
Learning Session 2024:
Health & Homelessness - Collaboration
Across Systems

Introductions

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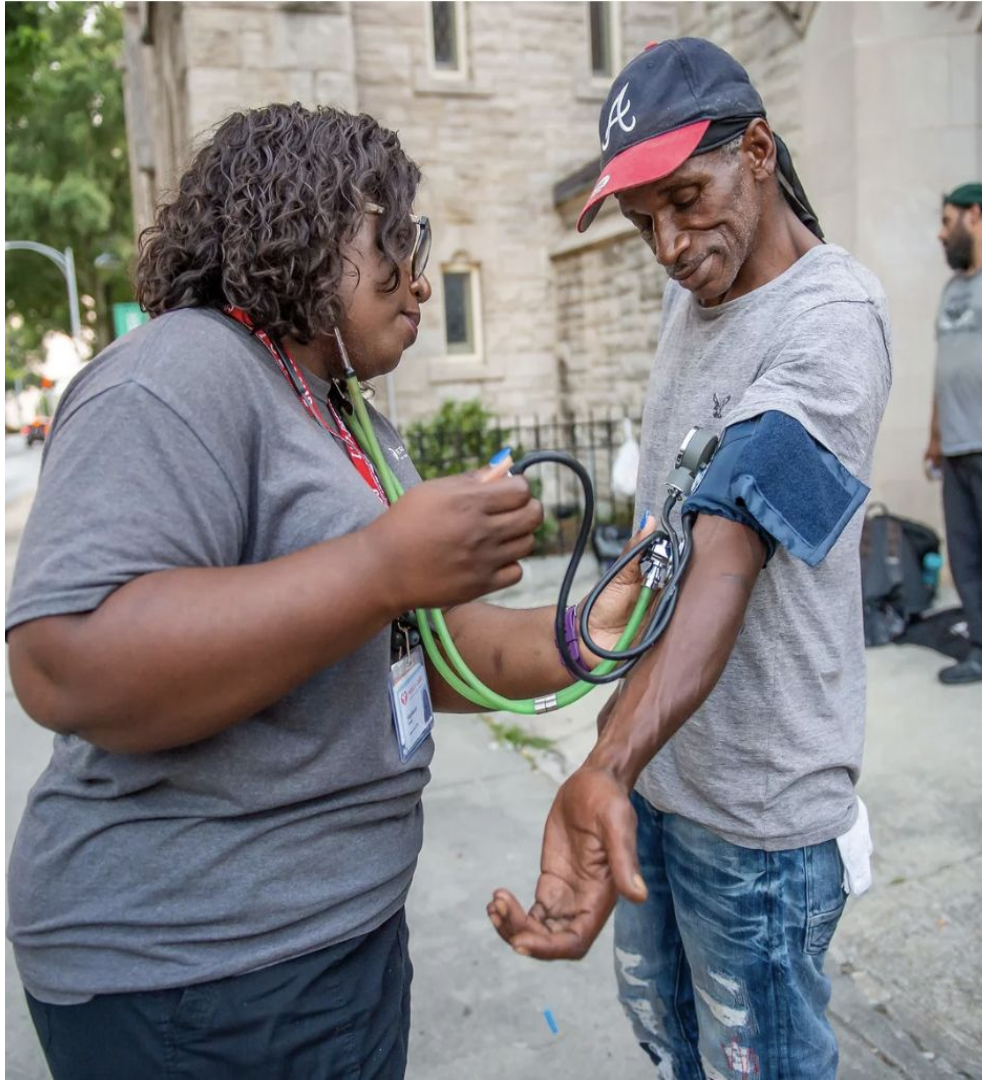
Why **Health & Homelessness** cross-sector projects are critical

Housing = Health

- PEH have significantly higher rates of mortality and reduced life expectancies
- Rate of several chronic conditions are significantly higher among people with a history of homelessness
- PEH visit emergency departments at higher rates than the overall population & have longer average hospital stays
- PEH are at an elevated risk of experiencing infectious disease, mental illness, and/or substance use disorders



Health Equity

Everyone should have the same opportunities to be as healthy as possible.

Within a population of people experiencing homelessness, there are health disparities along identity categories:

- Race and ethnicity
- Gender, gender identity and expression
- Sexual orientation
- Age

Consider:

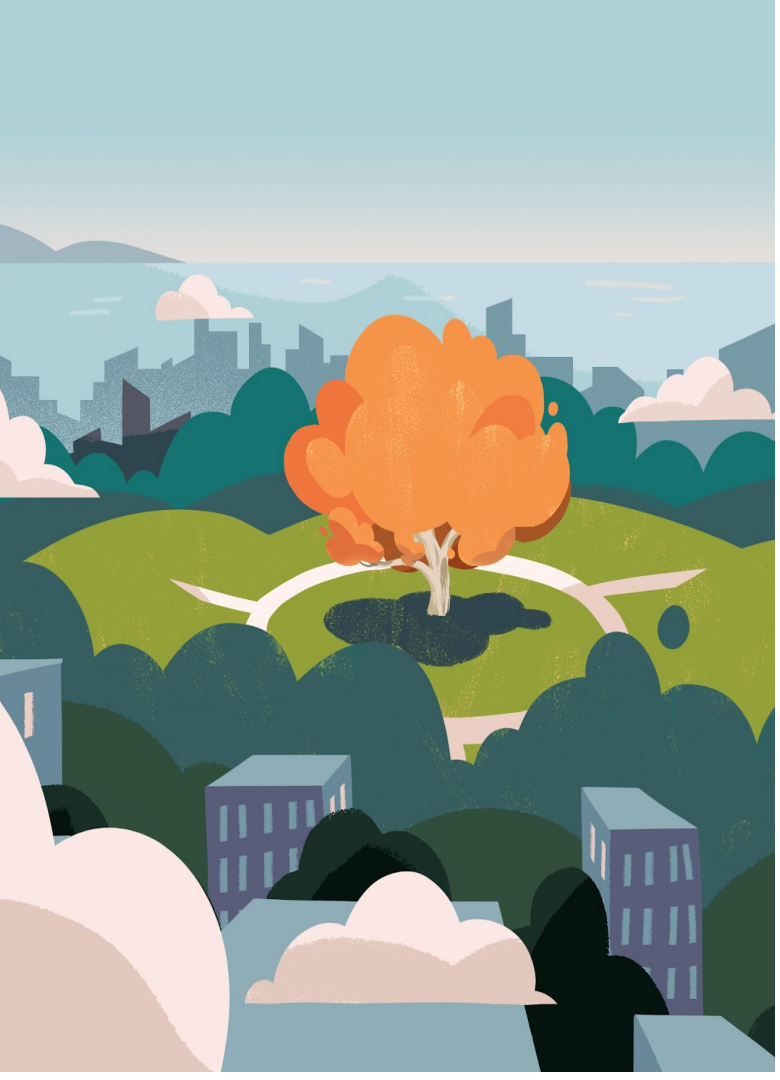
- How does bias show up in the work to achieve health equity?
- What is the historical context for health disparities?
- How might your own bias show up in the work to achieve health equity

"The system is perfectly designed to get the results that it gets"

Health & Homelessness
At Community Solutions

Healthcare and Homelessness

Our Aim: Identify the most meaningful, measurable and transformative role health care can play in ending homelessness



Healthcare x Homelessness

Current focal communities:

- Sacramento, CA
- Washington County, OR
  Chattanooga, TN
- Anchorage, AK
- Multnomah, OR Clackamas, OR

- Current health systems:
  Providence, Kaiser Permanente, Common Spirit

Healthcare x Homelessness Pilot Initiative

- Identify the role that healthcare can play in creating system change
- Test interventions/ways of working across systems that have the greatest impact
- Demonstrate relationship between health and housing for individuals
- Establish sustainable collaboration between health and homeless response systems

Public Health x Homelessness @ CS

Our Aim:

By July 31, 2026, produce replicable models for Public Health Agencies to measurably contribute to a system that can reduce homelessness.

Public Health x Homelessness @ CS

Our How:

Coordinated Pilot with State Health Departments across the U.S.

Launching Harm Reduction and Substance Use TA for select communities in 2025

What these **cross-sector collaborations** can look like

Keys to Building Partnerships

1. Spend time learning about each other's systems
2. Build commitment with leadership
3. Establish early mechanisms for coordination and governance
4. Select one collaborative project to start

Cross Sector Case Conferencing

Case Conferencing is:

- Used in the homelessness response system
- Brings together providers to problem solve and connect clients to appropriate housing supports.

Cross-sector case conferencing:

- Homeless response system, health systems, and health plans participate in collaborative problem-solving
- Connect clients services to meet health and housing needs.

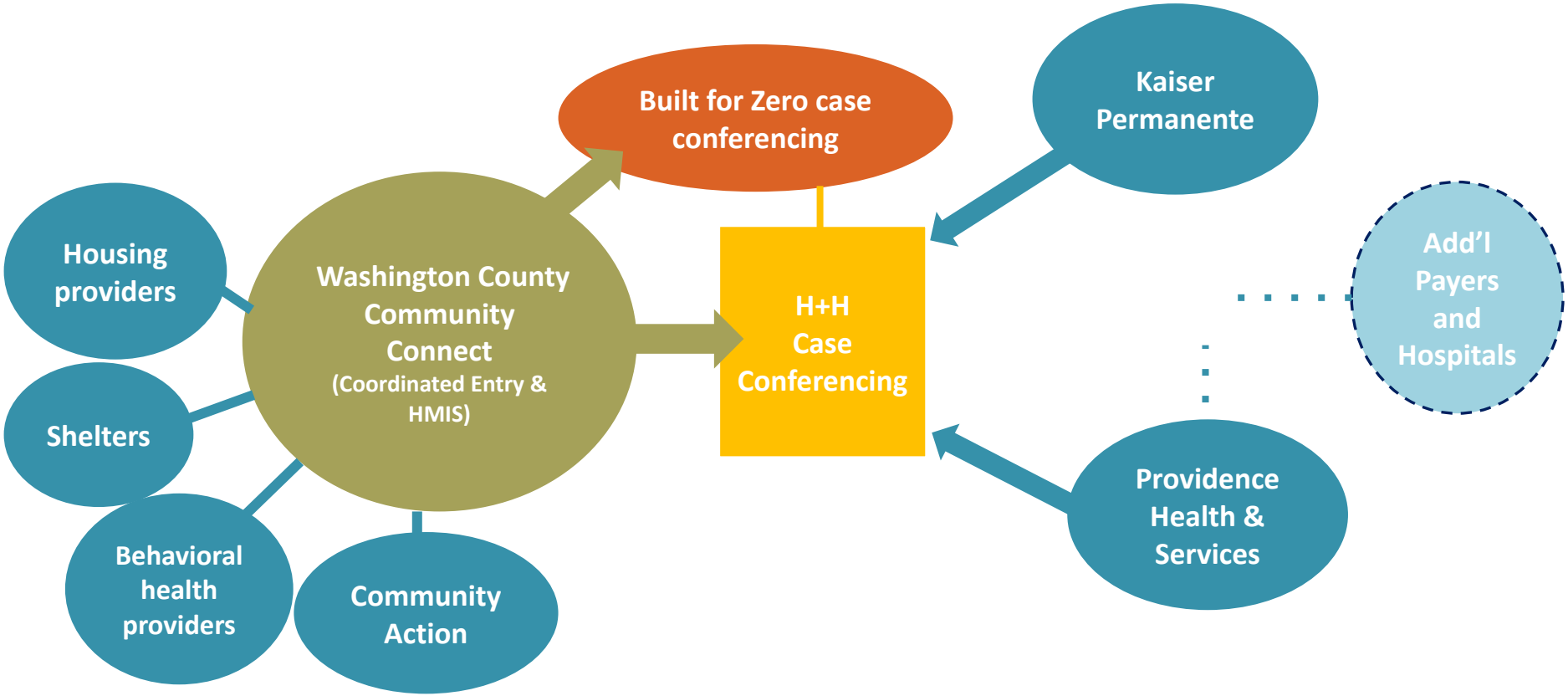
Community Examples

1. Cross-sector case conferencing & data integration
(Washington County, OR)

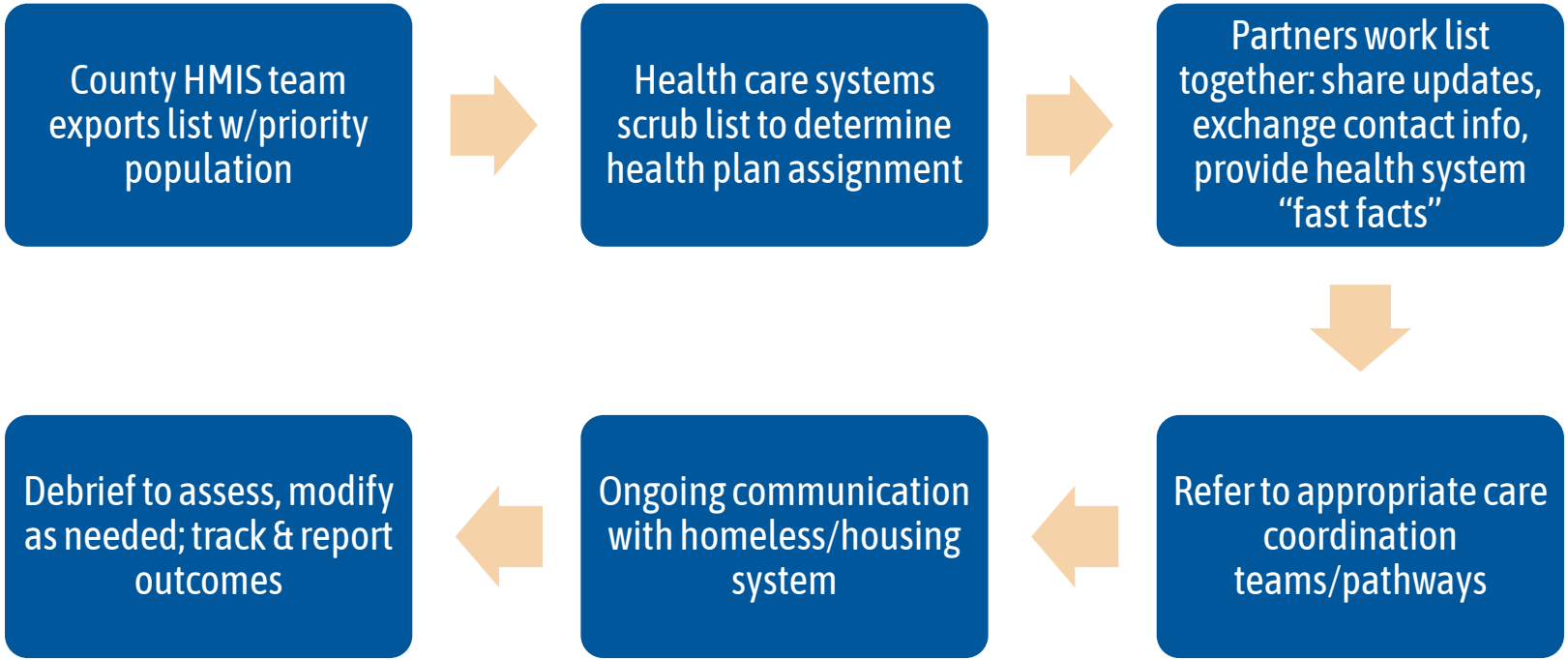
Community Example: Washington County, OR

- Connect with health services/resources, esp. primary care
- Establish housing plan and ongoing engagement
- Establish cross-sector communication and build relationships
- Achieve health stability to move toward stable housing
- Ongoing case management and care coordination

Community Example: Washington County, OR



Community Example: Washington County, OR



Community Example: Washington County, OR

87 Participants - Avg Length of Homelessness 4.8 years

15 housed after case conferencing

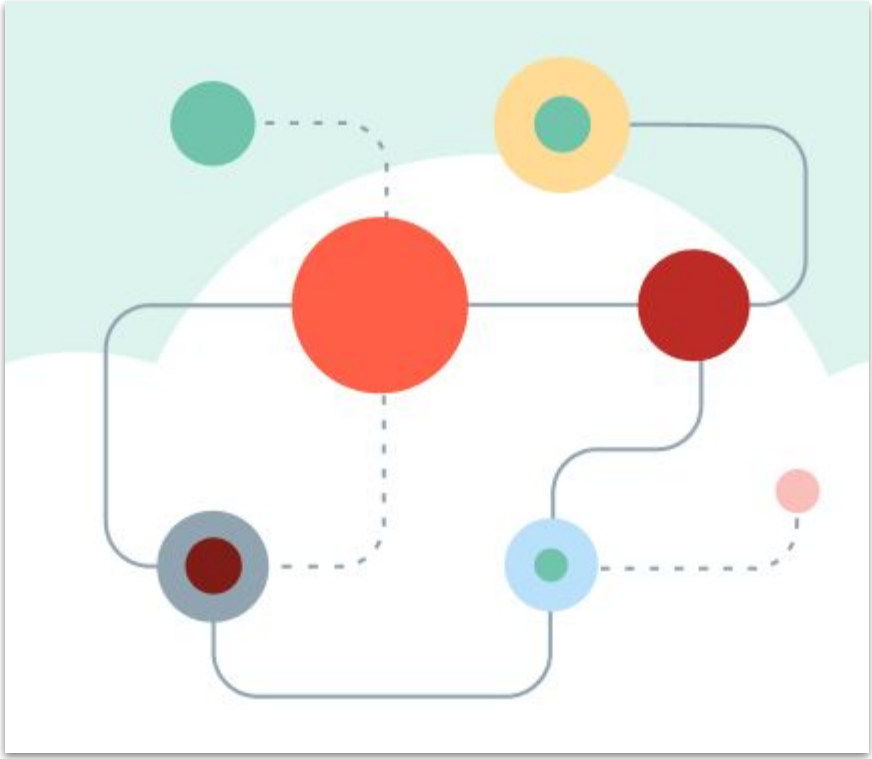
33 participants maintained housing

Data Integration: Why it Matters

1. Comprehensive understanding of who is experiencing homelessness and their housing and health needs

2. Healthcare workers can help build trust with people who have lost faith in the housing process

3. Healthcare and homelessness systems can pool resources to disrupt discharges to homelessness and meet the health and housing needs of people experiencing homelessness



Community Example: Washington County, OR

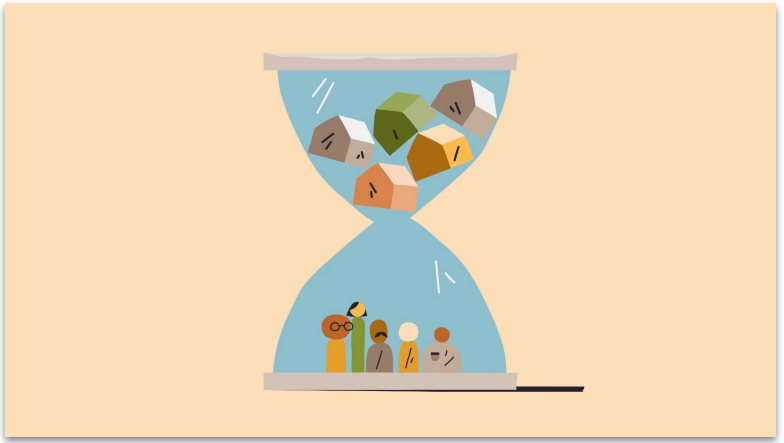
- The CoC-lead agency in Washington County proposed a DSA to health systems
- Health Systems received approval to sign an agreement with the CoC lead agency
- The CoC-lead agency provides individual-level data to these health systems
- Health systems have “read only” access to HMIS to view client level data

2. Medicaid Waivers & Health Related Social Needs

(Nationwide)

Medicaid Waivers & MCOs

- Medicaid 1115 waivers provide enabling conditions for collaboration and additional resources
- Medicaid 1915c waivers provide home-based community services



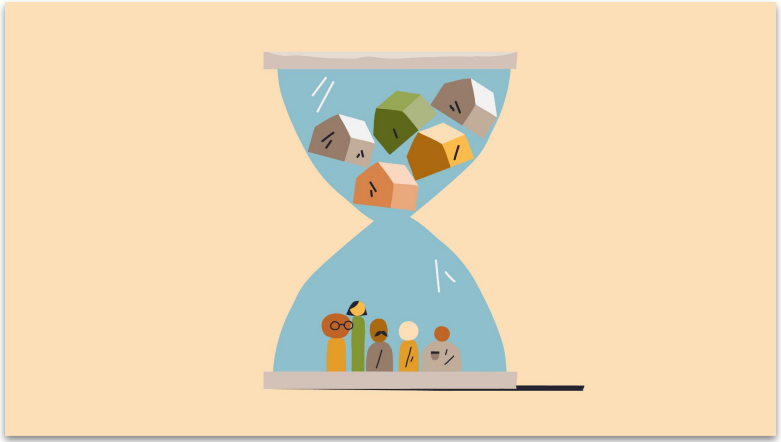
Community-Based Organizations

Health Plans

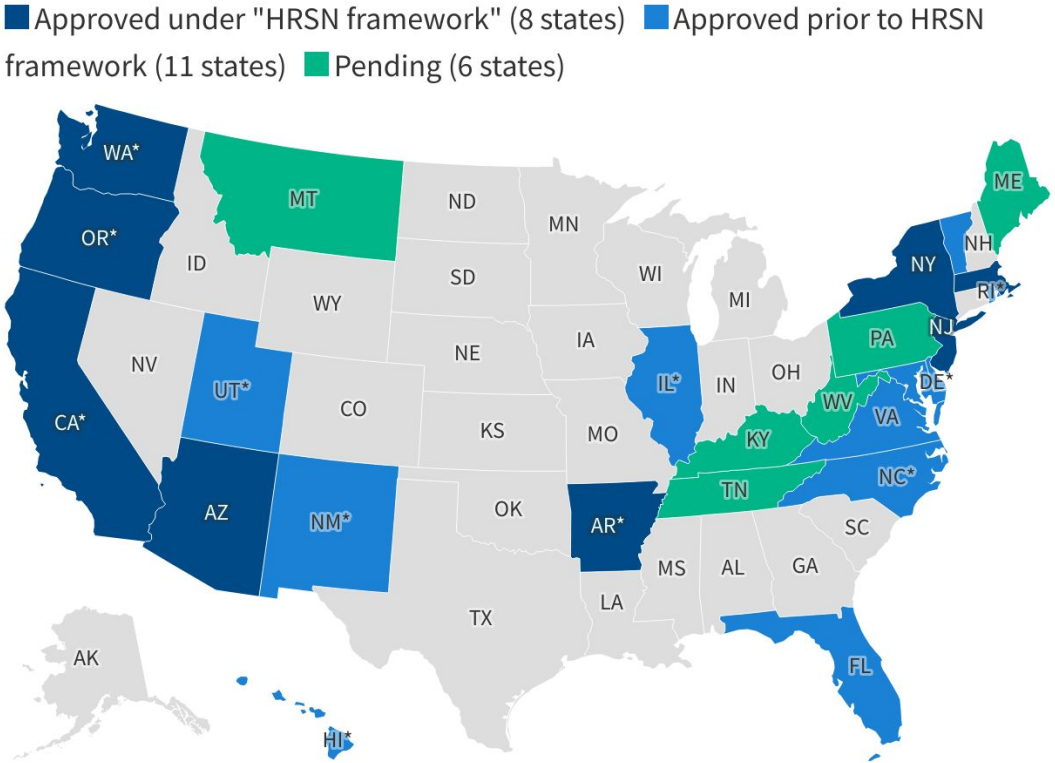
Health Systems and Providers

Health-Related Social Need Waiver Resources

1. Enhanced care management and community supports
2. Respite and recuperative care
3. Climate supports
4. Housing supports
5. Nutritional supports



Section 1115 Waivers with Provisions Related to Social Determinants of Health (SDOH), as of February 2024



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3. Medical Respite

(Chattanooga, TN & Bakersfield, CA)

Medical Respite

Types of Respite Care:

- Welcome Home; provides shelter & care for homeless individuals facing serious illnesses or end-of-life situations. They offer a community of hope and healing, partnering with local hospices for medical care.
- The Home Place is a residential facility that provides a stable, healthy environment and intensive case management services for individuals who are homeless with limited income who are living with HIV/AIDS.
- Coordination between the hospital and CoC begins when a patient is admitted and determined eligible for services.

Medical Respite

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:

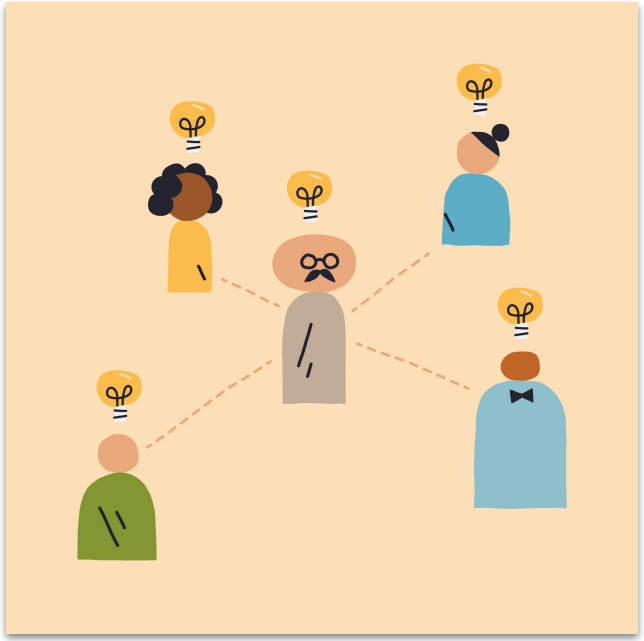
- Opening 39 recuperative care beds in the community
- Opening a navigation center where agencies will co-locate for coordinated services
- Mapping of discharge processes for unhoused clients from each health system
- Care coordination meetings engaged with the key RCP providers
- Shelter resource guide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

4. Medical Liaison Roles
(Sacramento, CA)

Liaison Roles

In building bridges across complex systems, **there's no singular way to connect and unlock the flow of data and information.**

One innovative example is to build out roles, either within a CoC or health system, **that can sit in both systems and serve as a liaison.**



Sacramento ED Navigator Pilot

- Initially the pilot attempted to stand up a centralized model to link patients who are chronically homeless and identified as regular users of the ED into the broader homeless system of care with HMIS access.

- This was tabled in favor of pilots within each health system using either new resources (Kaiser Permanente), pivoting existing ED navigators (Dignity and UC Davis Health), or issuing a new RFP (Sutter Health).

Sacramento ED Navigator Pilot

- Early results from the first three months of Kaiser Permanente's navigation program:
  - 25% reduction in ED utilization
  - 52% referred to pathways to housing through CAS
  - 18% referred for CAL AIM enrollment
  - 42% PCP connection - left with an appointment
  - Will connect to HMIS data to see long term housing outcomes

Sacramento Lessons Learned

- Ensure that this role does not overlap and therefore duplicate any other roles currently existing
- Ensure that liaison positions are able to connect people to the most appropriate hospital teams
  - ED clinicians
  - Inpatient Social Workers
  - Street medicine clinicians

Discussion

Discussion Questions

What ideas/thoughts did this presentation spark for you? What might you want to explore in your community?

Discussion Questions

What roadblocks or challenges exist that you'll have to overcome?

Discussion Questions

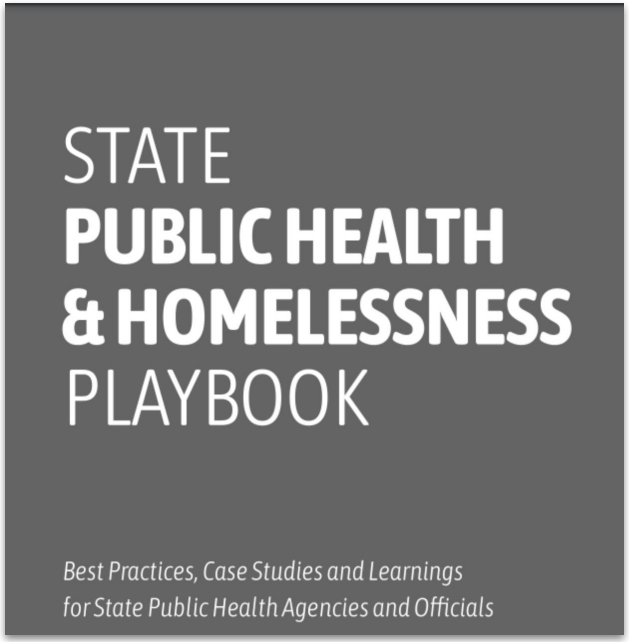
What's your organization's **ideal role**? What roles might other organizations and sectors best fit?

Discussion Questions

What's one action you can take immediately to get your project into motion?

Help us out!

Help us plan Harm Reduction & Substance Use webinars for Built for Zero Communities in 2025 via this **VERY** short survey!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Learn more!