
# Year One

# A Look Back at 2018

## Strategic Initiatives

HEALTH CARE for the HOMELESS

# 2018-2021 Strategic Goals

Homelessness is unacceptable—and health care and housing remain out of reach for far too many people. In 2018, we set out on an ambitious path to end homelessness guided by these three goals:

## Goal 1

100% of the people we serve will have timely access to quality, whole-person health care and affordable housing.

## Goal 2

We will design and implement sustainable business models for affordable housing development and supportive housing.

## Goal 3

As a result of our care, the health outcomes of our clients will rival the health outcomes of a stable population.

# 2018 Strategic Initiatives Scorecard

At the beginning of the year, we set annual initiatives to help us reach our strategic goals come 2021. The score card below shows how we've done, based on projected progress by December 2018. Initiatives fall into three categories: complete (**green**), in the works (**yellow**) and moved to 2019 (**red**). After Year One, we are more committed than ever to achieving health and housing for all.

## Goal 1

| | |
|---|---|
| **1.1 Clearly define Goal 1 to create measurable multi-year outcomes** | |
| ✓ | Convene a staff taskforce to create clarity around “the people we serve” |
| ✓ | Develop definition for what “quality” looks like for the agency |
| | Convene a staff and client taskforce to define what “access” looks like for the agency |
| **1.2 Increase the quality of care for our clients** | |
| ✓ | Redesign behavioral health service delivery |
| | Begin to transform 421 Fallsway layout to support a person-centered, team-based care model |
| **1.3 Expand clinical services and access for clients to our services** | |
| ✓ | Address communications needs of clients |
| | Expand operations at our Baltimore County clinic |
| | Improve access to convalescent care |
| | Create new partnerships for obstetrical care |
| | Increase number of available appointments |
| | Improve access to dental care |
| **1.4 Prepare and support staff to provide excellent care and service, as well as to advance their careers** | |
| ✓ | Build a culture of learning, providing tools, training and resources to staff |
| ✓ | Strengthen culture of communications across agency |
| | Embed competencies into agency practice and tools |
| | Launch a new Performance Management System |
| **1.5 Grow community support & engagement** | |
| | Strengthen our engagement and advocacy in communities where we are located |
| | Increase community participation in our work |
| | Increase client participation and leadership in our work |

## Goal 2

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| **2.1 Expand housing in the Greater Baltimore region** | |
| ✓ | Maximize Medicaid waiver |
| ✓ | Pursue public and private partnerships |
| ✓ | Prepare for capital campaign |
| | Develop a role in housing advocacy |
| X | Research financial models |
| **2.2 Build agency leadership expertise and capacity in housing** | |
| ✓ | Build Board of Directors' expertise in housing |
| | Build staff capacity in housing |
| X | Begin to create a multi-year plan for integrating housing and health care in Baltimore City |

## Goal 3

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| **3.1 Utilize identified national data sets to drive improvements in client health outcomes** | |
| ✓ | Introduce, incorporate and create visibility into 13 new health outcomes measures |
| ✓ | Improve screening, tracking and treatment of clients through performance improvement process |
| | Identify and prioritize treatment for clients with high acuity conditions |
| **3.2 Collect and utilize clients' social determinants of health to improve care and outcomes** | |
| ✓ | Collect structured data for social determinants of health |
| **3.3 Begin to establish and identify clients' risk levels to help prioritize and provide appropriate care** | |
| | Introduce providers to the concept and practice of risk stratification |

# Goal 1

### Convene a staff taskforce to create clarity around "the people we serve" | COMPLETE

During our strategic planning process, staff said they needed guidance about who is eligible for our care. Seven staff members, three clients and one Board member developed guidelines for eligibility. The workgroup shared those guidelines with staff, and we have incorporated them into orientation for new staff.

*For staff: www.hchmd.org/people-we-serve-guidelines*

### Develop definition for what "quality" looks like for the agency| COMPLETE

We matched our definition of quality with the six categories used by the Institute of Medicine: safety, effectiveness, efficiency, timeliness, client centeredness and equity. In 2019, we'll drill down into the standards for each category and create a roadmap to ensure 100% of our clients receive quality care.

### Redesign behavioral health service delivery | COMPLETE

We simplified the way clients access behavioral health treatment, including substance use disorder (SUD) treatment, at our largest site. We redesigned our SUD treatment curriculum and streamlined our process for medication-assisted treatment. We expanded our use of the industry standard PHQ-9 tool to not only screen for depression, but also to measure depression remission over time. In 2019, we'll compare our clients' rates of progress to state and national standards.

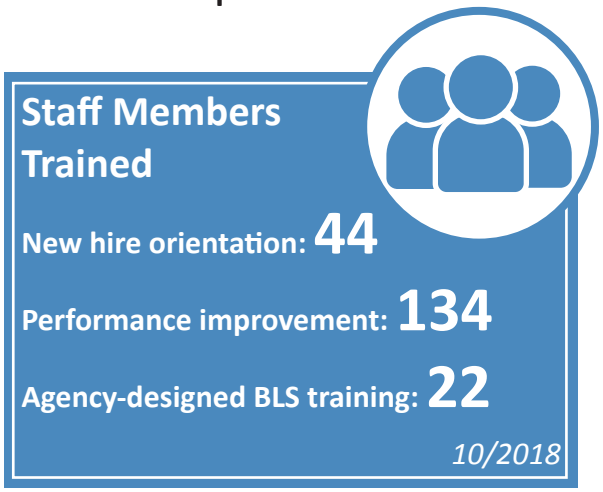
### Address communications needs of clients | COMPLETE

A staff workgroup developed priorities around the needs of clients who experience language barriers and require special accommodations. We conducted a survey of Spanish-speaking clients, which will inform improvements to systems and tools in 2019. In partnership with Lutheran Volunteer Corps, we brought on a full-time Spanish-speaking volunteer to help clients navigate our largest site. We launched a new health education resource section on our staff portal to give providers easy access to client materials. Our client experience survey was benchmarked nationally and will drive our client experience performance improvement goal in 2019. We also expanded use of automated text messages to let clients know when they miss appointments, encourage them to reschedule, and raise awareness about our after-hours phone line.

*For staff: www.hchmd.org/clinical-resources*

### Build a culture of learning, providing tools, training and resources to staff | COMPLETE

In April, we introduced a five-day new hire orientation that runs every four weeks. All new staff members visit our clinics, learn about our programs and budget, share lunch with clients, and immerse themselves in our mission and core values. We also completed a full year of monthly supervisory trainings to support agency leaders. We moved basic life support (BLS) training in-house, and by year's end we will launch online annual compliance testing and begin building our own clinical competency training program. We have strengthened our population health program and our agency-wide culture of performance improvement—both keep us focused on how to continuously improve client care.



## Strengthen culture of communications across agency | COMPLETE

During our strategic planning process, staff identified improving communications as a priority. Since then, we've launched monthly brown bag discussions with the executive team across all sites, introduced regular break-out groups at monthly all-staff meetings to ensure staff know about agency-wide changes to our practices, and created a host of new, easy-to-use communications tools on the staff portal. We also now share meeting minutes on our staff portal. Staff health benefit registration went paperless this year, as did all mandatory new hire paperwork. Thanks to a combination of talented data analysts and new software, we began sharing important clinical data through easy-to-read graphs and charts at clinical, management and staff meetings. 2018 also marked one full year of a new community-wide quarterly newsletter.

*For staff: www.hchmd.org/communications-resources*

## Convene a staff and client taskforce to define what "access" looks like for the agency | IN PROCESS

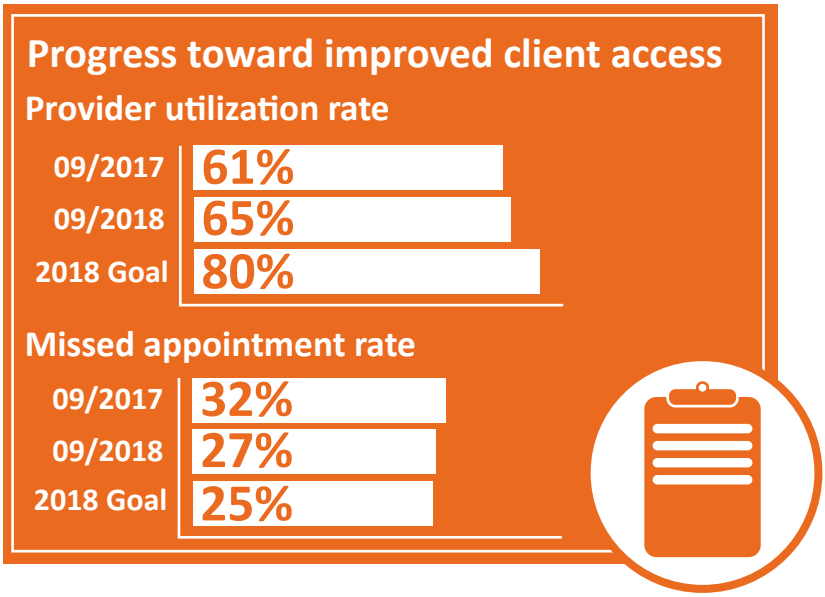
Defining access begins with our clients. In the last quarter of 2018, we are working with the Board Consumer Relations Committee and other clients to assess how they interpret access to care—what it means and what it looks like to them. That insight will be used as a jumping off point for a 2019 taskforce.

## Begin to transform 421 Fallsway layout to support a person-centered, team-based care model | IN PROCESS

Care teams are the most critical component for creating a true health home. This year, we researched best practices in care team communication and looked at models of shared space, a key component in high-functioning teams. We visited care teams at the Colorado Coalition for the Homeless, Johns Hopkins, Mercy Health System and Greater Baltimore Medical Center. In 2019, we will use that knowledge to improve our physical space, clinical workflows and communication, particularly at 421 Fallsway.

## Increase number of available appointments | IN PROCESS

Clinical and administrative teamwork resulted in good progress toward this initiative. Staff underwent training, experimented with new schedules and tested a variety of appointment reminders. We also began to work with medical outreach sites to increase the number of clients we serve during our site visits. While we have not yet hit all of our goals, trends are moving in the right direction.



# Goal 1

### Create new partnerships for obstetrical care | IN PROCESS

We have a willing hospital partner, but the timing of this project is highly dependent on physician availability. We are working toward having a partnership in place by Q2 2019.

### Improve access to dental care| IN PROCESS

As of May 2018, we were fully staffed at all three of our dental clinics. We also secured a $50,000 governmental grant to cover dental specialty services by referral to community providers. In 2019, we'll develop a plan to increase our in-house capacity to care for clients with dental needs.

### Embed competencies into agency practice and tools| IN PROCESS

Through a series of discussions and activities this year, we identified core, functional and leadership competencies to support professional growth among all staff. In the coming months, we will align our job descriptions with our competencies and launch trainings in HealthCareSource, our new performance and learning management system.

*For staff: www.hchmd.org/competencies*

### Expand operations at our Baltimore County clinic | IN PROCESS

We fully staffed our Baltimore County clinic and set ambitious goals for the number of clients we wanted to serve at our new location. Our goal was to increase visits per session by 35%, and we hit 11%. We are focused on decreasing the missed appointment rate with guidance from clients. To this end, we are strengthening our relationship with the co-located Baltimore County shelter, expanding our referral network and targeting reminder calls to clients who tend to miss appointments.

### Launch a new Performance Management System| IN PROCESS

We trained staff and supervisors in performance evaluation, synchronized the performance evaluation process and introduced merit-based pay increases. In 2019, staff members and their supervisors will set specific, measurable goals to align with their job descriptions and new success profiles. And HealthCareSource, our performance and learning management system, will enable us to go digital with the process.

**100%**
**of staff have completed annual performance evaluations**

### Improve access to convalescent care | IN PROCESS

In 2018, we focused on speeding up the intake process when partner hospitals refer clients to our 25-bed program. We hired a Client Access Associate to manage referrals and collect baseline data to track and improve referral response time. In 2019, we will implement an online referral database and set goals for improvement. We are also hiring a new Medical Director to oversee the North Fallsway clinical site, including convalescent care.

## Strengthen our engagement and advocacy in communities where we are located| IN PROCESS

In the second half of the year, we hired a Director of Engagement and reorganized community, client and volunteer relations onto one functional team. Additionally, we welcomed a new Director of Advocacy in October. We have created a plan for developing key relationships in West Baltimore to improve client access, referral networks and advocacy efforts.

## Increase community participation in our work| IN PROCESS

We recruited talented community members to serve on our newly-formed Housing and Compliance and Risk Management Board committees, as well as the Public Policy Committee. We doubled the number of Days of Service, conducted dozens of clinics tours, and participated in almost two dozen community events and presentations. We also hosted a Housing and Leadership Educational Series with senior staff, the Board of Directors, and community partners to learn about affordable housing and the current housing landscape. We introduced new internships in communications, performance improvement, compliance and information technology. We started a child life research project with students from Johns Hopkins. We also began to streamline our process for accepting clinical learners from area schools of medicine, nursing, occupational therapy and social work.

### Community Participation

**17** new Board committee members

**38** clinic tours

**21** community events and presentations

**4** Days of Service

*10/2018*

## Increase client participation and leadership in our work | IN PROCESS

We hit a record high for client representation on our Board of Directors, with five clients serving as Board members, including our first-ever Baltimore County client Board member. Clients are also serving on our colorectal cancer, cervical cancer, client experience and diabetes performance improvement subcommittees. Every new hire orientation includes lunch and discussion with members of our Board Consumer Relations Committee. Our clients have also taken on leadership roles with the National Health Care for the Homeless Council by joining the Respite Care Providers' Network, attending the annual conference and joining national lobby days in Washington, D.C. Clients have also given written and oral testimony and attended rallies in support of our legislative priorities in Annapolis and Baltimore County. More clients participated in our Client Art Show, 5K and Chocolate Affair than in 2017. Lastly, around 15 clients gave feedback during a Consumer Relations Committee meeting to inform our "people we serve" guidelines and three clients joined the "people we serve" workgroup.

# Goal 2

## Maximize Medicaid waiver | COMPLETE

A new Medicaid pilot provides our best opportunity yet to secure sustainable funding for the "supportive" side of permanent supportive housing. In partnership with Baltimore City, we can now finance housing services through Medicaid for 100 people, part of a 300-person statewide pilot. We're working with the Mayor's Office of Human Services to connect clients with chronic conditions to housing. So far, we've matched more than 70 units, with momentum to reach 100 this year. Six new housing staff support this work, with two more to come. We've also supported the application of the Housing Authority for additional federal vouchers for "chronically homeless" individuals. And we worked with the Maryland Health Department to request a doubling of the waiver (pending federal approval) from 300 to 600 next year.

**Housing Units Matched**

**Goal: 100** **Total: 71**

**12** at Sojourner Place

**8** at New Shiloh II

**7** at Metro Heights

**30** through vouchers and subsidies

**14** through public housing renovations

*10/2018*

## Pursue public and private partnerships | COMPLETE

Just one year after our Sojourner Place supportive housing collaboration, we've partnered again with Episcopal Housing Corporation to provide supportive services for 20 more people at a planned 78-unit development in downtown Baltimore, Four Ten Lofts. We also established MOUs with Bon Secours Health System and Enterprise Homes to deliver supportive housing services for 15 individuals and families at two developments. Productive conversations with hospital leaders and preliminary data exchanges with the regional health information exchange (CRISP) to measure health care cost reductions promise expanded partnerships in 2019.

## Prepare for capital campaign | COMPLETE

Pre-campaign planning is well underway. Members of the development team completed a major gifts training program and integrated new tools and practices to improve performance. We engaged a consultant to help us develop a legacy program and identify planned gift prospects. Before the end of the year, we will convene a Core Committee that will create the vision and spearhead the capital campaign.

## Build Board of Directors' expertise in housing | COMPLETE

The Board of Directors now has a new standing committee: the Housing Committee. Its members represent a wealth of housing planning, financing and construction expertise. The Committee promotes opportunities for affordable and supportive housing and advises agency leadership on sustainable business models for housing development. Members are getting grounded in our current supportive housing work and have begun to educate other committees (such as the Board Finance and Facilities Committee) about housing financing.

*www.hchmd.org/strategic-plan-goal-2*

## Develop a role in housing advocacy | IN PROCESS

We worked with the Housing for All coalition and the Baltimore Housing Roundtable to pass legislation to fund the Affordable Housing Trust Fund in Baltimore City. We called, wrote, rallied and canvassed in support of the bill. Our CEO signed a joint op-ed in the Baltimore Sun supporting the measure. In October, the City Council passed the Fund the Trust Act (to reach $20 million annually by 2023). Our housing partnerships brought us closer to developers in the Maryland Affordable Housing Coalition, which dedicated their 2018 annual conference to the exploration of homelessness and housing. Expect more advocacy like this in the months ahead.

## Build staff capacity in housing | IN PROCESS

We've spent this year researching various housing models, starting with a visit to the Colorado Coalition for the Homeless in Denver. We also participated in a five-month learning collaborative with the Corporation for Supportive Housing and Capital Link for health centers interested in expanding health services in collaboration with housing facilities. And we joined Episcopal Housing Corporation as a partner in a second housing development (Four Ten Lofts) in order to learn more about the development process. We now better understand the type of staff support we need to lead our work in developing housing partnerships in the years ahead.

## Research financial models | MOVED TO 2019

Before mapping out financial models, we first have to firm up partnerships, increase staff capacity and develop a multi-year plan. Financial research will come next in this sequence of events.

## Begin to create a multi-year plan for integrating housing and health care in Baltimore City | MOVED TO 2019

This initiative happens in conjunction with our capital campaign plan, expanded housing partnerships and progress in community engagement. We will be positioned to begin this work in 2019.

# Goal 3

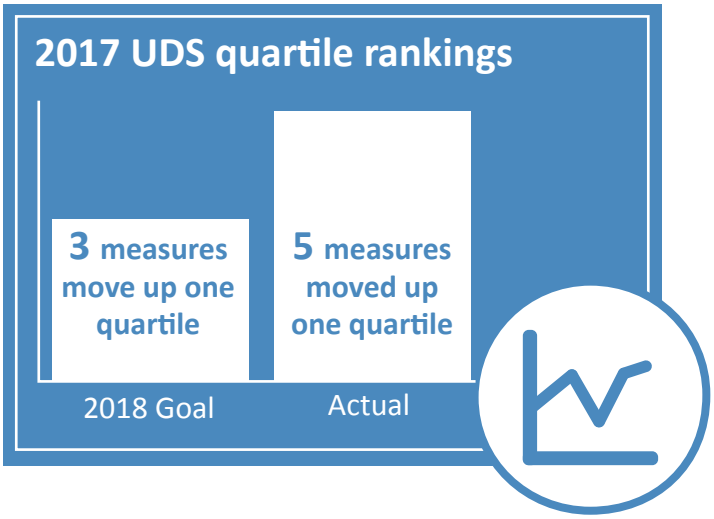
## Introduce, incorporate and create visibility into 13 new health outcomes measures | COMPLETE

By aligning our health measures with these new health outcomes, we can compare our clients' health to national and state benchmarks. We established baseline data for 10 of the 13 outcomes, and we are working to capture data on the other three: food insecurity, quality of life and depression. In 2019 we'll start making changes to get us there.

## Improve screening, tracking and treatment of clients through the performance improvement process |COMPLETE

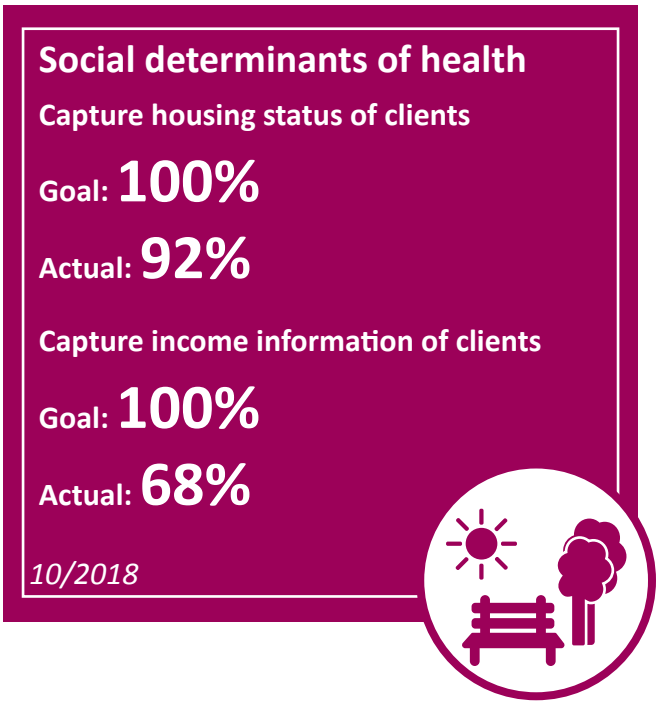
All areas targeted in 2018 improved. While we fell short on decreasing anxiety levels and increasing flu shots, we are very close to meeting our other goals: cancer screenings, diabetes management, access to a provider after hours and reducing missed appointments. We launched the inaugural Staff Innovation Challenge, in which 21 staff members submitted ideas. This culminated in the creation of a new client benefits group at 421 Fallsway. We implemented universal flu screenings and will implement Hepatitis C/HIV universal screenings in 2019.

*www.hchmd.org/performance-improvement-0*




## Collect structured data for social determinants of health | COMPLETE

Because so much of what affects our clients' health takes place outside of our clinic walls, we're collecting information about the environment in which our clients live and spend their time. At the end of 2017, we introduced a new tool (PRAPARE) to better assess the social determinants of health. In our first full year of standardized data collection, we have almost reached our goal of collecting 100% of housing status data and are well on our way to collecting 100% of income data for every client we currently see. This information has already helped us to identify and proactively address client needs and speed up the process for benefit and housing applications.



### Identify and prioritize treatment for clients with high acuity conditions | IN PROCESS

We began creating lists of clients (registries) based on specific health needs. Registries are now in use for clients who have HIV, diabetes and for clients whose cancer screenings are abnormal. In 2019, we'll create registries for Hepatitis C and high utilizers of emergency departments. We'll train more staff on how to use registries to provide timely care for those who need it most.

### Introduce providers to the concept and practice of risk stratification | IN PROCESS

Risk stratification helps us provide the right care to our clients at the right time. In July we discussed the population health framework and how risk stratification fits into our work. We've taken steps to standardize provider risk assessments for HIV, diabetes, and cervical and colorectal cancer. We are working to create a two-way interface between the regional health information exchange (CRISP) and our electronic health records system so that we can track hospital and emergency department utilization rates among our clients. We are exploring the creation of a model that factors in social determinants of health.

## Learn more: www.hchmd.org/2018-2021-strategic-plan

**“We want to do everything we can to help our clients succeed in life. With our strategic plan, we’re growing and expanding our services to do that.”**

***—Ieshia Carr***
***Client Access Associate I***


**Everyone deserves to go home.**

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