Session Starting Shortly!

We will be **recording** today's webinar.

Everyone is **muted** to reduce background noise.

Have a question?

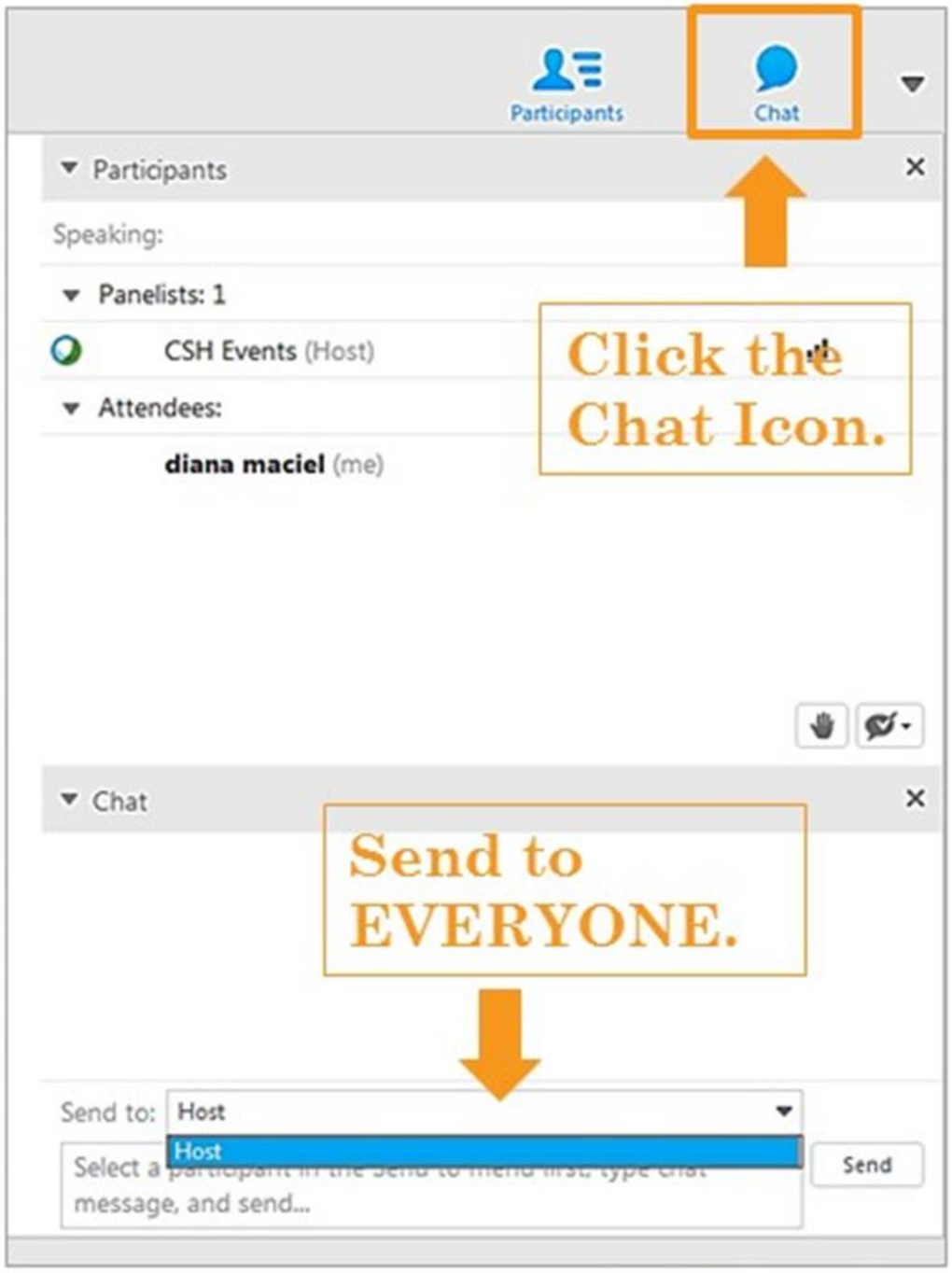
- Click the chat button.
- Type your message into the box and click send.

Audio Trouble?

- Close the webex window and re-launch the webinar.

Accessing today's recording and materials

- As soon as the recording is available, we'll send out a link.

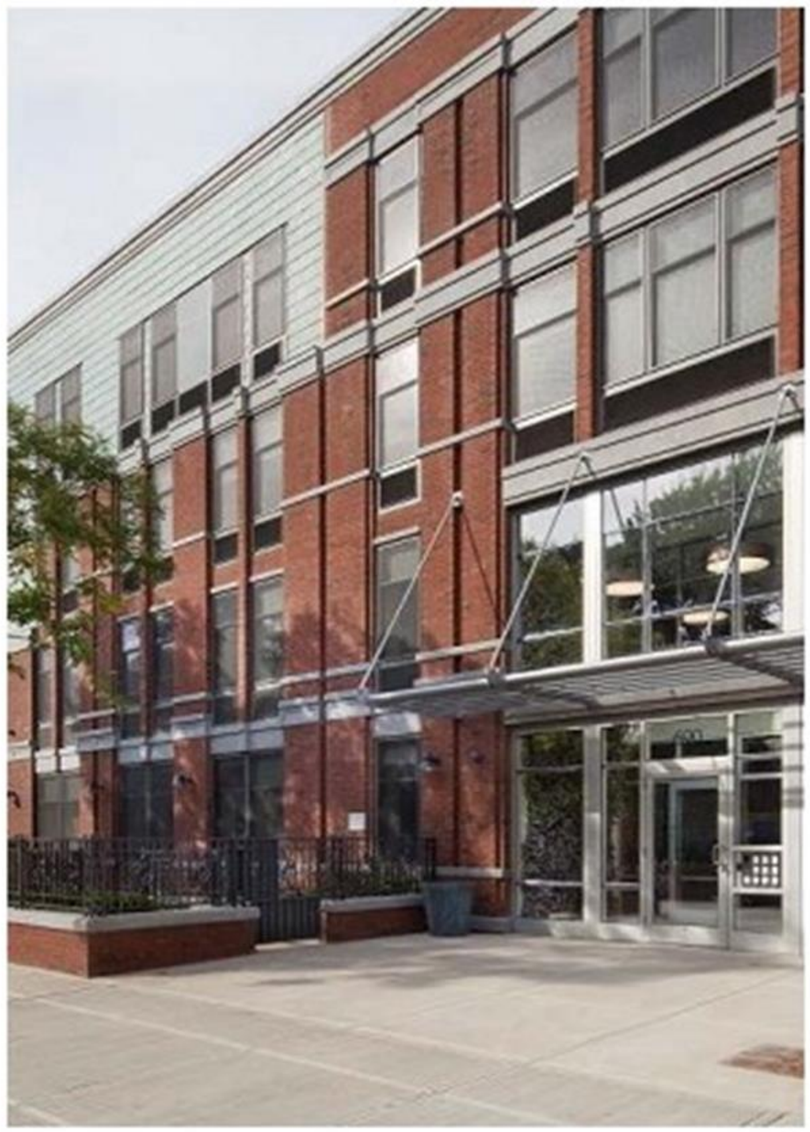


Multi-System Coordination: Building and Maintaining a Coordinated Provider Community

May 30, 2018

CSH

Advancing Housing Solutions



Improve the lives of vulnerable people

Maximize public and private resources

Build strong, healthy communities

CSH

CSH HRSA Training & Technical Assistance

GOALS:

- **Foster and expand Health Center collaboration with other health system stakeholders, and supportive housing**
- **Improve healthcare outcomes for extremely low-income individuals who frequently use crisis systems, have housing instability, and lack a connection to primary and preventive care services.**

Webinar Series

Direct Technical Assistance

Online & In-Person Trainings

Peer to Peer networks

Resources

PARTNERS: Deep collaboration with

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

Also partnering with:
NACHC
CHPS
HRSA BPHC

Visit us on the Web: www.csh.org/hrsaTA

CSH

Today's Speakers

Lauryn Berner, Project Manager, National Health Care for the Homeless Council

Mary Takach, Senior Health Policy Director, Boston Health Care for the Homeless

Anita Cordova, Director of Development, Planning & Evaluation, Albuquerque Health Care for the Homeless

CSH

Agenda

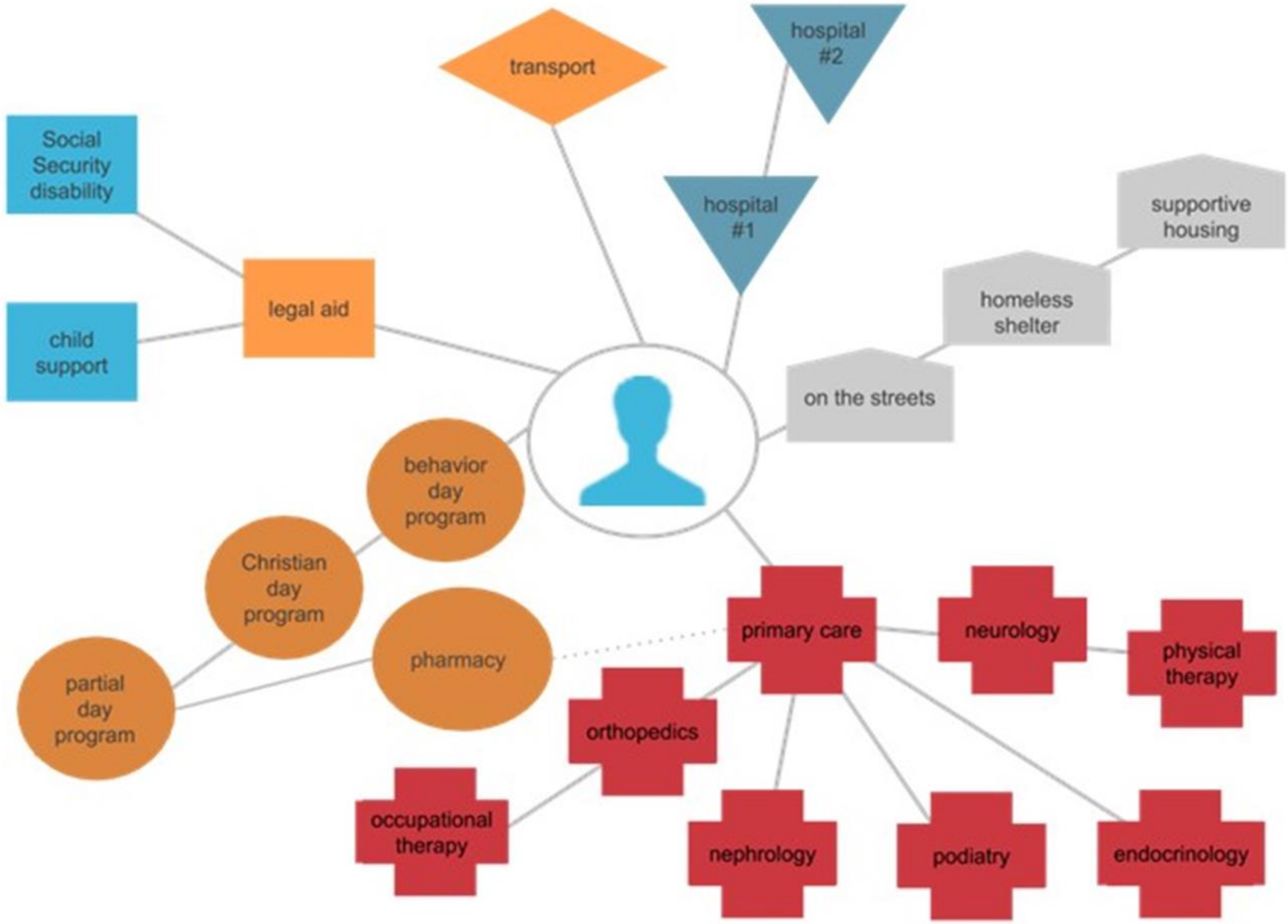
- Overview of Multisystem Coordination
- Hear from the Field
- Facilitated Discussion
- Q&A

Overview of Multisystem Coordination

Lauryn Berner, MSW, MPH, National Health Care for the Homeless Council

CSH

Uncoordinated Patient Care



Source: Camden Coalition of Healthcare Providers

CSH

Coordinated Patient Care

CSH

Who are the potential partners?

CSH

Key Components of Care Coordination

- Ability to share data
- Defined team structure, roles, & responsibilities
- Coordinated care planning
- Strong partnerships at all levels
- Trauma informed care
- Harm reduction approach

CSH

Partners and Approaches

Health

- Health Centers & Primary Care
- Hospitals
- Insurance Providers

Housing

- Continuum of Care
- Housing Authorities
- Housing Providers

Justice

- Police Department
- Probation & Parole
- Jails & Prisons

CSH

What are the benefits for each system?

Health

- Care coordination
- Address SDOH
- Broad reach

Housing

- Outreach Access
- Access to needed services
- Increased preventative care

Justice

- Reduce encounters and recidivism
- Ensure connection to resources upon release

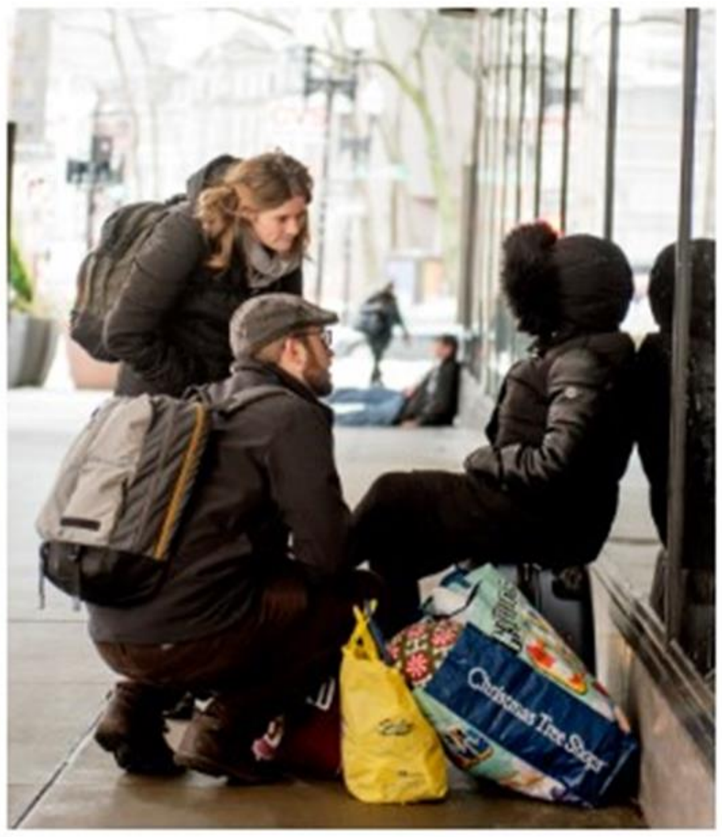
CSH

Hear from the Field

Mary Takach, MPH, RN, Senior Health Policy Advisor,
Boston Health Care for the Homeless Program

Anita Córdova, Director of Development, Planning &
Evaluation, Albuquerque Health Care for the Homeless

CSH



Boston Coordinated Care Hub for Homeless Adults

Mary Takach, MPH, RN
Senior Health Policy Advisor
Boston Health Care for the Homeless Program
May 30, 2018

BOSTON HEALTH CARE *for the* HOMELESS PROGRAM

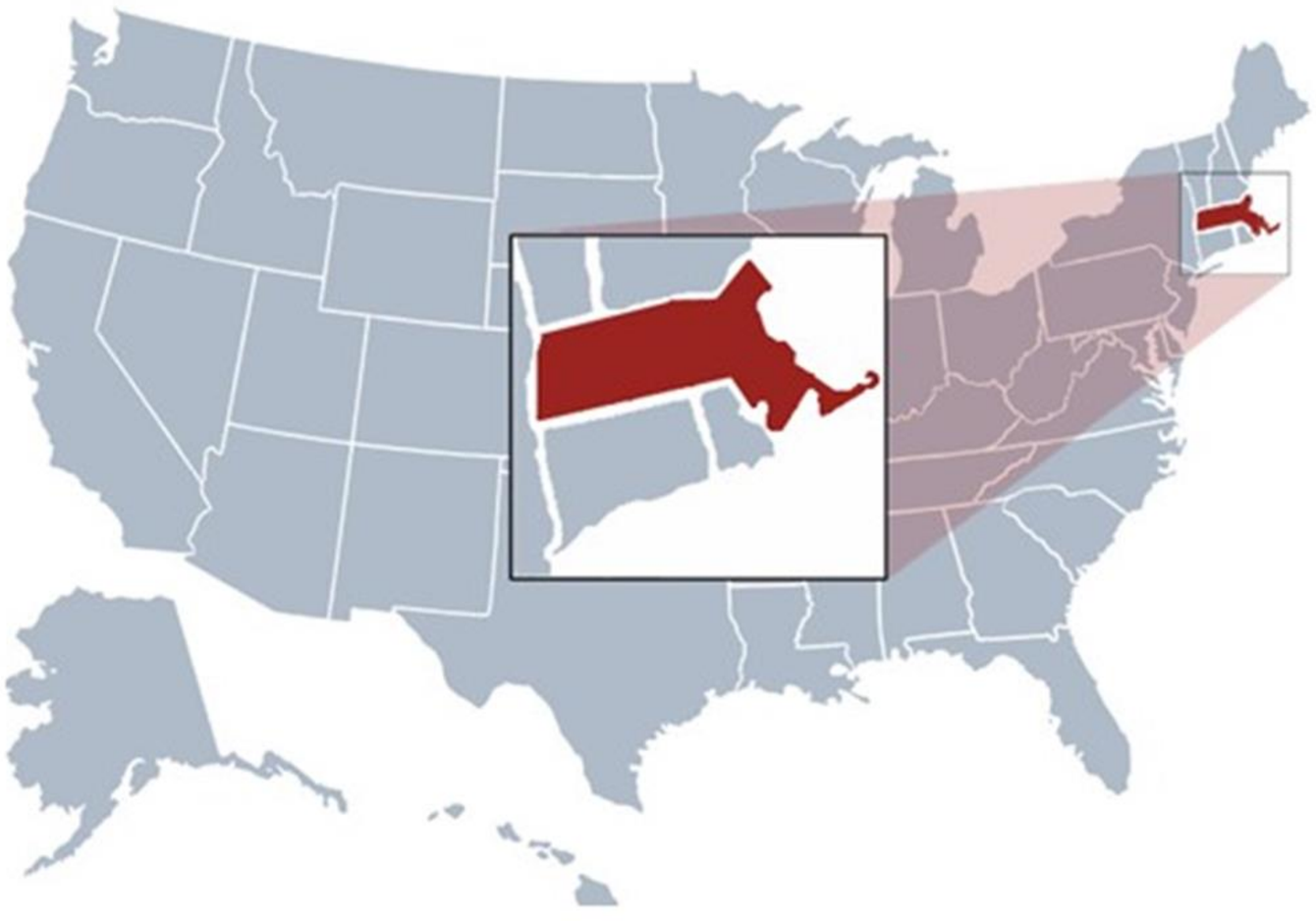
BHCHP Mission

Since 1985, our mission has remained the same:

To provide or assure access to the highest quality health care for all homeless individuals and families in the greater Boston area.

BOSTON HEALTH CARE *for the* HOMELESS PROGRAM

Massachusetts

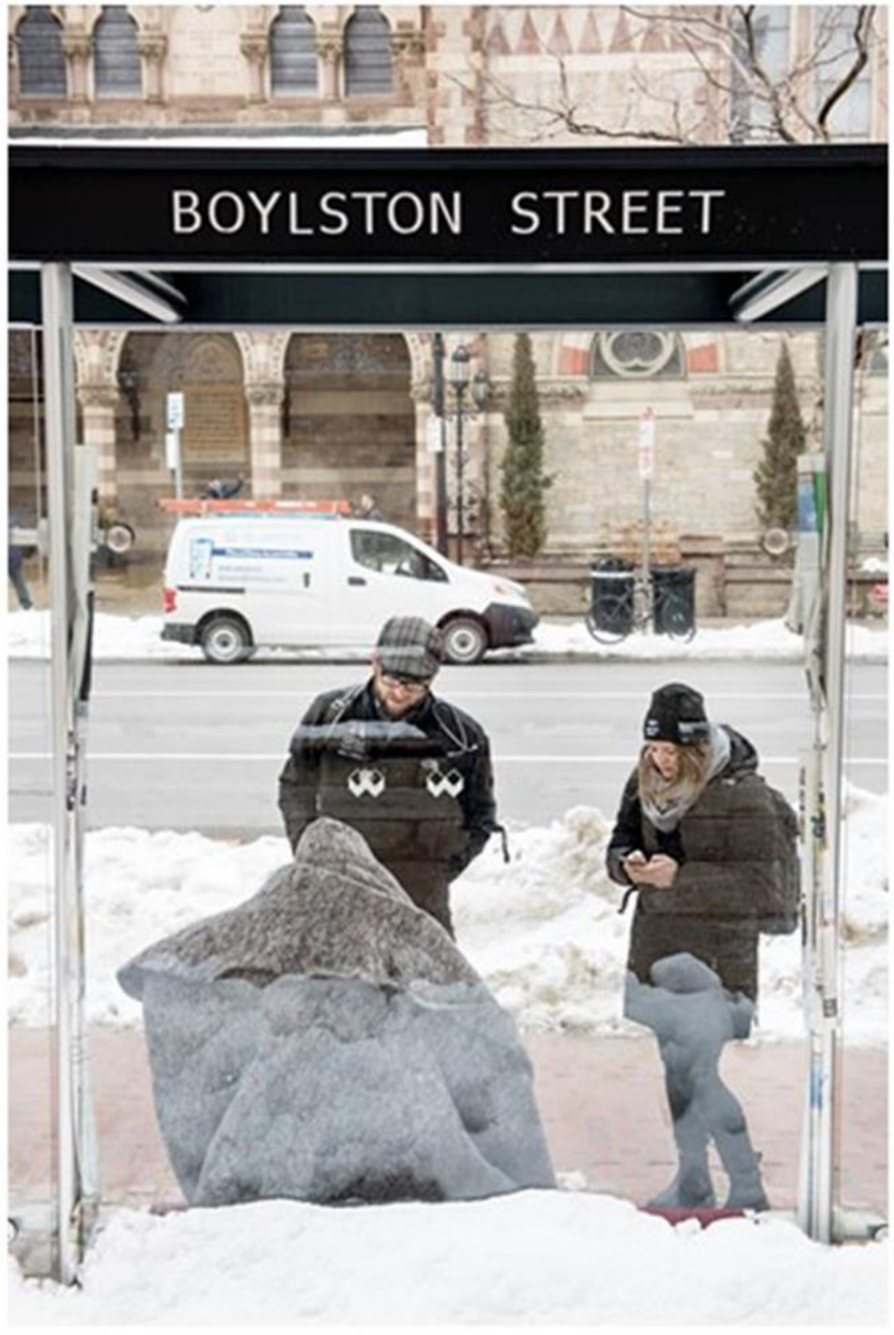


- 27,337 sq.km (44/50)
- 6.7 million people (14/50)
- #1 Healthiest state (2017)
- #1 State with highest rate of health care coverage (97.5%)
- #2 State with highest per capita health care costs ($11k/person)

Boston Health Care for the Homeless Program Population

➢ **Our patients are complex:**

- 68% mental illness
- 60% substance use disorders (SUD)
- 48% co-occurring mental illness & SUD
- High prevalence of medical illnesses, e.g. HCV (23%) & HIV (6%)
- High prevalence of chronic illnesses, e.g., 37% hypertension, 26% COPD or asthma, & 18% diabetes mellitus
- Disease burden = DxCG score of 3.8 (average = 1.0)



➢ **Our patients are costly:**

- $2,036 PMPM vs. $568 for all MassHealth members
- >1/3 had 6 or more ED visits/year; 1/5 had 3 or more hospitalizations
- 10% population accounted for ~50% total expenditures

Bharel, M., Lin, W.C., Zhang, J., O'Connell, E., Taube, R. and Clark, R.E., 2013. Health care utilization patterns of homeless individuals in Boston: preparing for Medicaid expansion under the Affordable Care Act. American journal of public health, 103(S2), pp.S311-S317.

BOSTON HEALTH CARE *for the* HOMELESS PROGRAM

SDH Consortium

Bay Cove Human Services

BOSTON HEALTH CARE *for the* HOMELESS PROGRAM

BOSTON PUBLIC HEALTH COMMISSION

CASA ESPERANZA

Pine Street Inn

Boston Rescue Mission

MASSACHUSETTS HOUSING AND SHELTER ALLIANCE

St. Francis House

NEW ENGLAND CENTER FOR HOMELESS VETERANS

victory programs

A history of collaboration

- Shared space
- Public health emergencies
- State Infrastructure & Capacity Building Grants
  - Legal agreement to share data across health, mental health, substance use, housing, social service sectors
  - Linkage to City of Boston Continuum of Care data platform

A need to stay relevant in changing delivery system

- Massachusetts is significantly restructuring public insurance (Medicaid) delivery into Accountable Care Organizations (ACOs)
- ACOs mandated to 'buy not build' and contract with 'Community Partner (CP)" entities (CPs and Australia's former Medicare Locals have many common characteristics.)
- 2016-2018 Massachusetts Health Policy Commission grant to build pilot for 60 patients
- July 2018 model will be scaled to 1000+ patients contracting with 8 ACOs as a 'Community Partner' to provide Complex Care management for high risk populations

Initial Health Policy Commission Grant Gave us Training Wheels

Objective:
Coordinate care across 10 agencies to better serve people experiencing homelessness, improve access to services that address SDH, and reduce avoidable ED and hospital utilization by 20%.

Timeline:
2-year, $750k grant from December 2016-2018

Target population:
~60 homeless individuals with high costs/high health care utilization

HEALTH POLICY COMMISSION (HPC) GRANT OVERVIEW

Objective: Coordinate care across 10 agencies to better serve people experiencing homelessness, improve access to services that address SDH and reduce avoidable ED and hospital utilization by 20%.

Timeline: 2-year $750K grant: December 2016– 2018
Implementation Phase begins June 2017.

Target Population: ~60 homeless individuals with high costs /high health care utilization.

Social Determinants of Health
Coordinated Care Hub
for people experiencing homelessness

1 DEDICATED RESOURCES
15:1 client-to-staff ratio

- Recognizes challenge of engaging highest-risk clients
- Delegated case management based on existing relationships
- At least weekly encounters
- Support from BHCHP RN

2 SHARED INFORMATION TECHNOLOGY
Enhances communication with other agencies

- shared care management platform (ETO)
- Consent required from client

3 SHARED CARE PLANS
Client's goals are created by him or her and supported by team

4 CONNECTION TO PRIMARY CARE

- Regular communication with doctor/nurses
- Joint training and case conferencing
- Accompaniment to appointments

5 DATA TO HELP UNDERSTAND CLIENT'S NEEDS & SERVICE USE
Information from Medicaid claims, EHR other social service agencies

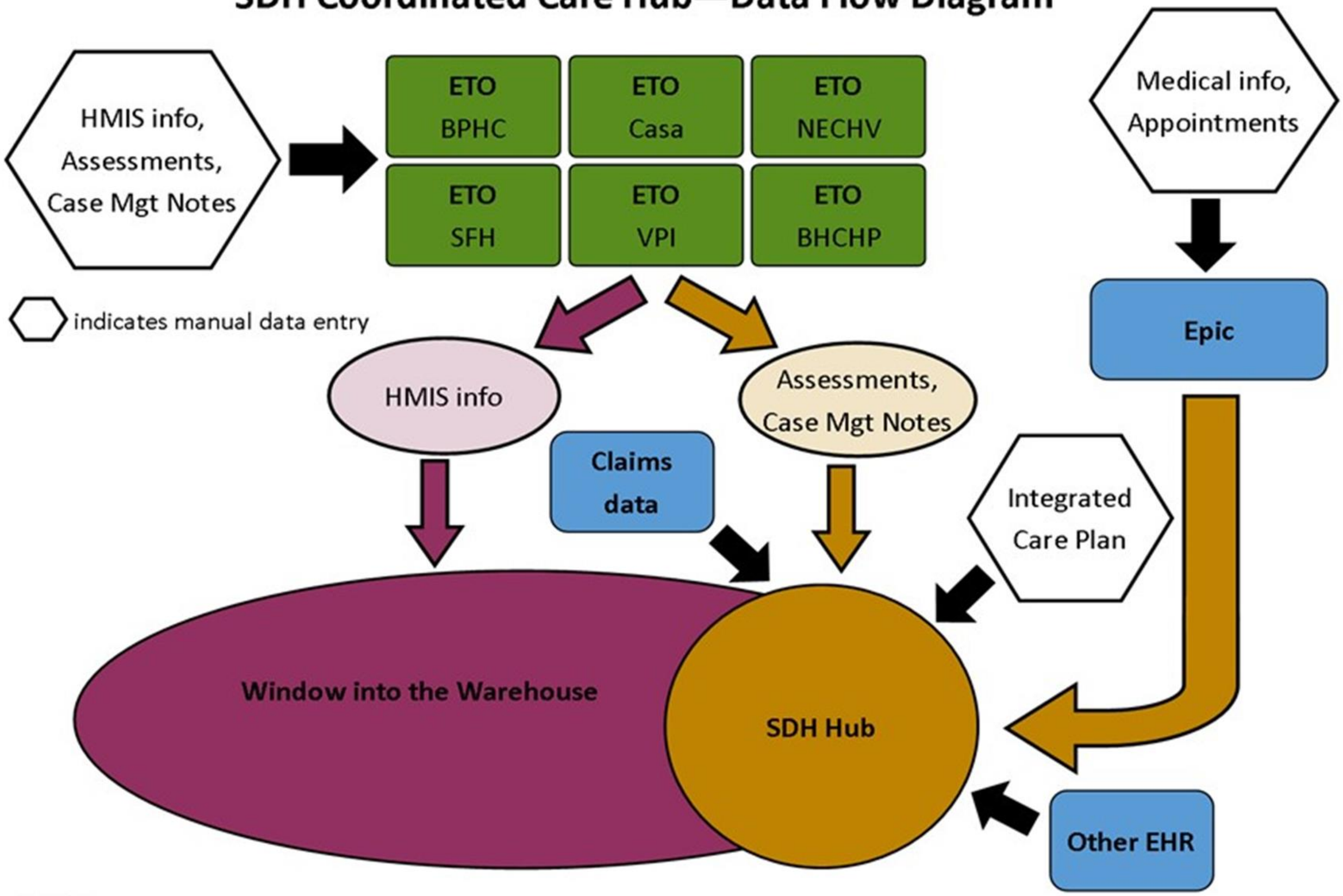
- Data to improve client's connection to care
- Data about recent hospitalizations/ED visits
- Data about care management & housing

6 SUPPORT FROM HUB LEADERSHIP TEAM
Meets regularly to troubleshoot and strategize about progress and "pain points"

- Monthly dashboard
- May be able to prioritize housing, services, or leverage other resources

Bay Cove Human Services · Boston Health Care for the Homeless Program · Boston Public Health Commission · Boston Rescue Mission · Casa Esperanza · Massachusetts Housing and Shelter Alliance · New England Center for Homeless Veterans · Pine Street Inn · St. Francis House · Victory Programs

SDH Coordinated Care Hub—Data Flow Diagram



2017-09-25

Coordinated Care Hub Record

BOSTON DND WAREHOUSE

ENDING VETERAN & CHRONIC HOMELESSNESS IN BOSTON

MENU

« Front Door Triage Search

Client Healthcare Dashboard for [redacted]

Basic Info & Programs | History | File Uploads | Health | Care Plan | Metrics

Patient Summary

[redacted]

SSN: [redacted] Medicaid ID: [redacted] Primary Care Physician: BRODY, JENNIFER K

Demographics

AGE: 62	GENDER: M	DISABILITY FLAG: Y
DOB [redacted]	RACE / ETHNICITY: White / Non-Hispanic	VETERAN STATUS: unknown

Allergies

CEFACLOR, CEPHALOSPORINS, HYDROCHLOROTHIAZIDE, VARENICLINE

- Patient Summary
- Cost
- Appointments
- Problems
- Medications

SDH Coordinated Care Hub Pilot Program

Cost and Utilization for Participating Patients

[redacted]

Cost

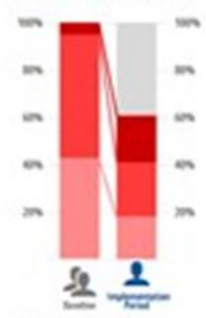
Total Cost	Months	Cost PMPM
$92,711	**4**	**$23,178**
$234,132	18	$13,007
		Variance: 78%

Utilization Metrics

ED Visits (past 6 months)	IP Admits (past 6 months)	Average Days to Readmit
0	**2**	**19**
0	1	30
	Variance	
N/A%	100%	-37%

- ED Visits that did not result in IP Admissions
- Acute IP Admissions only (i.e. no SNF/Rehab/Respite/Psych)
- For readmits, average only for those who had at least two admissions

ED Visit Severity (NYU Algorithm)



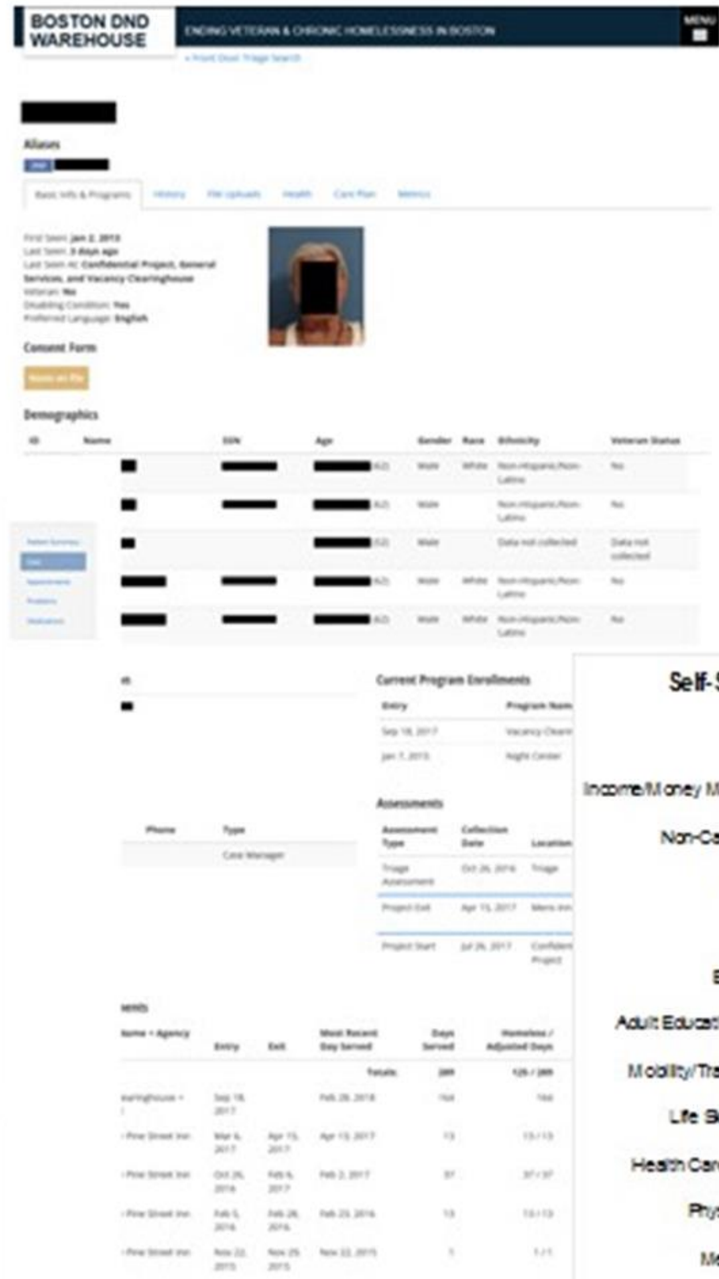
- Unclassified
- Emerg, not prev/ avoid (ED Visits that did n result in IP Admissions
- Emerg, prev/ avoid
- Emerg, PCP treat
- Non-emerg

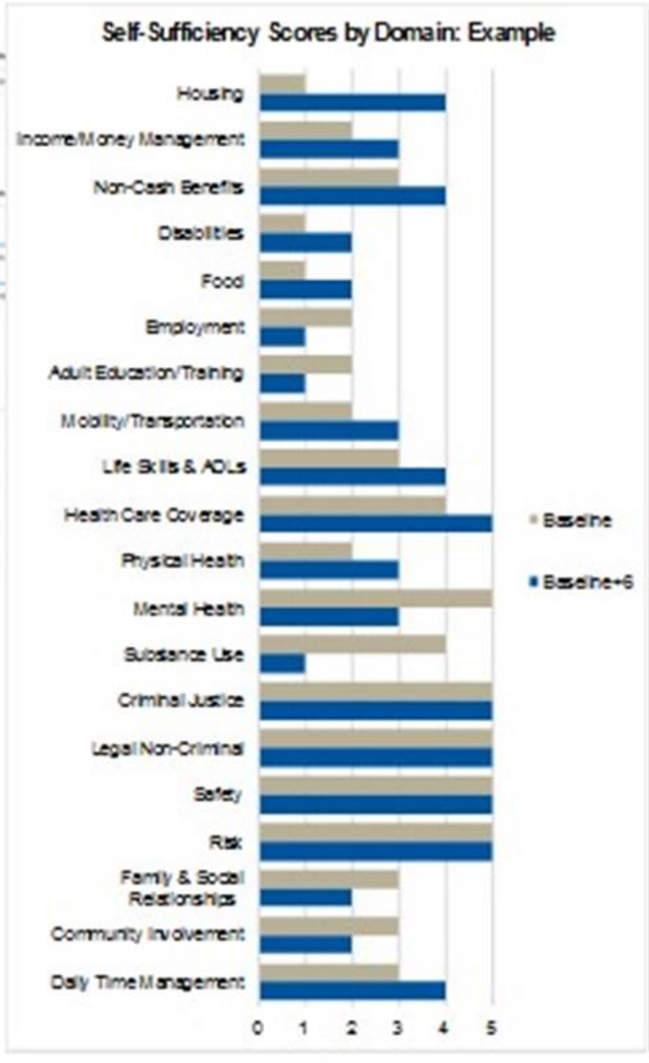
[redacted]

Housing Status (August 2017 - December 2017)

Self Sufficiency Scores

- 12/26/2017 Social Determinants of Health Pilot (total score: 59)
- 07/26/2017 Social Determinants of Health Pilot (total score: 56)





Coordinated Care Hub Record

BOSTON DND WAREHOUSE

ENDING VETERAN & CHRONIC HOMELESSNESS IN BOSTON

MENU

« Front Door Triage Search

Collaborative Care Plan for [redacted]

Basic Info & Programs | History | File Uploads | Health | Care Plan | Metrics

Print Care Plan

Assessments

Last updated: Mar 1, 2018 2:32 pm UPDATE

Assessment	Date Completed	Case Worker
SDH CASE MANAGEMENT NOTE	Feb 16, 2018	Carli Russell
SDH CASE MANAGEMENT NOTE	Feb 9, 2018	Carli Russell
SDH CASE MANAGEMENT NOTE	Feb 5, 2018	Carli Russell
SDH CASE MANAGEMENT NOTE	Dec 28, 2017	Carli Russell
SELF-SUFFICIENCY MATRIX	Dec 26, 2017	Carli Russell
SDH CASE MANAGEMENT NOTE	Dec 22, 2017	Carli Russell
SDH CASE MANAGEMENT NOTE	Dec 22, 2017	Carli Russell
SDH CASE MANAGEMENT NOTE	Dec 14, 2017	Carli Russell
SDH CASE MANAGEMENT NOTE	Dec 4, 2017	Carli Russell
SDH CASE MANAGEMENT NOTE	Dec 4, 2017	Carli Russell
SDH CASE MANAGEMENT NOTE	Dec 4, 2017	Carli Russell
SDH CASE MANAGEMENT NOTE	Dec 1, 2017	Carli Russell
SDH CASE MANAGEMENT NOTE	Nov 13, 2017	Carli Russell
SDH CASE MANAGEMENT NOTE	Nov 8, 2017	Carli Russell
SDH CASE MANAGEMENT NOTE	Nov 1, 2017	Carli Russell
SDH CASE MANAGEMENT NOTE	Oct 16, 2017	Carli Russell
SDH CASE MANAGEMENT NOTE	Oct 10, 2017	Carli Russell
SDH CASE MANAGEMENT NOTE	Oct 6, 2017	Carli Russell
SDH CASE MANAGEMENT NOTE	Oct 5, 2017	Carli Russell
SDH CASE MANAGEMENT NOTE	Oct 5, 2017	Carli Russell

Showing 1 to 20 of 76 entries Previous Next

Care Plan Dates

SDH ENROLL DATE	BASELINE DUE	FINAL DUE
Jul 26, 2017	Jul 26, 2017	
FIRST MEETING WITH SDH CM	**BASELINE COMPLETED**	**FINAL COMPLETED**
Jul 26, 2017	Jul 26, 2017	

UPDATE DATES

Team Members

Team Goals + ADD GOAL

Housing Last Modified: **Mar 2, 2018 by Kaitlyn McGary**

Self Management Last Modified: **Aug 10, 2017**

Team Members

Basic Info & Programs | History | File Uploads | Health | Care Plan | Metrics

Team Goals

Team Members

Last Modified: **Sep 7, 2017 2:18 pm by Kaitlyn McGary**

+ ADD TEAM MEMBER

SDH Case Manager	Other Important Contact	Provider (MD/NP/PA)
Carli Russell, Case Manager St. Francis House crussell@stfrancishouse.org	Astrid Mora BHCHP amora@bhchp.org	Jennifer Brody, MD BHCHP jbrody@bhchp.org

previous team members

SDH Case Manager

Complete housing applications

RN

BH

< past versions

The Boston DND Warehouse is operated by the Department of Neighborhood Development as the lead agency of the Boston Continuum of Care.

Integrated Care Management: Does it work?

SDH Coordinated Care Hub Pilot Program

Cost and Utilization for Participating Patients

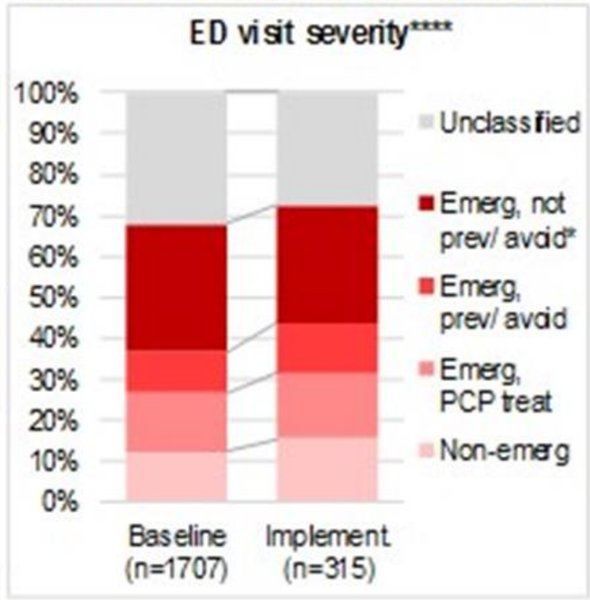
Baseline period: 12/1/2015 to 5/31/2017; **Implementation period:** 6/1/2017 to 9/30/2017, paid through 12/5/2017

Demographics	*Total enrolled*	*Active 9/1/2017*	*% Male*	*% Disabled*
SDH pilot average	66	61	76%	84%

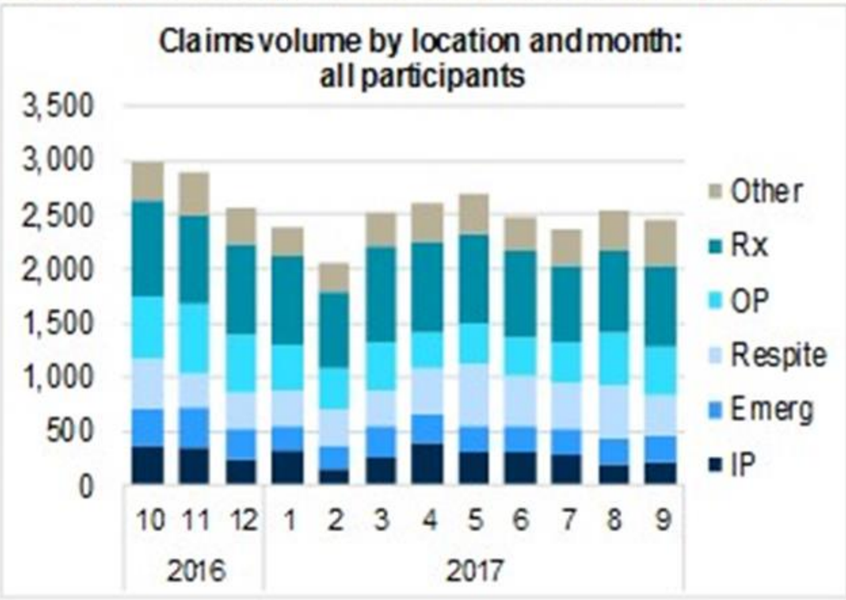
Cost	*Total cost*	*Months*	*Cost PMPM*
SDH pilot average (Baseline)	**$181,182**	16.4	**$8,809**
SDH pilot average (Implementation)	**$39,199**	3.8	**$8,193**
Variance	*N/A*	*N/A*	-7%

Utilization metrics	*Avg ED visits/ month**	*Avg acute IP admits/ month***	*Average days to readmit****
SDH pilot average (Baseline)	1.63	0.28	35.5
SDH pilot average (Implementation)	1.29	0.26	26.5
Variance	-21%	-7%	**-25%**

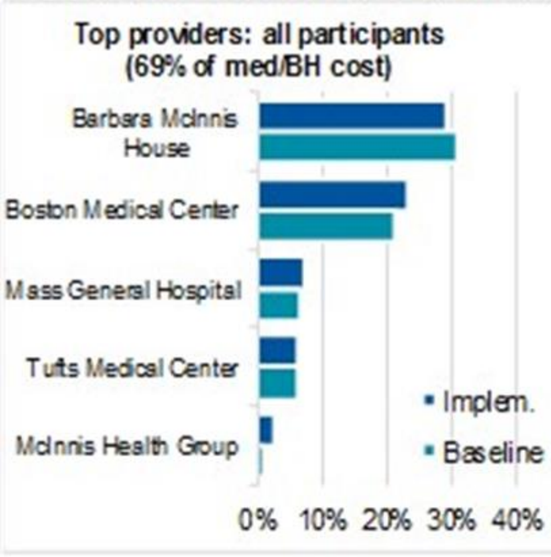
Drilldown: Emergency and Inpatient

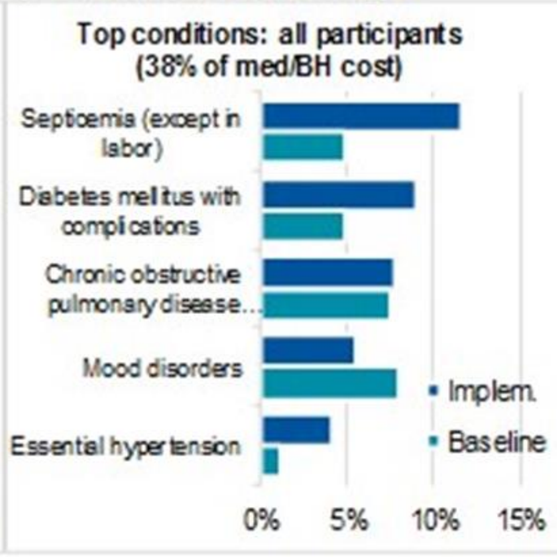


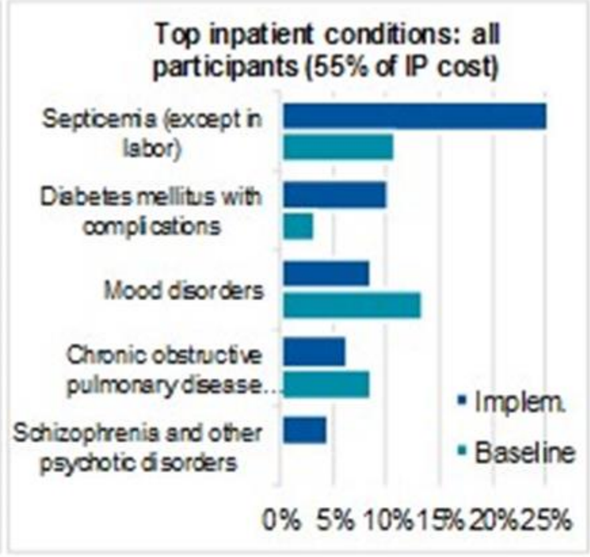
Trends over time (claims volume and amount paid)

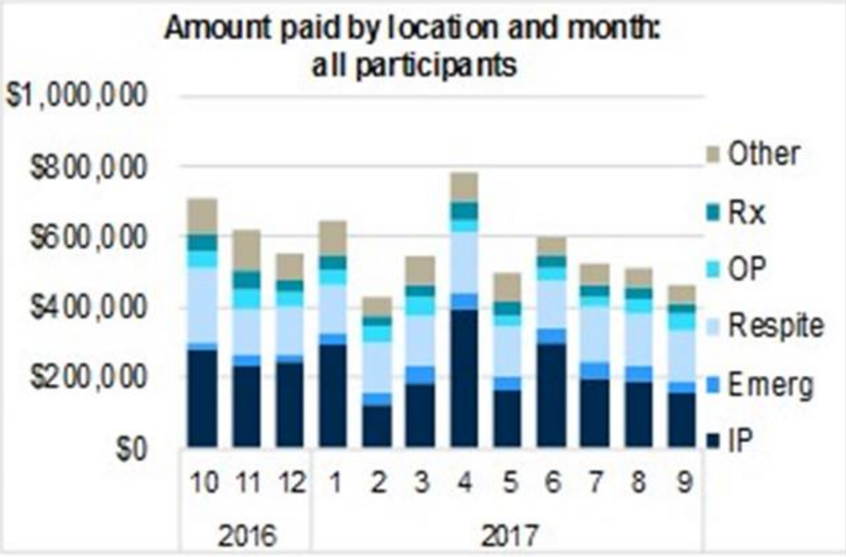


Top providers and clinical conditions (medical/BH claims only)









** ED visits and visits that led to IP admissions*

*** Acute IP admissions only (i.e., no SNF/Rehab/Respite/Psych)*

**** For readmits, average only for those who had at least two acute admissions AND* ***had at least one readmit within 30 days***

***** ED visit severity based on NYU algorithm, showing likely distribution of ED visits; "Unclassified" also includes Diagnosis Missing.*

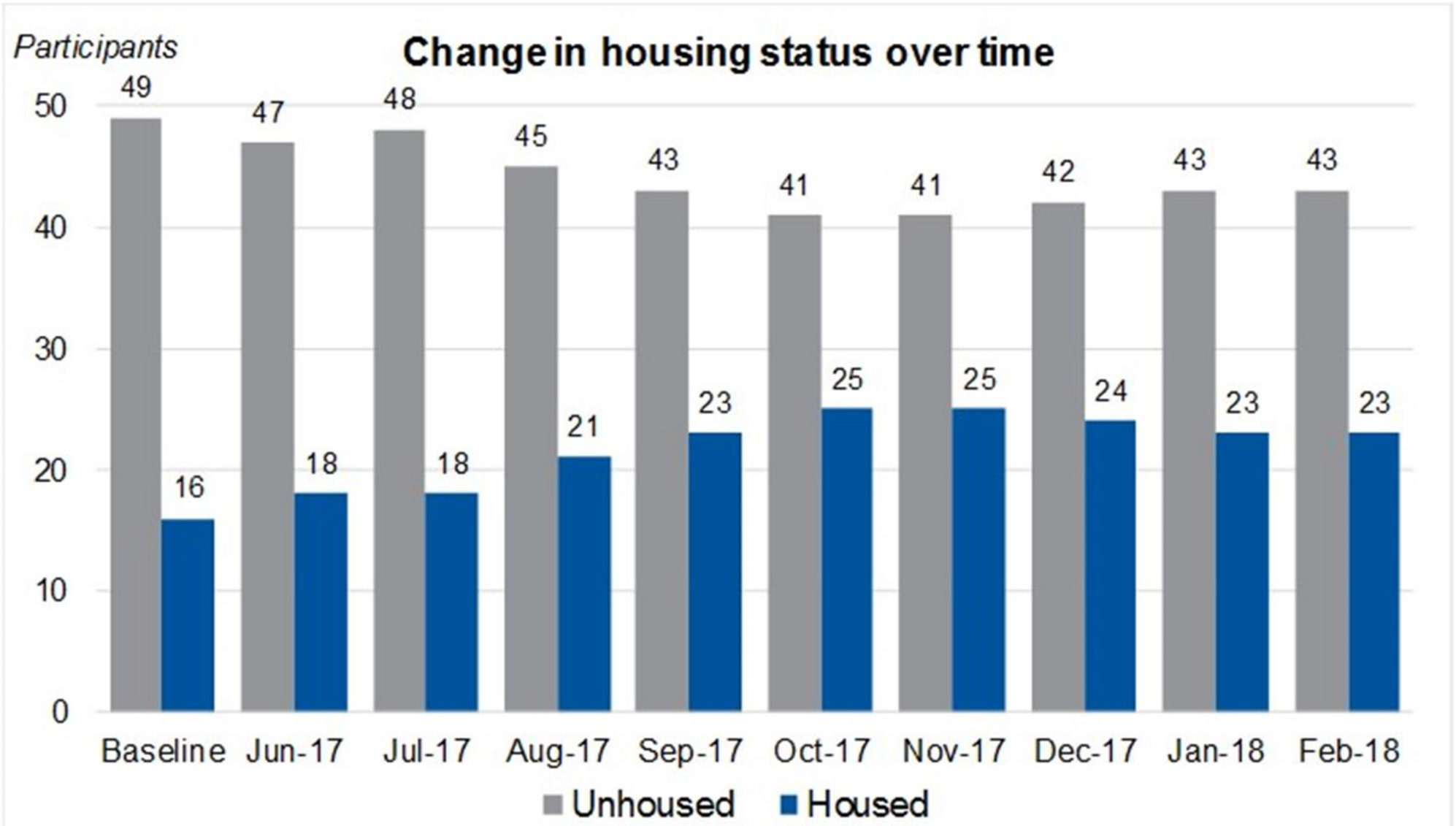
IP = Inpatient; Respite = BMH; OP = Outpatient; Rx = Pharmacy

"Other" includes transportation, home care, etc.

"Other" also includes all BMC HealthNet costs.

Tracking changes in housing status

25% of participants were housed at the beginning of the pilot;
that number is now up to 35% (23 of 66)



Looking Ahead to July 2018
Community Partner Funding Streams

Updated CP Accountability Framework

CP funding streams	Performance Accountability	CP Quality Score	Domains	Individual Measures
Care Coordination Supports Infrastructure)	• Funding at risk with increasing pct over time, based on DSRIP Accountability Score			• For all measures, state sets an attainment and excellence benchmark • BH CP: 13 measures + member experience • LTSS CP: 9 measures + member experience

Care coordination payments = $180 PMPM. Infrastructure support payments decline over 5 years. Infrastructure payments are also held at risk tied to Accountability Score.

Source: Massachusetts EOHHS Updates to BH and LTSS CP Accountability Slates, February 2018

Looking Ahead: July 2018 Accountability Slate

BH CP Slate (pending final CMS approval)

#	Measure	Domain Weights*
1	Community Partner Engagement	
2	Annual Treatment Plan Completion	
2*	Placeholder: Enhanced Person-Centered Care Planning Measure	Care Integration (40%)
3	CP Care Transition: Follow-up with any provider after hospitalization	
4	CP Care Transition: Follow-up with any provider after any ED Visit	
5	Annual Primary Care Visit	
6	Community Tenure	
7	Initiation of Alcohol, Opioid, or Other Drug Abuse and Dependence Treatment	
8	Engagement of Alcohol, Opioid, and Other Drug Abuse and Dependence Treatment	Population Health (35%)
9	Follow-up after Hospitalization for Mental Illness (7 days)	
10	Diabetes Screening for Individuals With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications	
**	Placeholder: Tobacco Use: Screening and Cessation Intervention	
11	ED Visits for Adults with SMI, Addiction, or Co-occurring Conditions	Avoidable Utilization (10%)
12	Hospital Readmissions	
	Member Experience : To Be Determined	Member Experience (15%)

ACO Measure | MBHP Measure | ACO and MBHP Measure

**Care Planning measures will use "Person-Centered Treatment/LTSS Care Plan Complete" Qualifying Activity for measurement purposes initial years of the program while a new measure for care plan completeness is under development*

*** MassHealth anticipates including a Tobacco Use measure in BP 3.*

Source: Massachusetts EOHHS Updates to BH and LTSS CP Accountability Slates, February 2018

Lessons learned

Good:

- Data sharing is powerful
- Nearly all patients have consented to participate
- High levels of ongoing engagement with case managers
- Face-to-face case management enabled by decentralized case managers

Bad:

- Logjam for addiction services treatment beds/affordable housing— "Bridge to nowhere"
- Some costs we cannot control. Pharmaceutical is huge cost center.
- Many patients have advanced disease—6 patients have died to date.

Conclusion

- Integration is hard, time consuming, cultures collide.
- Universal agreement that this is the right path--really the only path in this health care climate.

For more information:
mtakach@bhchp.org

Albuquerque Health Care for the Homeless

-- *Anita Córdova*

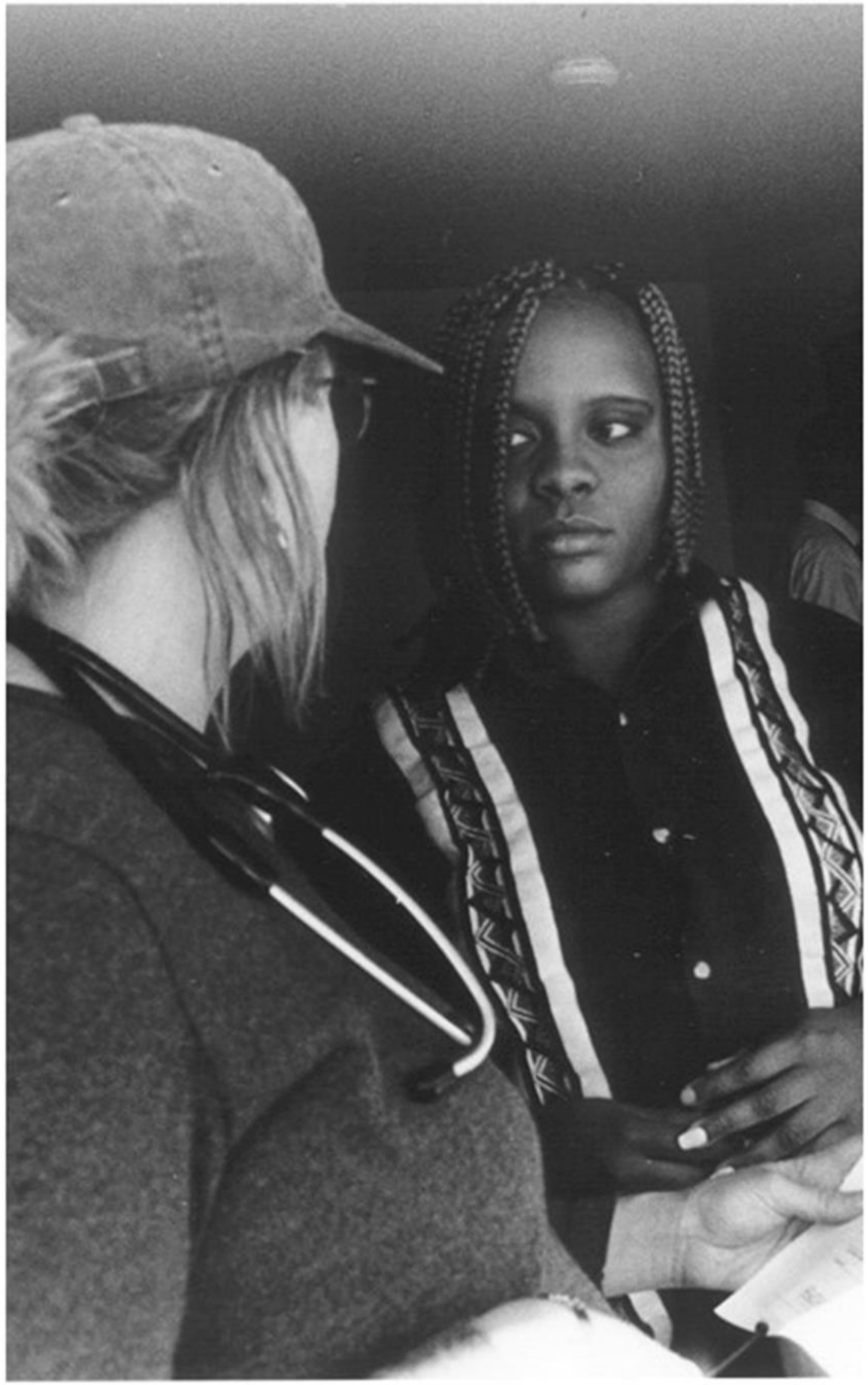
Multi-System Coordination:
Building and Maintaining a
Coordinated Provider Community

May 30, 2018

1985 to Present

AHCH is a freestanding Health Care for the Homeless, providing integrated primary medical and dental, behavioral health and social services through extensive outreach and at its central services campus.

Albuquerque Health Care for the Homeless, Inc.



Leading with and Anchored by Our Vision & Mission

Mission: Provide caring and comprehensive health and integrated supportive services, linking people experiencing homelessness to individual and collective solutions

and

Be a leader in implementing innovative service models and a catalyst for solutions to homelessness

and

Uphold a commitment to diversity and equity

Vision: To live in a world that is just and without homelessness.

Albuquerque Health Care for the Homeless, Inc.

Albuquerque HEALTH CARE for the homeless

AHCH Hallmarks

- Outreach, two-pronged
- Comprehensiveness
- Integration
- Access
- Person-centered care
- No wrong door
- Harm reduction

Integrated Resource Center Services

Integrated Traditional + Non-Traditional Services

Low-Demand Entry Thresholds

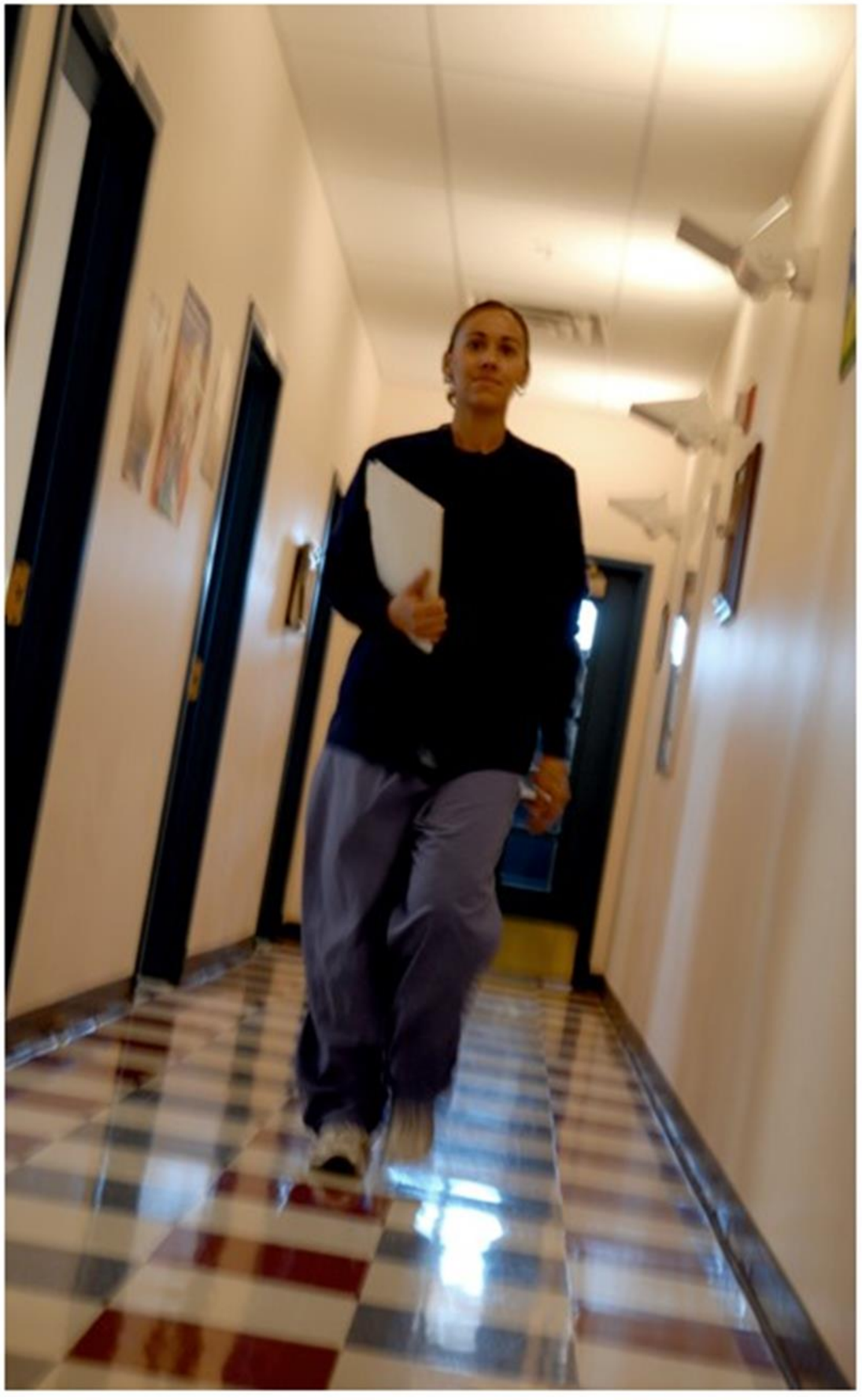
Outreach takes services to the field

Resource Center links to additional services

Housing and engagement specialists

ArtStreet

Extensive collaboration



Ending Homelessness

Work at local/state/ national levels

In collaboration with others

As care-givers and as advocates

Albuquerque Health Care for the Homeless, Inc.

Examples of Multi System Coordination

- Pathways to a Health Bernalillo County
- AHCH Re-Entry Collaborative
- Albuquerque Heading Home Initiative
- Community Connections
- Accountable Health Communities
- Data-Driven Justice/Behavioral Health Institute
- ER Diversion
- 1% for the Arts, UNM Dept. of Fine Arts, and AHCH Mural Partnership Project

Examples of Multi System Coordination

- **Pathways to a Health Bernalillo County:** 2007 community-based participatory planning process with multiple organizations to determine program goals and gain their interest through January 2009
- Project design team comprised of the *Pathways* program manager, *Pathways* committee members of the former Health Sciences Center Community Advisory Council (CAC), members of the *Pathways* Working Group, and a technical advisor from the UNM Health Sciences Center (HSC)
- **AHCH didn't even apply in first round to ensure enhanced and expanded community capacity to do navigation**

Examples of Multi System Coordination

- **AHCH Re-Entry Collaborative (REC): 5 year SAMHSA demonstration grant**
- **Public /private partnership**
- **Criminal justice, Dept. of Health, Health Centers, Project ECHO, including telehealth staffings and access to a learning community**

Examples of Multi System Coordination

- **Albuquerque Heading Home Initiative (AHH): collective social impact model**
- **city-wide collaboration that includes many public, private, government, and non-profit partners.**

Albuquerque Health Care for the Homeless, Inc.

Examples of Multi System Coordination

- **Community Connections: Housing, Criminal Justice, Homeless Services Providers/Case Management**
- **Challenges: boundaries (staff and participant), fidelity to models, competing philosophies**

Examples of Multi System Coordination

- **Accountable Health Communities (AHC): O**ne of 11 sites to receive a Community Health Worker as a part of a Center for Medicaid/Medicare Services 5-year grant that will screen 75,000 Medicaid enrollees for 5 social determinants of health, including homelessness, and then will navigate into the social services identified from screening. Includes quarterly advisory board (leadership from community orgs) and monthly community-wide consortium convenings.

Examples of Multi System Coordination

- **Data-Driven Justice/Behavioral Health Design Institute (DDJ/BHI):** Systems Initiative – a unique opportunity sponsored by the Substance Abuse Mental Health Services Administration (SAMHSA), Laura and John Arnold Foundation, and the Association of Counties DDJ & BHDI. with this cross-community leadership group (Congresswoman Maggie Heart-Stebbins, Katrina Hotrum-Lopez, Director of Behavioral Health, Bernalillo County, Paul Guerin, UNM Institute of Social Research, Eric Garcia, Deputy Chief of Police City of Albuquerque, Lisa Huval, Policy Director New Mexico Coalition to End Homelessness, Valorie Carrajo, UNM Physician) to determine and detail the ways in which data and analytics will be used across organizations, including AHCH data, to address needs and avoid cracks in care for people who end up crossing systems (public safety, criminal justice, healthcare, shelters, and other first responding services).
- **Challenges: buy-in, data-sharing at individual level, HIPPA, financial resources, electronic systems/records, data ownership**

Examples of Multi System Coordination

- **Outreach Initiatives**
- **ER Diversion**

Examples of Multi System Coordination

- **AHCH, 1% for the Arts, UNM Dept. of Fine Arts, Mural:**
- Selection Review Committee – board, neighbors, representative staff, ArtStreet artists, social and racial justice advocates, scoring matrix
- Funded by City of Albuquerque with approval of city arts board
- Students – 7 groups

Unique Characteristics and Challenges

- Data-Sharing (esp., Pathways, Accountable Health Communities, Data-Driven Justice/Behavioral Health Institute, HMIS/CAS – AHH)
- Convening leaders from across systems
- Multi Systems Initiatives Development
- BAAs/MOUs/MOAs
- Consent Forms
- Shared Resources
- Cross Organizational Staffing (e.g., Pathways, AHH, AHC)
- Challenges: Sustainability, competing philosophies, financial resources, buy-in, time oppression (competing priorities), competing interests

Contact Information

Anita Córdova

Director of Development, Planning & Evaluation

Albuquerque Health Care for the Homeless

Direct: 505-767-1172 | Admin: 505-766-5197

Email: anitacordova@abqhch.org

Website: www.abqhch.org

Facilitated Discussion

Discussion

What was the background or identified need in the community?

How did the partnership get started?

What convinced you to come to the table?

Discussion

What systems came to the table?

What types of agreements are in place?

Discussion

Describe the staffing model.

What does your staff look like?

Who on your team interacts with other organizations?

CSH

Discussion

Is there a financial consideration for your coordination?

CSH

Discussion

How did your coordinated system decide on a program model?

Who leads the effort?

How did the model as implemented change from the original proposal?

What were the main points raised in negotiating these changes?

CSH

Discussion

What challenges have their been in building and maintaining coordinated systems?

What has worked well?

CSH

Discussion

What advice do you have for folks who want to build these types of partnerships in their community?

Q&A Discussion

Have a question?

- Type into the Chat box.
- Enable Chat by clicking the icon in the top right corner.

Next Steps

Today's Recording & Slide Deck

- As soon as the recording is available, we will send you the slide deck and a link to the recording.

Upcoming Webinars

- Health & Housing Needs of Justice Involved Populations, June 19, 2018 (Tentative)

Survey

- When you log out of today's event, a pop-up window should appear displaying a survey about this webinar. We value your input!

CSH

CSH

National Cooperative Agreement

National Cooperative Agreements (NCAs) are national organizations receiving HRSA funds to provide technical assistance to help health centers and look-alikes to:

1. Increase access
2. Improve health outcomes
3. Promote health equity
4. Improve operations and infrastructure sustainability to health services
5. Increase capacity and partnerships to address social determinants of health

"This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under cooperative agreement # U30CS26935, Training and Technical Assistance National Cooperative Agreement (NCA) for $450,000 with 0% of the total NCA project financed with non-federal sources, if any. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government."

CSH