development Fund. [See worksheet 3-A.]

- Maximize use of Medicaid presumptive eligibility for homeless population. (H^2 leadership team should lead H^2 stakeholders.)
  - Determine what hospitals, if any, are utilizing PE and for whom.
  - Create connections with housing providers (including shelters).
  - Ensure follow up to ensure full applications then are processed.

**Strategy A-22.** Research alternative methods of reimbursement of paramedics serving people experiencing homelessness and PLWHA at non-ER locations.
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