HUB ANALYSIS OCTOBER 2020

Spotlight Series: Circle the City

Interview with Linda Ross, Chief Executive Officer

The NORC Medicaid Managed Care Organization (MCO) Learning Hub shares timely and relevant resources to support Medicaid MCOs and other stakeholders in improving the health of their members and increasing advancements in health equity and health care transformation. We encourage you to share your experiences with us and welcome your feedback on future MCO Learning Hub work to better serve your needs. To start the conversation or join our distribution list, please email us at MCOLearningHub@norc.org.

The Medicaid MCO Learning Hub "Spotlight Series" highlights key initiatives addressing social determinants of health (SDOH) and health equity that are driven by, or in partnership with, MCOs to inform the Robert Wood Johnson Foundation (RWJF) and its grantees. In addition, the series provides MCOs, community based organizations, states, and other key stakeholders with examples of successful models of organizations working together to advance health equity.

This "Spotlight" is focused on a federally-qualified health center working with MCOs and other service organizations to provide medical and other social services to individuals experiencing homelessness in Maricopa County, Arizona. Forthcoming Spotlight Series briefs will center on other existing initiatives and partnerships around SDOH and health equity.

COVID-19 underscores the importance of protecting and strengthening social determinants of health (SDOH). Individuals experiencing homelessness or with inadequate shelter are vulnerable to a lack of SDOH services, which can negatively impact their health. It is clear that the risk of homelessness for the populations that Medicaid managed care organizations (MCOs) support is and will become an even greater need and concern in the coming months. The COVID-19 pandemic, coupled with a heightened awareness of the disparities impacting people of color in the health and social services arena, provides us with a unique opportunity to explore how leaders are working to address homelessness, SDOH, and disparities for the Medicaid population before and during this pandemic.

Circle the City is a non-profit, federally-qualified health center (FQHC) focused on providing quality health care to people experiencing homelessness in Maricopa County, Arizona. They offer a comprehensive array of services, including primary care, medical respite care, and mobile health outreach. NORC's Medicaid MCO Managed Care Learning Hub recently spoke with Linda Ross*, Chief Executive Officer (CEO) of Circle the City, to discuss how the organization is addressing homelessness and how it works with Medicaid MCOs to support this population.

Q: Can you tell us about Circle the City and its mission?

Circle the City provides medical, behavioral, and other wrap-around services to people experiencing homelessness in Maricopa County, Arizona. Maricopa County is large, with a homeless population of around 22,000-25,000 individuals dispersed over a large geographic area. We have been designated as an FQHC

by the Health Resources and Services Administration (HRSA).

Our mission is "to create and deliver innovative healthcare solutions that compassionately address the needs of men, women and children facing homelessness". Our approach is we provide holistic, integrated care with compassion and excellence meeting patients where they are and treating all with dignity and respect. At Circle the City, we provide care to all, regardless of their ability to pay. We provide that care in a number of different ways:

- We have two free-standing **outpatient clinics in the central Phoenix area**, where patients can access medical and behavioral health care, and other vital services. Pharmacy and lab services are available as well as assistance with case management, health education, and insurance eligibility. These services are for patient convenience and to remove barriers to care.

- We provide mobile medical outreach to various parts of Maricopa County. We have **four mobile medical units**, each with two exam rooms, which we take around Maricopa County to provide care to people where they are. This way of providing care works quite well for us; it requires a smaller team, is a less expensive footprint, and is truly meeting patients where they are. For the homeless population, it is a challenge for them to come to our sites. Maricopa County is a large county with a limited public transportation system. This proves to be an issue especially when our weather is extremely hot with excessive temperatures. People usually avoid walking back and forth to places. Through our mobile medical units, we develop routes that includes shelters and transitional housing to provide services for individuals experiencing homelessness. This works very well for us and our patients.

- We are a **respite care provider**; this is a feature unique to us. We have two respite centers with 50 beds each. We admit patients through an intake process. Patients come to Circle the City in a variety of ways but most often through a hospital discharge. Regardless of the reason for a patient's hospital stay, we will be contacted by the hospital and then will conduct an assessment. If the patient meets the assessment criteria and is admitted to respite care, we will care for them for a period of 30 – 60 days, sometimes shorter or longer. Many times, we find that there are other things patients need or they have co-morbidities; for example, they may have uncontrolled diabetes. Our respite facilities are 24/7 and dormitory-style setting. We provide meals, bed, clothing, activities, transportation to specialty appointments, and medical and behavioral health care. Our patients see a clinical provider 5-7 times a week. As soon as they are admitted, we being the search for transitional housing for the patient so they have a place to go when they are discharged from respite care.

> **"In [the respite] setting, we become basically everything for our patients. We work hard to transition them when they are ready, but focus first on getting them well, and ensure we do everything we can so that they don't have to come back to us again."**

- At Circle the City, we have one respite care center and outpatient clinic, which are located side-by-side on the **Human Services Campus** in Phoenix, AZ. This is a unique model, which provides a multi-disciplinary, multi-organizational approach providing various services in one location to people experiencing homelessness.

  There are other organizations on the campus, including shelter services and those that provide social services, meals, job placement support, and services for veterans. In addition, the Department of Economic Security is onsite along with an organization that works with individuals to obtain IDs, birth certificates, and other documents that are needed for individuals to look for work and housing. Approximately 15 organizations provide services within the Human Services Campus; it's a cohesive group of providers for individuals experiencing homelessness.

Q: How many patients do you serve in a given year?

We serve approximately 7,000 unique patient per year. We track and report this information to HRSA. We see a predominantly Medicaid population; about 85% of our population is on Medicaid and most of the remainder are uninsured.

Q: How has COVID-19 impacted the work that you do?

We recognized early on, in March, that we were going to have an issue with regards to helping the homeless population during COVID-19. You can't say to someone who is homeless, 'go home and spend x amount of days there in self-isolation,' because they don't have a home.

For the Human Services Campus, we worked even more closely with the onsite organizations to keep track of people entering and exiting the campus to access services in order to contain the spread of COVID-19 and ensure the safety of employees and people accessing the services. That has truly strengthened our relationship with the other organizations on campus. We created an internal task force to develop these processes.

COVID-19 Testing. Early on, we didn't have the tests to provide mass testing to the population, so we had to prioritize who would be tested. We began with our own patients. Based on conversations with partners, we developed a process to help Circle the City assess clients and then decide regarding testing. Circle the City became the conduit and the catalyst for handling the pandemic on the campus.

The first stop at the Human Services Campus is the Brian Garcia Welcome Center; that is the entry point of the campus. It is here where we provided the staff a questionnaire and information to help determine a person's symptoms and plan of action. Initially, we had people who were symptomatic come to the clinic. After a short time, we installed a process to ensure that everyone entering the campus was given a formal assessment by one of our clinical providers.

We also have a partnership with Maricopa County to conduct COVID-19 testing. The County came to us because we are the entity that knows how to treat individuals who are experiencing homelessness. We started doing testing in our clinics and on the campus on blitz testing day. We also utilize our mobile medical units to test people that are seeking care but also those who are in congregate settings, such as transitional housing. If people test positive, we help them receive the appropriate resources and a place to stay. We spent much time working through all the processes, which are now seamless for us.

Housing during COVID. Initially, it took us a week or longer to receive test results, which meant we needed to determine where individuals who had been tested and were waiting for their test results would go. We also had to figure out what to do with individuals who had positive test results. We initially installed large tents with cots in our parking lot, along with portable showers, toilets, and handwashing stations. We housed those waiting for their test results in tents and those who tested positive in a separate dorm in our respite center. Once it became too hot and we couldn't keep the tents cool, the County rented hotels and motels in the Phoenix area and we moved individuals who were positive or awaiting test results to those rooms. We provide care at the hotels, with a provider doing rounds and nursing staff available 24/7.

We created an assessment to help determine cohorts of people in the shelter to determine their placement. The shelter is a big open area so we helped them with that process. We've also set up telehealth visits for our patients who could not come in person to our sites.

> **"Our collaboration between our partners in human services and with Maricopa County and the City of Phoenix has increased and been enhanced. There is a lot of collaboration now that didn't exist before COVID."**

We also have projects in the pipeline that have been put on hold; several projects that had started in the beginning of 2020 were stopped as we have limited staffing and resources. I believe that processes are working well now and we'll be able to pick these projects back up.

Q: Has there been a disparate impact of COVID based on race/ethnicity?

That question has been asked quite a bit. We track all of the work we do, especially since we have received federal grants related to COVID-19. There are metrics we report on through a weekly submission to HRSA that covers COVID testing, patients seen, and other factors. I don't see anything unusual during COVID that differs from our traditional patient base and who we see every year.

Q: What is Circle the City's relationship with Medicaid MCOs?

Our organization works with eight different health plans. Based on membership, Mercy Care is the biggest one we work with. We work well with our MCOs. We follow the same administrative procedures that any provider does when working with MCOs, such as filing of claims, payment considerations, etc. Those are standard across the board. When the state integrated medical and behavioral health care in 2015, it required a transition for both the health plans and for us.

MCOs have helped Circle the City from a philanthropic perspective, providing in-kind donations, especially during COVID-19. **Arizona Complete Health** provided us with significant amounts of [personal protective equipment] PPE

for our providers. Additionally, they awarded a $25,000 capital grant.

We've also received $25,000 in donations and smaller gifts of $5,000 or $2,500. **Mercy Care** awarded us $25,000 in unrestricted use for COVID expenses. Some of the smaller plans have provided in-kind donations that are so important for our population, such as bottled water, hand sanitizers, sunscreen, etc.

Through their foundation, **UnitedHealthcare** provided us with a three-year, million-dollar grant, from 2017-2019, to create our respite center on the Human Services Campus. It was a big investment, based on the fact that respite care helps individuals recover and stay healthy so that they don't have to return to a hospital or go to the [emergency room] ER. A Centers for Medicare & Medicaid (CMS) study released in late 2017 shows that respite care helps decrease ER visits and hospital admissions, which saves the health care system overall, and insurance plans specifically, a great deal of money.

We work with as many patients as we can, especially in our respite centers, to connect them to housing. We do experience challenges, at times, finding housing for our population due to behavioral health issues or other factors. We always want to find a setting that will work for them as well as others living in these locations. UnitedHealthcare, also has housing units and we work with them to place our patients into these units, if possible. Our case managers and UnitedHealth coordinators work together with the housing entities to find the best fit for our patients.

We are also talking to one of the plans to fund a "navigator" program. A navigator is a person inside a hospital system who can intercept patients who are experiencing homelessness when they are ready to be discharged, assess their need for respite care, and present Circle the City services and the benefits of respite care. We presently work with two hospital systems that have navigators. These navigator programs have worked well for the hospital and Circle the City, thus the reason health plans are interested in learning more about it.

Hospital systems and plans recognize that if we are able to engage a patient who is homeless before they are discharged from the hospital, conduct an assessment, and take them in for post-discharge services, the hospital won't discharge a patient to the street. We have great relationships with our hospital partners. They intervene on behalf of the patient and contact us. Having a Circle the City navigator at the hospital who can talk with the patient directly before they are discharged works well.

Respite care is a big part of our business from a revenue perspective. Our designation as an FQHC allows us, from a payment perspective, to charge for the work that we do and receive reimbursement via the prospective payment system (PPS), which is usually at a higher rate. We aim to see a patient at least five times a week, which is considered a billable visit each time. It is impossible in an outpatient clinic setting to see patients in this fashion. We're able to bill for these frequent, high-touch services, which creates an important and needed revenue source for us that we would not otherwise receive, while providing in-depth, quality care.

MCO partnerships and financial support have helped Circle the City be successful. We were the only respite center in Maricopa County and, up until recently, the only one in Arizona.

> **"Circle the City couldn't have evolved without MCOs. In the beginning, we were not set up as an FQHC. We wouldn't be sustainable to do the work we do without this relationship with managed care."**

Q: How do you work with other community-based organizations (CBOs) in your community?

While I'm new to working with the homeless population specifically, I am not new to working with disadvantaged populations. At Circle the City, we do what we do well and have support from many others to do what we do. What we don't do as well, but would love to be able to do, is continuing to support our patients after they leave our respite care. Once people are in transitional housing, and we have invested time to get them well, who is doing the after-care and ensuring that the person is stabilized and able to stay in housing? Circle the City has not tackled this in-depth yet.

What we find, and we don't yet have statistics on this, is that people come back to us. We become patients' family and their home when they're with us. We do a lot for them, such as take them to appointments, provide their meals, provide clothing, and safety -- all things to enable them to get better. When we then place them in transitional housing, how are they receiving that same support? We sometimes expect them to do this all themselves, but they have not been equipped to handle this own their own, so we may end up seeing them in respite care again.

We haven't created a community for them to become self-sufficient and handle the things we did for them previously that now they have to do on their own, e.g., money management, learning to buy meals, managing a schedule, etc. As a provider of health care for the homeless, I would like to see us be able to do that. That would create long-term success that would truly impact the community and dollars spent on the services. Right now, that support in transitional housing happens only through access to case workers, as we're unable to have our case managers follow up with patients for an extended time after they leave us.

Another issue is that there are only so many supportive housing units available; we just don't have enough of those supportive or transitional housing mechanisms, with services embedded, available to meet the demand.

> **"There's a gap in financing – Arizona has a mechanism with Circle the City, through the unique respite model, that allows for individuals to be served by Circle the City and be paid through Medicaid. But we haven't yet figured out the financing mechanism for placing individuals into transitional housing and paying for that case management."**

Q: How can we move the service delivery system forward in the best direction?

From a success perspective, the Human Services Campus is a good model. Together, we are providing all types of services that individuals need to be successful in what we consider to be everyday life. The campus has an organization that can help individuals find jobs, for example, and that group knows how to do that well. Circle the City does not do that, but that service is critical for our patients. Another organization, for example, provides veteran services – we're skilled, but we don't know all that we need to know about veterans' services that are available. The campus scenario works quite well.

There is also some talk here in our county among the entities we partner with, about creating another campus like this in a different area. From a community perspective – the community loves and hates the Human Services Campus. They love it as a place for individuals who are homeless to go and get services, but hate it because it may be in their neighborhood. Other areas have the same issues you see in big cities, and the campus creates a central place for people to go to access services. We are looking at the North Phoenix area, which is a place Circle the City already provide health care services, as a possibility. There is need and a campus would create a central place for those experiencing homelessness to receive needed services, all in one place.

Conclusion

Based on our conversation with Linda Ross from Circle the City, there are various considerations MCOs, CBOs, and other key stakeholders can take into account when looking for potential examples and models of collaboration to support individuals experiencing homelessness:

- Mobile medical units provide an effective and lower cost option for providing services to individuals experiencing homelessness, particularly because it allows providers to travel to places and communities where individuals experiencing homelessness congregate. This may be a helpful strategy, particularly in locations lacking robust transportation systems.
- Respite care offers individuals experiencing homelessness an opportunity to receive the after-care they need after being discharged from the hospital, and creates a setting in which providers can address other medical issues individuals may be facing.
- A human services campus model allows health and human services organizations to specialize in the areas in which they are skilled while providing individuals experiencing homelessness a central location to manage all of their health and social needs.
- There are opportunities for partnerships between community health organizations and MCOs to fund:
  - Development of respite care centers, which have the potential to reduce ER visits and hospitalizations, providing savings for community and the MCOs. In addition, a designation as an FQHC allows community health organizations to receive PPS payment from Medicaid for services provided to patients in respite care, which helps offset costs for services that cannot be covered by Medicaid.
  - Navigators in hospitals that can help serve as the bridge between hospitals and other types of services (e.g., respite care), by intercepting patients experiencing homelessness at the time of discharge to offer connections to respite care, housing, and other social services.

The conversation also highlighted existing gaps:

- Additional support is needed for the development of supportive housing units or other housing arrangements that provides additional wraparound services to individuals experiencing homelessness.
- There is a gap in funding for supporting individuals experiencing homelessness once they are outside of respite care and in transitional housing, e.g., funding for case managers to continue following up with and connecting individuals in transitional housing to services, etc.

*Interview has been edited for length and clarity.

ABOUT NORC MEDICAID MCO LEARNING HUB

The key goal of the NORC Medicaid MCO Learning Hub is to serve as a source of information, expertise, and best practices to support managed care organizations in moving forward with system reform. NORC and its partner organizations identify, develop, and disseminate promising approaches and emerging opportunities for MCOs to improve the physical health, behavioral health, and social needs of their members.

Your ideas and opinions are important to us. We welcome your feedback on future MCO Medicaid Learning Hub work or programs you are working on to better serve your needs. To start the conversation, please contact the senior staff listed here:

www.norc.org/Research/Projects/Pages/medicaid-managed-care-organization-learning-hub.aspx

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