Systems Change Collaborative

Meeting #1 – Standards of Care
March 2, 2022 – 1:30 pm – 3:00 pm

Welcome

The first Systems Change Collaborative meeting was kicked off by Dr. Erica E. Taylor, Medical Director of Congregate Settings at the Chicago Department of Public Health. Dr. Taylor began by orienting everyone with the purpose of this Collaborative.

The Systems Change Collaborative is convened by the Chicago Department of Public Health and hosted with the Illinois Public Health Institute and Wilburn Strategic Solutions. The Collaborative was built to bring together stakeholders and allies to look at expanding high quality and comprehensive care for people experiencing homelessness and those transitioning into housing through a focus on the following:

i. Benchmarking standards of care
ii. Disseminating best practices
iii. Identifying common needs
iv. Advocating collectively for policy and system changes

The COVID-19 pandemic has shown how closely systems worked than ever before and the convening of this collaborative is to continue this momentum and increase collaboration between homeless services and advocates, public health, and healthcare communities in order to improve health equity for Chicagoans experiencing homelessness.

Dr. Taylor then goes into a brief introduction of the Special Populations Team at CDPH. The Special Populations team at CDPH works to improve the health, life expectancy, and quality of life for vulnerable populations, particularly Chicagoans experiencing homelessness and Chicagoans living in confinement settings. Their programs include Shelter-Based Services Teams, providing onsite medical care including vaccination and public health partnership in shelters, COVID-19 testing in shelters, providing public health guidance specific to homeless service and corrections environments, promotion of systems-level change to advance health equity, address root causes of homelessness through initiatives such as this Collaborative and CoC participation, and funding of street medicine services. Members of the Special Populations Team at CDPH include Dr. Erica Taylor, Mary Kate Schroeter, Colleen Mahoney, and Lauren O'Rear.

Afterwards, Colleen Mahoney from CDPH, reviews the meeting's agenda and meeting objectives, and introduces a list of the Systems Change Collaborative Members. Colleen takes this opportunity to thank the participants for joining the Collaborative.

Level-setting on Systems Change Collaborative

For this next piece, Sydney Edmond, from the Illinois Public Health Institute, goes through the context behind this project.

The Systems Change Collaborative started with a Landscape Assessment that occurred between August and December 2021, before the convening of this first meeting. This Landscape Assessment was done to identify the key policies and system issues that are affecting the health of people experiencing homelessness. Several methods of information collection were utilized during the landscape assessment. These methods included: Over 30 key informant interviews with service providers and stakeholders, discussion with people with lived experience, review of existing conditions, data and information collected by the LCOs and CDPH and DFSS throughout the pandemic, and a review of local and national best practices.

Edmond then leads the group through a list of key policies and system issues that came from the landscape assessment. This list will guide the Collaborative:

i. Data and Technology

ii. Standards of Care
iii. Housing Models and Shelter Models
iv. Care Continuity
v. Sustainable Funding
vi. Workforce Development

Afterwards, the Collaborative is presented with a list of tables and coalitions working in this space. Edmond remarks how throughout the landscape assessment and the planning process, there has been intentional strategic alignment with these groups while uplifting the work already being done.

The Collaborative is taken through the proposed timeline of the Collaborative. There are three key phases, and the initiative is currently in phase two.

Lastly, there is a list of group norms introduced with intention of having a productive meeting.

Mission Moment

Kuliva Wilburn, from Wilburn Strategic Solutions, and Colleen Mahoney lead the group through a Mission Moment. This segment is a grounding effort that will be a part of every meeting. It is a tool for members to reconnect with the work about to begin, the people being served, and to build collaborations between partners.

In this activity, Mahoney asks the group a series of statements related to access and housing, and asks members to raise their hand if they identify with the statement. Throughout this process, it is seen that over half of the members actively identify with the statements made today.

Policy and Systems Change Framework

Wilburn then leads the group through the framework of the Collaborative. This collaborative will meet five times throughout the year, and each meeting has a different topic. While the range of topics varies, data and technology will be integrated into each of the policy and system topics.

Wilburn then highlights the topics of each of the five meetings, and the goals set for each meeting. Meetings are arranged as followed:

i. Standards of Care
ii. Shelter Models
iii. Housing Models and Care Continuity
iv. Sustainable Funding Models
v. Workforce Development

Standards of Care

Furthermore, Wilburn walks the group through the background of Standards of Care. The term Shelter-Based Care Teams, is regarded as an important term in relation to this meeting's topic, "Shelter-based health care provides our homeless neighbors with more direct and improved access to the health care system."

Dr. Taylor introduces takes the opportunity to present the meeting's Subject Matter Experts, Mary Tornabene from Heartland Alliance Health and Thomas Huggett from Lawndale Christian Health Center.

Dr. Huggett, MD, MPH, has worked on the West Side of Chicago since 1995. He now serves as a family physician and medical director of Mobile Health at Lawndale Christian Health Center. He sees patients of all ages and is a part of a team that sees 12 homeless shelters from the West Side, providing primary care and care to patients with HIV, serious mental illness, and recovery care to those with opioid use recovery disorder. Since 2016, he has started medication for over 100 patients with opioid use disorder, most of them experiencing homelessness on the West Side of Chicago. He is a certified medical assisted treatment, independent waiver trainee instructor who has trained over 48 providers. Dr. Huggett was named the 2018 Family Physician of Illinois of the Year.

During the pandemic, Dr. Huggett was the medical director of the Hotel 166 project, including 269 high-risk persons experiencing homelessness. After the hotel project, he led the Lawndale Health

Service team in infectious control and COVID-19 vaccination efforts to 22 West Side sites that also serve people experiencing homelessness.

Mary Tornabene, MS, APRN, FNP-BC, has been working with Heartland Alliance since 1990, serving people experiencing homelessness in their Northside Centers throughout the city and suburbs. As a family nurse practitioner, Tornabene serves people throughout their life cycle including those living with HIV, and through the Margery Caudler Center she provides care in collaborative rehabilitative services to survivors of torture. In addition to patient care, Tornabene is a project manager for shelter-based coordinated care at over 40 shelters in the Chicago area. Tornabene serves on the Healthcare for Homeless Clinicians Network Steering Committee since 2016 through 2021, and as chair from 2020-2021. She was on the board of directors for NHCHC through 2019-2021.

Tornabene begins the presentation by introducing the Standards for Shelter-Based Healthcare document. The Standards for Shelter-Based Health Care in Chicago was formalized in 2020 as part of the COVID-19 response work among people experiencing homelessness, building on more than 30 years of clinical work. Heartland Alliance Health and Lawndale Christian Health Center have been working with shelter partners to implement standards of care throughout 2021, through the City-funded shelter-based care team model.

This document was built as a tool for equity and care. It has helped center care and the work being done for people experiencing homelessness. It is a guide for providing services and a playbook for shelter and healthcare providers to have shared expectations on processes and communication. The work developed is a blueprint of what to do and how to do it.

Dr. Huggett joins the conversation and emphasizes Tornabene's leadership in contributing to the layout of these Standards of Care. Furthermore, Dr. Huggett expands on the guiding principles for the Standards of Care. These principles are there to guide providers in serving people who have a history of mistreatment. Dr. Huggett provides some examples of these principles in action.

These examples include the importance of addressing patients with Mr. or Miss, holding events such as Christmas parties and foot washing experiences to create trust and develop a strong patient and provider relationship. Furthermore, being honest, having a regular schedule, and emphasizing how everything done is confidential, while affirming the strength of the patient is important for patient encouragement, and providers acknowledging how the goal of patients is growth and not perfection. Integrating care with these aspects is important.

Tornabene then takes the group through components that patient care must encompass to meet the needs of the patient. These components include delivering care the participant desires, hearing the expertise of people with lived experiences, and having the intention of doing work for health promotion. This also includes giving people a follow-up appointment and encouraging positive healthcare. Trauma-informed healthcare and data sharing are also integral to the Standards of Care.

Dr. Huggett emphasizes the leadership of people with lived experience, and their expertise that has helped lead the work of building these Standards of Care. Moreover, Dr. Huggett implores the need for a Consumer Advisory Board for the City of Chicago.

Finally, Dr. Huggett leads the group through a Status Update. This update includes progress and lessons learned from implementing these standards. These lessons include the importance of having face-to-face encounters, pivoting quickly from primary care to infection control, and the importance of data sharing between all providers for people experiencing homelessness.

Mary Tornabene closes the presentation by going to the next steps for the Standards of Care. These next steps are looking to engage students, shelters identifying people to sit on Consumer Advisory Boards for the City, and the importance of people experiencing homelessness seeing both a behavioral and primary care provider.

Discussion

The discussion portion of this meeting goes through a series of questions posed by the hosts of the Collaborative while holding space for participants to ask their own questions and engage in meaningful conversation with each other.

Questions posed during this session were on the following topics:

1. Sharing best practices and implementing standards in shelter settings
2. Engaging people with lived expertise in refining standards of care
3. Standards that make the most difference for people experiencing homelessness
4. Develop standards for bridging care as people are moving between settings and/or transitioning to housing
5. Data and technology

The notes for the discussions are below.

Next Steps

Following the discussion, Sydney Edmond asks the participants to fill out a short survey. The next meeting for the Systems Change Collaborative will meet next on April 6th on the topic of Shelter Models.

Question and Answer Session from Collaborative

1. Discussion
    - v. *What are the next steps for sharing the best practices that are included in the Standards of Care for Shelter-Based Care?*
        1. Are we considering street medicine?
            a. Night Ministry is planning to participate in this collaborative, and others on this call participate in providing care to unsheltered homeless and street medicine. DFSS and CDPH are both interested in integrating street medicine.
        2. "We have four/five chapters of Chicago Street Medicine started by students." Would love for students to go through orientation of Standards of Care, to introduce the concepts of trauma and dignity. University of Rush, Loyola, UIC, and UofC.
            a. CHHRGE group can be utilized for this group as well.
        3. As a shelter provider, we work within program guidelines with DFSS, integrating Standards of Care into a standard model would be great for shelters.
        4. Some places were still having in-person dining (hot food), is there a thought for Standards of Care beyond the street? Some organizations used to partner with places where people received food, and healthcare would be partnered with housing agencies, etc.?
            a. Heartland Alliance does this with Catholic Charities, a good reminder to continue this effort.
            b. Is DFSS a funder for meal programs? Can we disseminate standards through shelter models?
        5. It's important to set a standard to value people who do the direct work; there have been a lot of turnovers, and many of those who are working in these areas are "one or two paychecks away" from facing housing instability. What are we doing to support them?
            a. Important to highlight these systematic issues.
        6. After the sharing of best practices, how and what does accountability look like? Is it the expectation of what shelter and food do? Or is this an ask?

    a. CDPH is not a direct funder of shelters, but our intention with this group is to work with the community to identify priorities, and where do we want to encourage for practices be adopted, and other things to be turned into requirements. We do not want this to work in a unilateral way and want to work with partners wherever possible.
7. Regulation and implementing standards in ER, inpatient, and Mental Health facilities? Care can be disrupted in these areas, and how can we push those standards out to other facilities? Some ER regulations require having housing as part of discharge.

vi. *How can people with lived expertise be supported to engage in refining standards of care?*

vii. *Could each shelter identify one or two people to sit on a Consumer Advisory Board?*

1. Many agreed with having a Consumer Advisory Board.
2. How do we get immediate input from people, because surveys in the traditional sense may not work.
    a. Technology is not the most accessible. Someone has done audio interviews, and while it is not as personable, it provides valuable input.
    b. Others in the chat emphasized that PWLE should be paid as staff and consultants. This is a systems issue.
3. CAB at the city level is imperative.

viii. *What standards are most crucial from a public health approach?*

ix. *Which standards impact equitable care delivery?*

1. Access to information and language access is important.
2. Trauma-informed standards of care, and training based on trauma care is essential.
3. Language access in the shelter and homeless service system is a large barrier in the system.
4. Health literacy is also an adjacent issue to language. Information needs to be written in culturally and educationally appropriate language. Many people are at a fourth-grade reading level.
5. Bringing as much care as possible TO the person, whether they are at a shelter or in an unsheltered environment.
6. Homeless people experience high rights of disabilities, and much of the services provided are not accessible.
7. Sustainable Funding Models, how can we do more to bring in funding from a National level?
8. Emphasized access for people with disabilities. We have an opportunity to learn from other communities, to accommodate people in systems, services, and shelters.

x. *What settings need these standards?*

xi. *How could standards of care help to facilitate care coordination during the transition to housing?*

1. What standards of care make the most difference for people experiencing homelessness as they transition into housing? And how do we not only find them housing, but continue to maintain their housing? Some people from Hotel 166 were successful in finding housing, but they were lonely, and all their networks were at the shelter, so they went back to the shelter. We need to find out, what our goal is: Healthy living, social network, people having their own apartment, or even shared apartments? This is one of the things we are observing from Hotel 166 and housing in the last couple years.
2. How does information get translated when people are transitioning into housing? We do assessments, but it's hard for supportive services to not become a second

thought. We try to find housing near supportive services, but it's not always possible. What would it take to make this happen?

3. Continuity and communication needs to be a standard: What is your healthcare plan? Who are we connecting you for your healthcare provider? How are we helping you to access your care?
4. We are so focused on verification for people's disabilities, we no longer complete physical exams. This is something we need to look into.

xii. Data and Technology

xiii. In the context of standards of care, what are the critical data and technology improvements needed to advance the solutions we've discussed?

xiv. What data/technology experts or researchers are best positioned not assist with these improvements?

1. An open HMIS system, would allow a broader group of people to get information that is already there.
2. HMIS is also self-reporting, would give more information. And having better IT support, and equipment to allow for better privacy when joining Zoom meetings and such.