Community Solutions:

Lessons from Built for Zero on Health and Homelessness

September 21, 2023

Introductions

Meghan Arsenault
Senior Strategy Lead
Community Solutions

Lauran Hardin
Faculty Coach
HC2 Strategies

Healthcare & Homelessness

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Overview of Pilot Project: Community Solutions & IHI

Healthcare & Homelessness Pilot Aim

Over the course of this 3 year Pilot initiative, pilot teams will have made measurable progress toward ending homelessness, with a focus on building racially equitable systems.

Objectives

- Prevent, reduce, end chronic homelessness through collaboration with health systems
- Identify interventions/ways of working across systems that have the greatest impact
- Understand the role that healthcare can play in reducing and ending homelessness
- Understand the effects of housing for the health of the homeless population and the impact on healthcare institutions operationally, including the morale of staff as a result of actively participating in problem solving

Pilot Teams


Washington County
Sacramento
Bakersfield/Kern County
Chattanooga
Anchorage
Washington
Olympia
WA
Montana
North Dakota
Bismarck
ND
Minnesota
St. Paul
MN
Wisconsin
Madison
WI
Michigan
Lansing
MI
New York
Albany
NY
Maine
Augusta
ME
Vermont
Montpelier
VT
New Hampshire
Concord
NH
Massachusetts
Boston
MA
Rhode Island
RI
Connecticut
CT
Pennsylvania
Harrisburg
PA
New Jersey
NJ
Delaware
DE
Maryland
Annapolis
MD
Ohio
Columbus
OH
Indiana
Indianapolis
IN
Illinois
Springfield
IL
Missouri
Jefferson City
MO
Kentucky
Frankfurt
KY
West Virginia
Charleston
WV
Virginia
Richmond
VA
North Carolina
NC
Tennessee
TN
South Carolina
Atlanta
Georgia
GA
Florida
Tallahassee
FL
Alabama
Montgomery
AL
Mississippi
MS
Louisiana
Baton Rouge
LA
Arkansas
Little Rock
AR
Oklahoma
Oklahoma City
OK
Kansas
Topeka
KS
Nebraska
Lincoln
NE
South Dakota
Pierre
SD
Iowa
Des Moines
IA
Wyoming
Cheyenne
WY
Colorado
Denver
CO
Utah
UT
Nevada
NV
Idaho
Boise
ID
Oregon
OR
California
CA
Arizona
Phoenix
AZ
New Mexico
Santa Fe
NM
Texas
Austin
TX
Alaska
Juneau
Hawaii
Honolulu
HI

Purpose:
Health care organizations make a meaningful, measurable, and transformative contribution to end homelessness across a community, with a focus on building racially equitable systems

Foundational:

Commitment
Build sustained belief in and action toward supporting the community to end homelessness

Governance
Establish processes and priorities for collaboration, measurement of system performance, and governance

Theory of what:

Housing Placements
Increase housing placements and retention rates for those experiencing homelessness

Inflow
Use short- and long-term strategies to prevent inflow of individuals into homelessness

Theory of how:

Holistic System of Care
Work alongside community partners to identify & fill gaps to create an equitable system of care

Financial Levers
Establish and build upon sustainable financial mechanisms that support overall system aims for ending homelessness

Activities of Healthcare x Homelessness Pilot

- Build team of cross sector partners with clear roles
  - Commit to a shared, measurable aim around population level reductions
    - Draft portfolio of projects using strategies from theory of change
      - Identify project measures to evaluate impact
        - Sustain partnerships and work

Healthcare & Homelessness Bright Spots

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Community Trends

1 Shared commitment and relationship building across systems

When this pilot was launched in Dec 2020 it was the first time leaders from the healthcare and homeless response systems were talking to each other in these communities

2 Data Sharing for case conferencing and care coordination

Sharing information between 2 systems facilitates care coordination. Case conferencing brings housing and healthcare systems together in housing process

3 Housing interventions for populations with complex medical needs

The Homeless Responses System often does not have adequate or appropriate settings for individuals with complex medical needs. Respite care or recuperative care has been identified as a way to disrupt discharge into homelessness

Community Trends

4 Newly funded liaisons

Positions established within homeless response system or within healthcare system

5 SDOH screenings

Identifying individuals experiencing homelessness or housing crisis earlier and systematically by adding field to EHR, standardizing process, and training for trauma informed screenings

6 Discharge planning

Workflow improvement to ensure that individuals are not discharged from hospital or respite care settings into homelessness

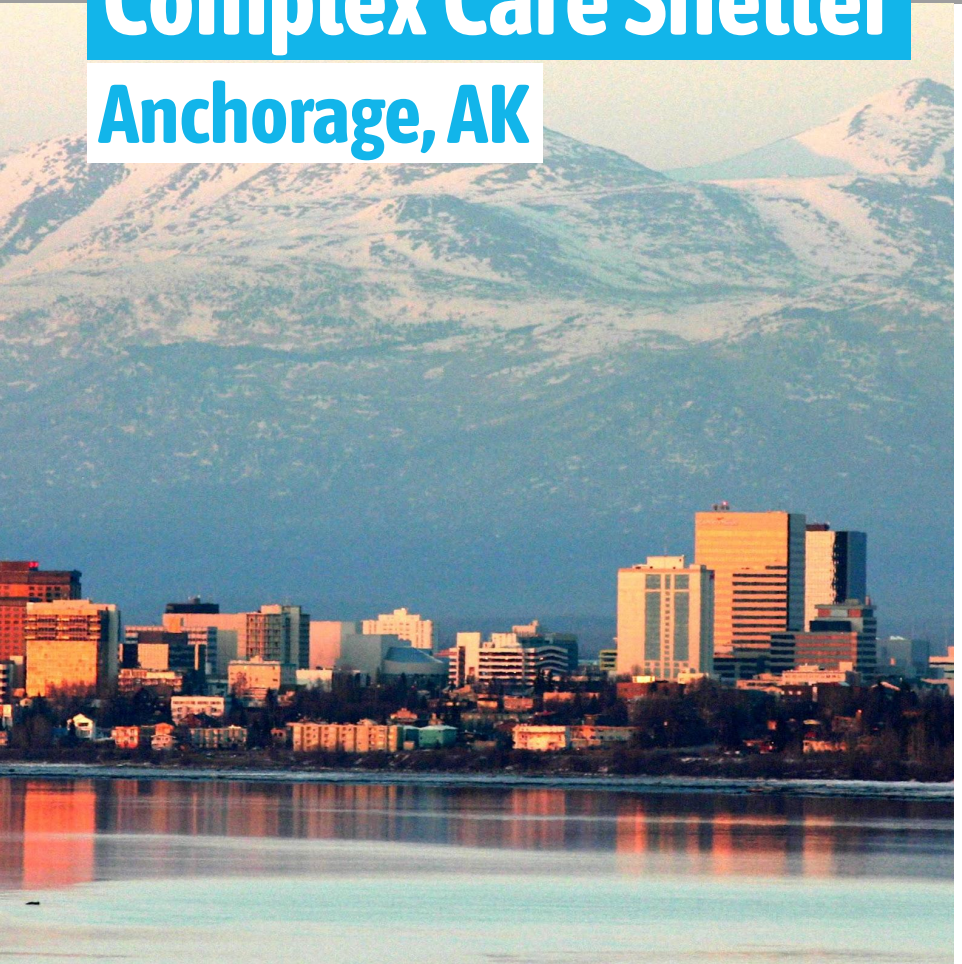
Data Sharing across Healthcare and Homeless Systems

Washington County, OR

The community signed and executed a **data sharing agreement between Washington County (homeless CoC), Kaiser Permanente and Providence Health**. Then they added payers serving the population (HealthShare & Care Oregon) This allows cross sector case conferencing for individuals prioritized by both homeless response and healthcare.

Complex Care Shelter

Anchorage, AK



Guests at the largest shelter have access to The Caring Clinic, which "provides free access to preventative care and treats acute illnesses, wound care & skin infections, injuries, cough/colds/flu, sore throats, and more."

The Southcentral Foundation provides staffing and support to Catholic Social Services, which runs the day to day shelter operations. The staff have the ability to escalate any healthcare issues that cannot be treated in-house, including referral to follow-up care, emergency services, or specialists.

Through targeted, preventative care, clinic staff aim to reduce calls for emergency services, ED visits, and eliminate the barriers to access that prevents many individuals from seeking healthcare.

Positive Patient Outcomes from Cross Sector Case Conferencing

Chattanooga, TN

"Health care is so much more than what happens within the walls of our hospital" - Betsy Kammerdiener (Chattanooga healthcare lead for HCxH Pilot)

Sharon suffered a stroke one evening while living in her car. Dallas, a community care worker at the hospital brought her story to the attention of the HCxH Pilot Case Conferencing.

Sharon has been housed for over eight months. She gets needed medical supplies brought to her home and has access to services and assistance through insurance that also helps pay for her groceries.

Sharon's health issues continue but she has a home to return to and a safe place to recover. Most importantly, one of her biggest health needs, housing, has been fulfilled.

Cross City Collaboration generates new possibilities

Sacramento, CA

A strong partnership was built between Sacramento Steps Forward (CoC) and Kaiser Permanente, Sutter, Dignity CommonSpirit and UC Davis Health Systems.

Over the course of the pilot the team implemented several initiatives impacting the population:

- Development of a Funders Collaborative to pool Community Benefit dollars and attract additional funders into collaborative investments
- Development of data sharing agreements
- Development of an ED Navigator role linked to the HRS
- Exploring cross sector case conferencing
- Engagement in re-design of the Coordinated Access System

Scaling Recuperative Care and Exploring Discharge Planning

Bakersfield, CA

Collaboration between the health systems and the homeless response system resulted in identification of key needs for recuperative care and a discharge planning pathway between the health systems and the homeless response system.
Over the course of the pilot they accomplished:

- Opening 39 recuperative care beds in the community
- Opening a navigation center where agencies will co-locate for coordinated services
- Mapping of discharge processes for unhoused clients from each health system
- Care coordination meetings engaged with the key RCP providers
- Shelter resource guide completed

Questions/Discussion

Who is best positioned to serve as the coordinator for cross-system projects like these? Why?

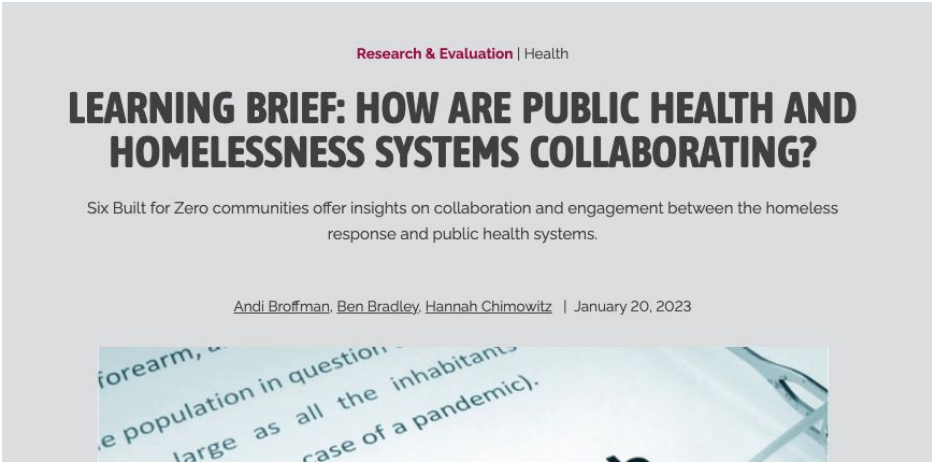
If you were to implement a health and homelessness project in your community, where would you start?

What common goals might a healthcare system and local homeless response system have?

With these “pilot” projects, it’s essential that we share and scale our learnings with the greater community.

What’s something you’ve seen be effective in sharing and scaling best practices in your own work & organization?

Learn more at Community.Solutions



Meg: marsenault@community.solutions
Lauran: lauran@hc2strategies.com