



How to replicate the Homeless Response Design Process

INTRODUCTION

Through a community-based planning process, the Northern Michigan CHIR developed a proposal to MDHHS for funding to improve the way that health and behavioral health serving organizations interact with the homelessness service sector to make sure that patients have safe discharge options when exiting any healthcare service, and don't fall through the cracks.

The overarching project related to this proposal develops a human centered service design process that informs discharge policies, including a visualization of:

- how people move through the health and behavioral health systems,
- information typically provided at each point of service, and
- responsibility for hand-offs from the health and behavioral health providers to the homelessness service system.

We've also done qualitative and quantitative research to better understand the constraints and opportunities on each side, so that together we can develop shared language, enhanced communications strategies, and cross training.

Within and beyond this primary project there were specific model discharge policies and procedures developed through pilots in healthcare discharge at Munson Hospital in Cadillac and in behavioral health with Addiction Treatment Services (ATS) in Traverse City. This document outlines the process taken to develop these changes so that any organization interested in replicating these projects will understand how best to move forward.

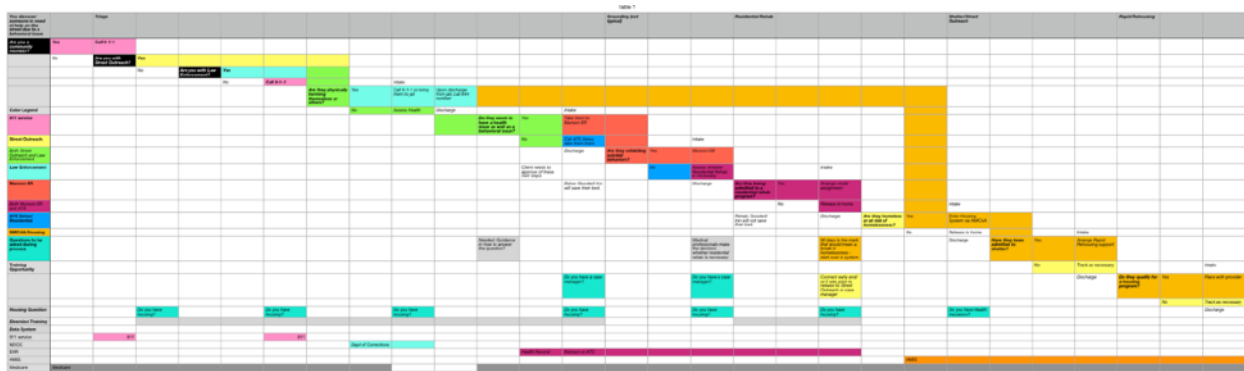
PARTICIPATION

In order to have the discussions that will lead to **policy and procedural changes**, the **people who can make those changes** need to be in the room and need to be willing to accept the limitations of the ways things are currently done and be open to brainstorming improvements. Since it is most likely that there will be **cross-training opportunities identified**, the **people who would both provide and supervise those receiving it** need to be involved to inform that process. The objective is to engage participants that are close enough to the clients being served, who **have intimate knowledge of clients** attempting to move through the systems so that they can tell the stories of those clients and where the systems succeeded and failed.

If possible, including clients in separate conversations is critical to understanding the barriers, not as practitioners see them but as those who receive the care see them. As in our larger project, it may be necessary to meet with clients separately from the meetings proposed above.

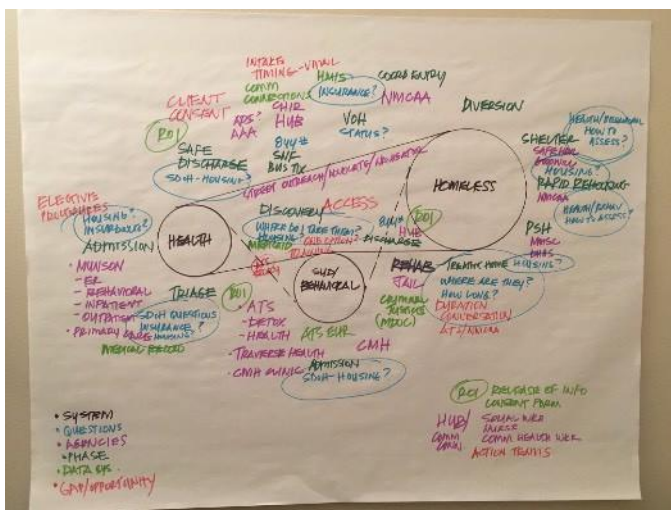
Meeting 2: Service Design

Bring the visualization(s) back to the group and verify that the stories previously collected are accurately depicted: phase by phase, with the individuals and organizations that were a part of the process for each specific client. Then engage in the “how might we?” discussion as the group brainstorms ways to better connect the systems to the client. Understanding that extraordinary measures are often taken to safely house clients, the goal will be to bring forward the experience of the “outliers” - those who have successfully navigated the system despite its barriers - and see if there are ways to replicate those successes for the majority of clients.



Sample Service Design visualization in Excel

Meeting 3: Proposed Solutions



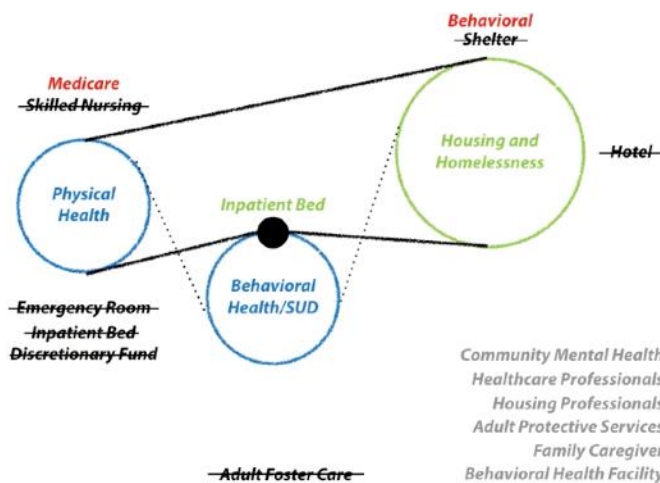
Based on previous conversations, hypothesize ways for individuals and organizations to partner more closely to fill identified gaps. Using the visualization(s) as the baseline “landmark(s),” trace the pathways of various clients through an improved system, noting where handoffs might be more effectively accomplished. Discuss these as a group so that feedback is incorporated into the understanding and experience in the final design discussion.

If there are organizational policies that are getting in the way of better client services and connections, the people who are able

to make those policy changes are charged with working toward that end. If there are procedural changes that can be made, create a decision tree to be used from either service system so that there is no doubt about what is done when and by whom. If the 2 systems involved were under one organizational roof, how would they make sure their clients received the help they need? As new procedures are developed remember that it's not an us vs them; it's all us.

Meeting 4: Confirmation and implementation

As a final step, the group confirms the final policy and procedural changes that workers can use to better support clients and begins to implement those changes. Are there specific forms that need to be used? Is there shared learning that needs to take place for the changes to take place? Create a timeline that is short yet doable to implement the procedural changes and make sure to set at least quarterly meetings to recheck to see how things are working over the next 2 years.



As time goes on and the new procedures are working, the expectation is that the group will see even better ways to better serve the clients in a collaborative way. Your goal as service providers is to make sure these new tools have “legs” - that the work done together will be immediately actionable and relevant, and can scale or change as supporting systems change.

Sample illustration showing gaps and opportunities



Homeless Response System

This application is designed to direct you through the process of decision making as you determine the correct course of action in helping a client.

You discover someone in need of help on the street due to a behavioral issue. You are a:

- Member of the Community at-Large
- Goodwill Street Outreach Staffer
- Law Enforcement Officer

Once client has been assessed and transferred:

- For Addiction Treatment Services Staff
- For Mission #1 Staff



Homeless Response System

Goodwill Street Outreach

Question:
Does the client seem to have a health as well as a behavioral issue?

TRAINING OPPORTUNITY
low to assess health issues?

Sample digital decision tree