Built For Zero.
COMMUNITY SOLUTIONS

Engagement between Local Public Health and Homelessness Response Systems

Built for Zero Baseline Survey: Results and Recommendations

October 2022

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Executive Summary

Although homelessness has long qualified as a public health crisis, local public health departments have not traditionally contributed to homeless response systems. Yet in the face of the COVID-19 pandemic, public health and homeless response sectors demonstrated remarkable will and capacity to partner to ensure people experiencing homelessness — and their broader communities — are safe. These partnerships emphasize the crucial role that public health can play in creating and sustaining systems designed to end homelessness at a population level.

Community Solutions' Built for Zero team now aims to understand the most strategic role for public health in driving reductions in homelessness and identify effective approaches for engaging public health agencies in this work. As part of this effort, an online survey was conducted to take stock of the extent and nature of partnerships across local public health and homeless response systems in Built for Zero communities in the U.S. The current report discusses findings from this survey.

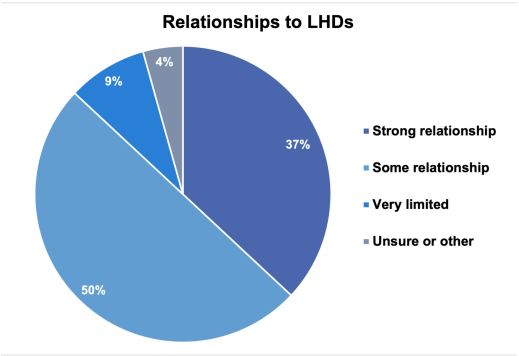
Methodology and Sample

Community Solutions surveyed Continuum of Care (CoC) and other local homeless response leaders across Built for Zero communities in the U.S. about cross-sector collaboration and working relationships with local public health entities. Nearly half of the invited community leads (46 out of 100) responded. Communities represented in our survey sample closely resemble all invited Built for Zero communities on community characteristics including geographic taxonomy,[1] region, and the racial demographics of populations experiencing homelessness.

Key Findings

Responses illustrated a range of engagement levels between local public health and homelessness response organizations. All communities (n = 46) reported cross-sector engagement in at least one form, but the extent of engagement varied across communities.

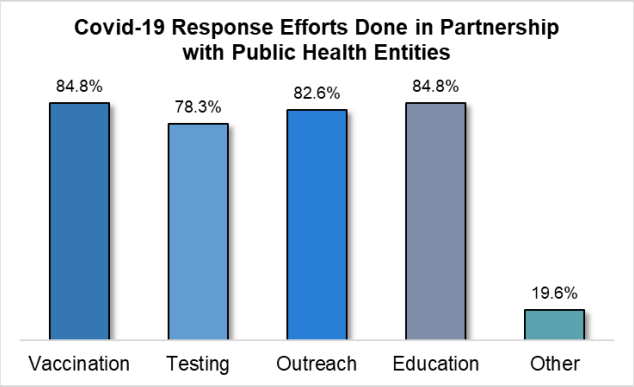
Homelessness response organizations in most communities have at least some relationship with their local health departments. Over a third (37%) of our respondents indicated that their organization has a strong relationship with their local health department. Yet some noted that these working relationships are often focused on select crisis issues, feel highly dependent on the individuals serving in key roles, and can become complicated when multiple public health entities overlap in a CoC's jurisdiction.

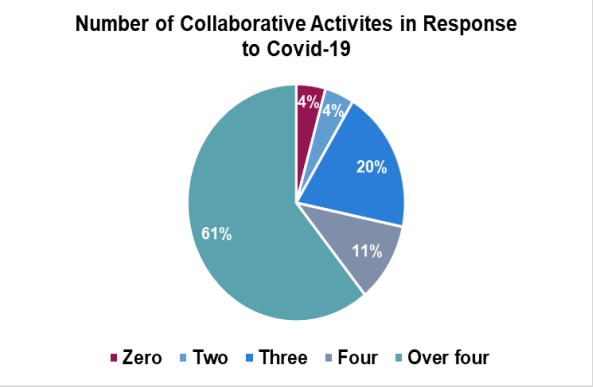


Local public health and homelessness response systems collaborated to respond to the COVID-19 pandemic in nearly every (95.7%) community.

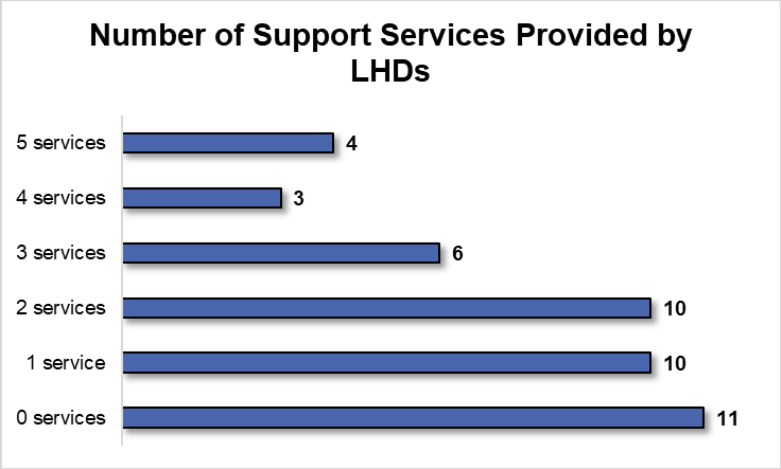
[1] We categorized respondents' communities along our Built for Zero community geographic taxonomy, which includes six categories: large city, midsize city, small city, suburban, rural, and state.

Respondents feel these collaborations opened lines of communication for relationship building and facilitated continued cross-sector partnership.





The number of support services related to homelessness provided by local health departments varies considerably across communities. A fourth of our sample (n = 11) indicated that their Local Health Department did not provide any of the five support services asked about (i.e., shelters, encampments, during the Point-in-Time count, mental health counseling, and medicaid/insurance challenges).



Common goals among local homelessness response and public health entities are rarely reflected in formal policies. Although half of the homelessness response organizations had set policies related to public health, a minority of respondents (26.7%) are aware of homelessness-related policies set by their local health department. Only seven respondents (15.2%) reported both.

Respondents frequently referenced healthcare systems or hospital partners in free-text responses, signaling ongoing confusion about the distinction between public health and health care among those working in homeless response systems.

Discussion and Recommendations

The Built for Zero team is developing an initial roadmap for local homelessness response systems and public health departments to forge effective partnerships that drive sustained, systematic responses to homelessness. We will test and refine this roadmap through future strategic work engaging public health agencies across a diverse set of Built for Zero communities. Our survey findings provide an initial understanding of the current nature and extent of cross-sector engagement between local public health and homelessness response systems in nearly half of the Built for Zero communities in the US and will inform ongoing discovery and future strategic work. Based on our results, we recommend the following:

- **Engage with Built for Zero community leads for further learning**. Free-text responses point to numerous setbacks, coalitions, and partnership models to unpack and explore in follow-up interviews.
- **Develop a deeper understanding of public health agencies' experiences and perspectives of cross-sector engagement.** Through interviews with local public health representatives in communities represented in the survey sample, the Built for Zero team can shed light on the unique and shared perspectives of engagement across both sectors.
- **Investigate the impact of community characteristics on partnership-building** across public health and homelessness response systems. Future research identifying and describing the community-level features that are consequential for cross-sector collaboration would be worthwhile.
- **Recruit communities across different levels of baseline cross-sector engagement for strategic Built for Zero work engaging local public health in homelessness response efforts.** Rather than exclusively targeting Built for Zero communities that are already demonstrating promising practices, including communities demonstrating different degrees of engagement between local homeless response and public health systems in Built for Zero communities would allow for inter-collaborative learning.

Introduction

In 2020, the US Department of Housing and Urban Development estimated that over 1.2 million people experienced homelessness in a shelter or transitional housing facility over the course of the year. As this estimate does not include people experiencing unsheltered homelessness, homelessness likely impacts significantly more people in the U.S. annually. For this sizable segment of the national population, homelessness functions as a powerful social determinant of poor physical and mental health. People without safe and stable housing are disproportionately burdened with high rates of acute, chronic, and infectious diseases, resulting in widespread community- and population-level impact.

Reducing and ending homelessness presents large-scale, systemic challenges that demand solutions to match. Homelessness needs population-level interventions, which public health is best at leading to impact policy and practice. While homelessness has long qualified as a public health crisis, the COVID-19 pandemic highlighted this stark reality, as people experiencing homelessness were identified among those at the highest risk for infection, transmission, and death.

According to Dr. Sandro Galea, the dean of the Boston University School of Public Health, three criteria must be met for an issue to be considered a public health crisis. The problem must affect a large number of people, threaten health over the long term, and require large-scale solutions. As evidenced above, homelessness clearly meets all three.

As homelessness becomes increasingly recognized as a public health issue, the next challenge is to leverage this consensus and engage public health agencies to play a meaningful role in contributing to homeless response systems. Amid growing recognition of the need for cross-sector collaborations between public health and homelessness response systems, the Built for Zero team is currently developing an initial roadmap for local homelessness response systems and public health departments to forge effective partnerships that drive sustained, systematic responses to homelessness. We will test and refine this roadmap through future strategic work projects engaging public health agencies across a diverse set of Built for Zero communities.

The first step in this work is strengthening our understanding of the current climate around public health and homelessness. Our initial learning serves as an important foundation, as very little is known about the barriers and facilitators to implementing partnerships between these two sectors and the conditions that need to be in place to drive reductions in homelessness. This discovery phase has involved desk research and conversations with community leaders and public health stakeholders. Our goals were to document common challenges and bright spots for cross-sector relationship building, and identify extant partnership models and methods for measuring public health progress.

We also sought to assess the current level of engagement between public health and homeless response systems across Built for Zero communities. Through an online survey, we have been able to take stock of the extent and nature of partnerships across local public health and homeless response systems in nearly half of the Built for Zero communities in the U.S. In this report, we describe the survey methodology and findings, as well as recommendations for future directions.

Methodology

We surveyed Continuum of Care (CoC) and other community leaders across Built for Zero (BFZ) communities in the U.S. to develop an understanding of the current level of engagement between public health and homeless response systems (HRS) in the communities we work with. We excluded a small number of BFZ communities, including one neighborhood and five subregions of a state involved in our Large-Scale Change initiative. CoC and other community leaders from the remaining 100 BFZ communities in the U.S. were invited to complete the online survey hosted in Alchemer.

To establish common understanding, we provided respondents with brief definitions of public health, public health systems, and local health departments (LHDs) at the start of the survey and at the top of each new survey page. The survey included questions about the presence and engagement of public health representatives on CoC boards, the existence of any local work groups including representatives from HRS and public health entities, activities undertaken in partnership in response to the COVID-19 pandemic, support services provided by LHDs, working relationships with LHDs and other public health entities, and cross-sector policy practices. The full survey is included in Appendix A.

Initial email invitations were sent on September 6, 2022, and reminder emails were sent to community leads who had not completed the survey approximately one week later. In an effort to get more representation from BFZ communities in the Pacific region, suburban communities, and communities in early Built for Zero stages, we also asked BFZ coaches working with select communities who had not responded to the survey to reach out to their contacts and encourage participation approximately one week before data collection closed. Survey data collection ran through September 23, 2022. Survey respondents were provided with a $25 Visa gift card in appreciation of their time.

Limitations

Our survey methodology and data present a few important limitations. Our survey was limited to homeless response leaders in BFZ communities, who likely have similar experiences and values as part of their work with BFZ. This sampling bias limits the generalizability of our findings to all CoCs in the U.S. Our findings also only speak to under half of the BFZ communities in the U.S., and this sample size limited our ability to make meaningful comparisons across different types of communities. Moreover, these data reflect the perceptions of a single homeless response leader within each community and rely on an individual point of view to represent community-level homeless response systems. Our findings also capture one side of cross-sector engagement and do not provide insight into local public health entities' experiences and perceptions. Finally, as illustrated in a multitude of free-text responses, respondents often conflated healthcare with public health.

Results

Survey Respondents

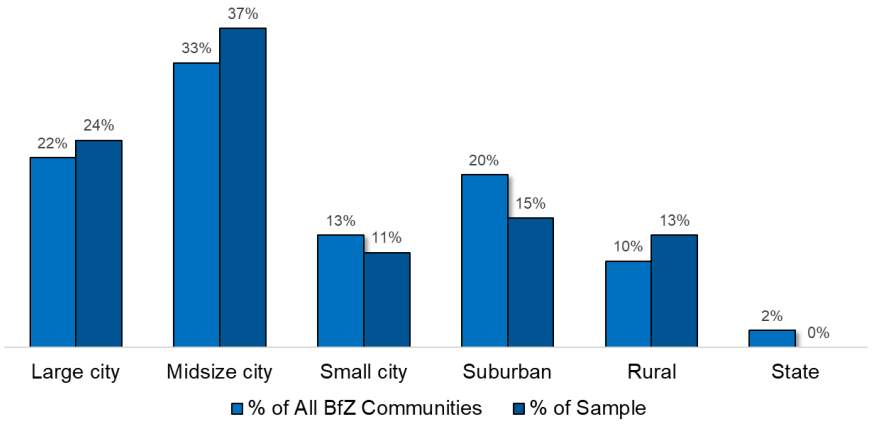
Community leaders from 46 Built for Zero communities responded to the survey. The majority of respondents (n = 31) work within CoCs, while nearly a third represented community

organizations (n = 15). Respondents held a variety of leadership positions; our sample included executives and/or directors (n = 23), program managers (n = 8), program or CoC coordinators (n = 6), administrators (n = 2), and those serving in other leadership roles (n = 6).

Community Characteristics

Respondents represent communities across stages of BFZ intervention work, geographic contexts, and national regions. Communities represented in our sample span early (n = 11), middle (n = 13), and later (n = 17) stages of BFZ intervention work.[2] A small number of respondents (n = 5) represented communities who are not currently engaged with BFZ. Our sample consists of community leaders from 17 midsize cities (37%), 11 large cities (23.9%), 7 suburban communities (15.2%), 6 rural communities (13%), and five small cities (10.9%). Respondents represented communities in the following Census Regions: Rocky Mountain (n = 8), Southeast-Caribbean (n = 7), Pacific (n = 6), Northwest (n = 6), Mid-Atlantic (n = 6), Midwest (n = 5), Great Plains (n = 3), Southwest (n = 2), New England (n = 2), and New York-New Jersey (n = 1). While some geographic categories and regions were slightly to moderately over- or under-represented in our sample, these distributions are fairly similar to the geographic and regional profile of the 100 BFZ communities invited to participate.

Geographic Distribution of Sample Versus All Invited BFZ Communities

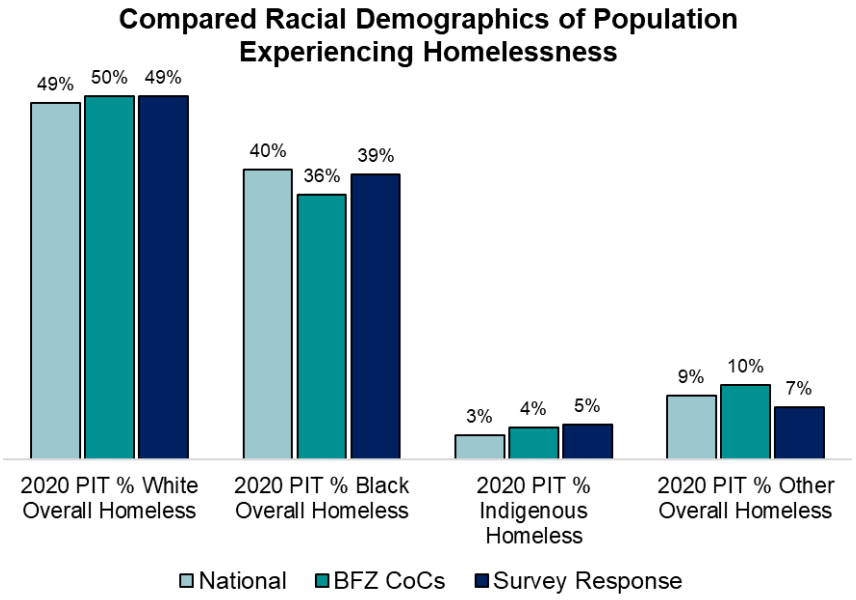


We utilized the 2020 Point-in-Time (PIT) count data to compare the racial distribution of the population experiencing homelessness in the communities represented in our sample to both the national and BFZ averages. This data, as many others have noted, has many limitations given the variability of counting methodologies across communities. However, it is the only available dataset that provides an indication of racial diversity in the homeless population at a community level, and relying on other community-level datasets on the general population (e.g., the American Community Survey) would be problematic given the rates of disproportionality of homelessness among Black and Indigenous persons.

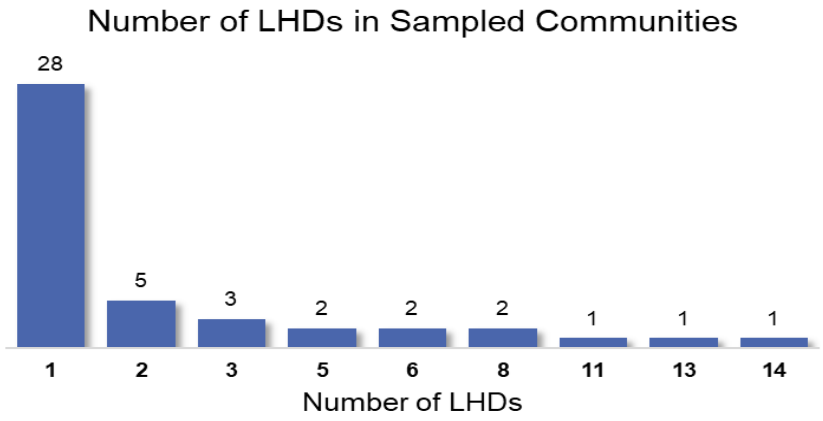
As there are communities in BFZ that are not considered full CoCs and we do not have the PIT data for these communities readily available, we omitted those communities from the BFZ and survey respondent totals in our comparison (BFZ n = 25; Survey Respondents n = 9).

[2] Each community's stage in BFZ intervention work was determined based on the BFZ intervention they are actively involved in.

We found similar rates of Black, White, Indigenous, and "Other Race" categories among the populations experiencing homelessness across communities in our survey sample, all BFZ communities, and the nation.



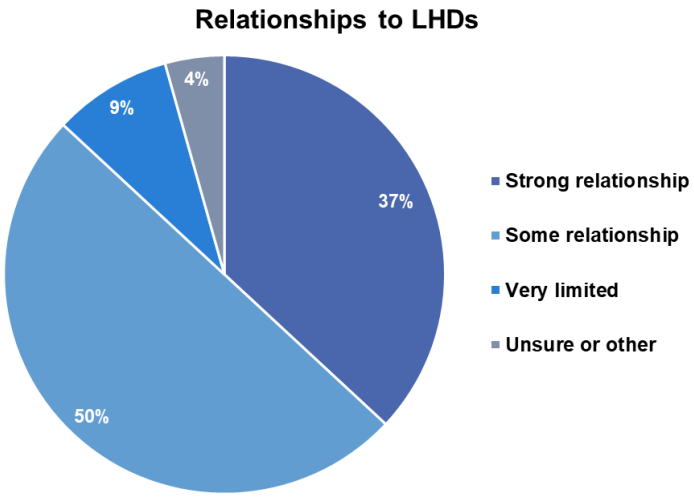
Lastly, by comparing the geographic overlap between Continuum of Care and Local Health Department geographic catchment areas using ArcGIS, we assessed the number of LHDs in our sample of communities and found that over half of the communities represented in our sample (62.2%, n = 28) have a single LHD within the CoC's jurisdiction. A smaller number of communities overlapped with two LHDs (11.1%), three to six LHDs (15.6%), or eight or more LHDs (11.1%).



Relationships between Local Public Health Departments and Homelessness Response Systems

The majority of community leaders in our sample reported that their organization has either a strong or some relationship with their LHD. While a number of respondents indicated

this relationship is very limited (n = 4), no one reported their organization has no relationship whatsoever with their LHD.



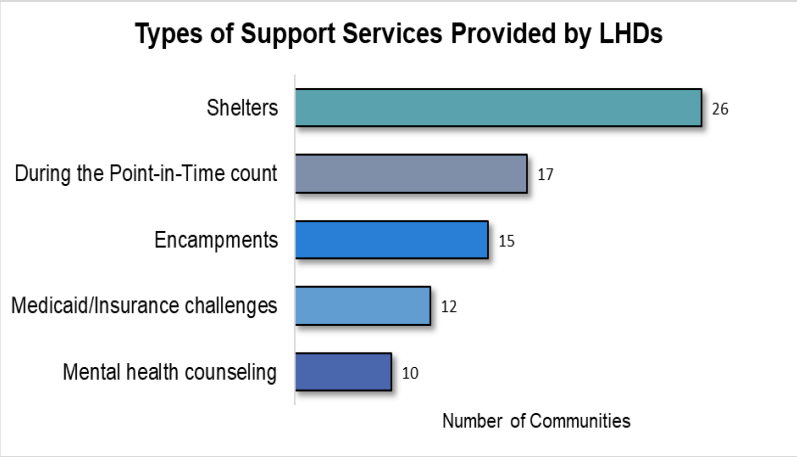
Fifteen respondents provided additional comments about the relationship between their organization and LHD. Multiple respondents described receiving support and engagement from LHDs on select public health issues, such as COVID-19 and Monkeypox. Two respondents noted that their ability to develop and maintain relationships with LHDs was contingent on the specific individuals serving in key roles. Four respondents mentioned jurisdictions of public health responsibility, which they considered an important factor in the ability to develop strong relationships with public health departments. Across communities, it appeared that engaging with multiple public health departments across municipalities can prove challenging.

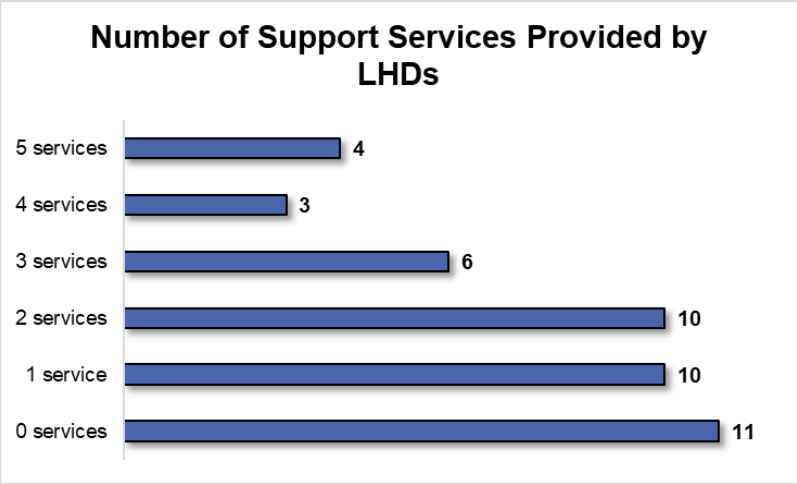
A few respondents detailed noteworthy instances of cross-sector collaboration. For instance, nurse practitioners from the Fairfax Health Department's Homeless Healthcare Program are assigned to the main homeless shelters and drop-in centers, where they provide community-based care and collaborate on outreach. The Phoenix/Mesa/Maricopa County Regional lead relayed that the Public Health Department is making efforts to gather HMIS data.

Support Services Provided by Local Health Departments

We asked community leads to indicate which support services their LHD provided in five key areas: shelters, encampments, during the Point-in-Time count, mental health counseling, and medicaid/insurance challenges. The most common support services provided were related to homeless shelters, the Point-in-Time count, and encampments.

There was considerable variability in the number of support services provided by LHDs within communities. Whereas most communities reported receiving one or two support services from their LHDs, a fourth of our sample (n = 11) indicated that their LHD did not provide any of the five support services, and nearly a third (n = 13) reported receiving three or more services from their LHD. The total number of communities reporting each type of support service from LHDs is depicted below.

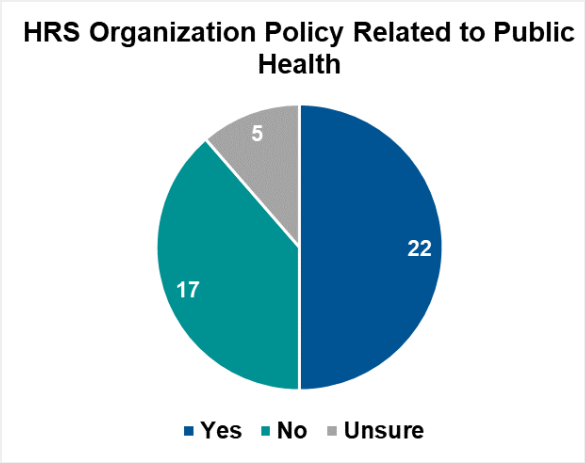


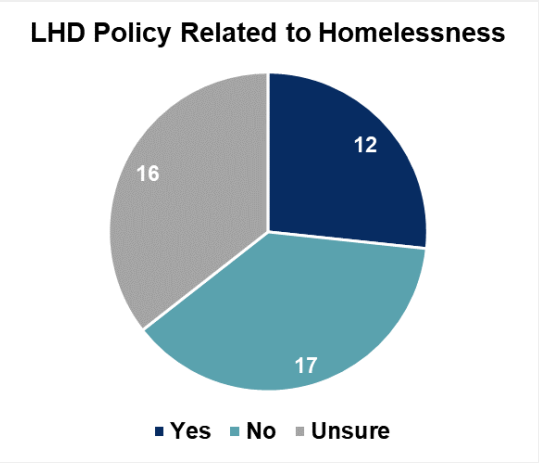


Cross-Sector Policies Among Local Health Departments and Homeless Response Systems

When asked whether their LHDs had set policies related to homelessness, seventeen respondents (37.8%) reported their LHD had not set such policies and sixteen (35.6%) were unsure. Out of the twelve respondents (26.7%) who shared their LHD had set policies related to homelessness, nine provided comments describing these policies. LHD policies most often pertained to COVID-19 protocols, shelters, and encampments. Community leads in two communities reported that multiple staff members in their LHDs are dedicated to homeless outreach and engagement.

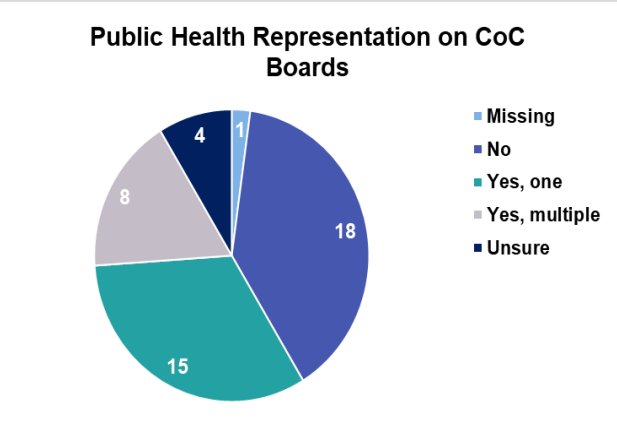
Conversely, half of the respondents (n = 22) indicated their organization had set policies related to public health. Seventeen respondents (38.6%) reported not having public health-related policies, and five (11.4%) were unsure. In describing extant policies, thirteen respondents described policies related to COVID-19 and Monkeypox. Others mentioned policies addressing extreme heat, prohibiting encampment disruptions unrelated to public health or safety, or detailing data collection and sharing protocols.

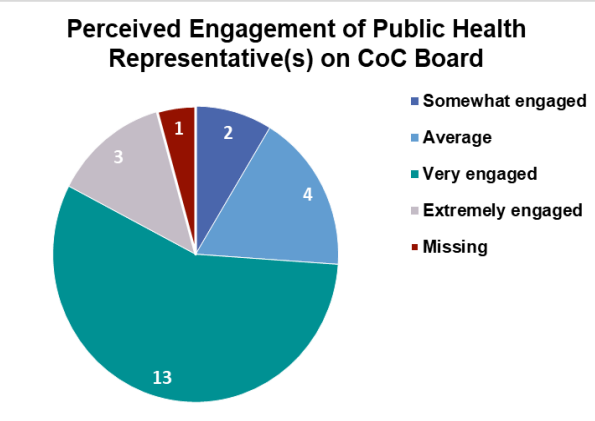




Representation from Public Health on Continuum of Care Boards

CoC Boards in half of the communities represented in our sample (n = 23) include one or more representatives from public health as board members. When asked to rate the level of engagement among CoC board members representing public health, respondents most often indicated these individuals are very engaged on the board (56.5%).



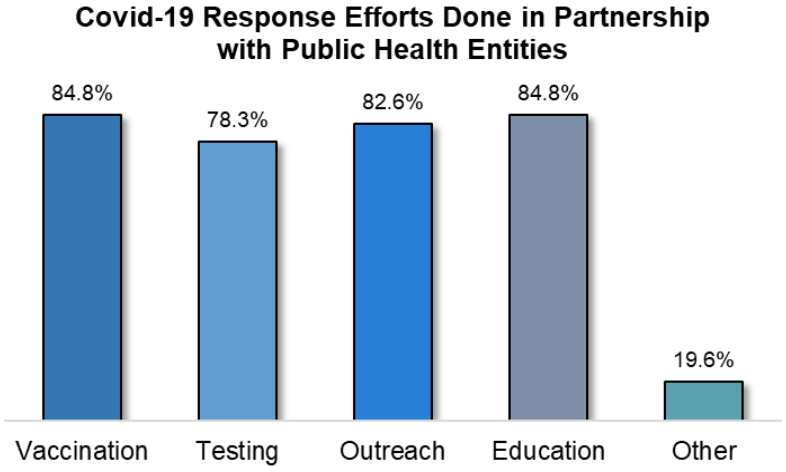


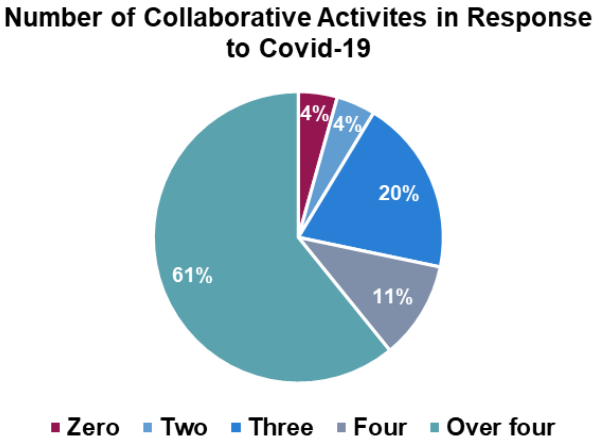
Cross-Sector Collaboration between Public Health and Homelessness Response Systems in Response to COVID-19

As the COVID-19 pandemic created an urgent need for collaboration between public health and homelessness response systems, we asked respondents if their organization worked with public health partners to respond to the pandemic and if so, which activities they undertook in partnership. Nearly all respondents (n = 44, 95.7%) reported collaborating with public health partners in response to the pandemic. All 44 of these respondents agreed that engaging with public health partners in response to the COVID-19 pandemic has allowed for continued collaboration across sectors.

As shown below, the majority of respondents reported collaborating with public health partners on vaccination, education, outreach, and testing efforts. Three fourths of these

respondents (n = 33) indicated their organization partnered with public health entities on four or more activities in response to the pandemic.





Respondents were given the opportunity to elaborate on how engaging with public health partners in response to the COVID-19 pandemic has allowed for continued collaboration across sectors, and twenty five respondents provided comments. Two of these comments mentioned either capacity constraints or difficulties in maintaining momentum for partnership activities. Otherwise, most respondents described doors opening for communication and collaboration at the onset of the COVID-19 pandemic, which facilitated invaluable cross-sector learning and relationship building. Numerous respondents expressed that this foundation can now be leveraged to expand partnerships on other efforts.

Other Partnerships Between Local Public Health and Homelessness Response Systems

Thirty-three respondents (71.7%) indicated that they knew of work groups, task forces, or other types of committees in their community that include representatives from the HRS and public health system. When asked to specify how frequently these groups meet, the majority of community leaders selected monthly (n = 13), every few months (n = 8), or other (n = 9). Thirty-two respondents described the nature of these work groups in free-text responses. Three of these responses referred to Built for Zero improvement teams.

Though a number of respondents described healthcare-focused committees in their free-text comments, others highlighted groups including representatives from public health specifically. The community lead in San Diego described one such committee:

> "The CoC has a committee on Health and Homelessness - the purpose [is] to work on the intersection of health services, both private and public, and the homeless system. It included FQHC [federally qualified healthcare center], Hospital Association, Hospital representatives, Health plan representatives, homeless service providers (shelter, outreach, and housing), and county public health."

Lastly, forty-four respondents (95.7%) indicated that their organization has a working relationship with other entities in the community that deliver public health services. A number of open-ended responses describing these relationships revealed that respondents were thinking about partnerships with hospitals, healthcare systems, or individual healthcare providers. Despite this seeming confusion regarding which entities provide public health services, many community leaders reported working relationships with churches or faith-based organizations, non-profits, community-based organizations, and governmental entities.

Cross-Sector Funding Efforts

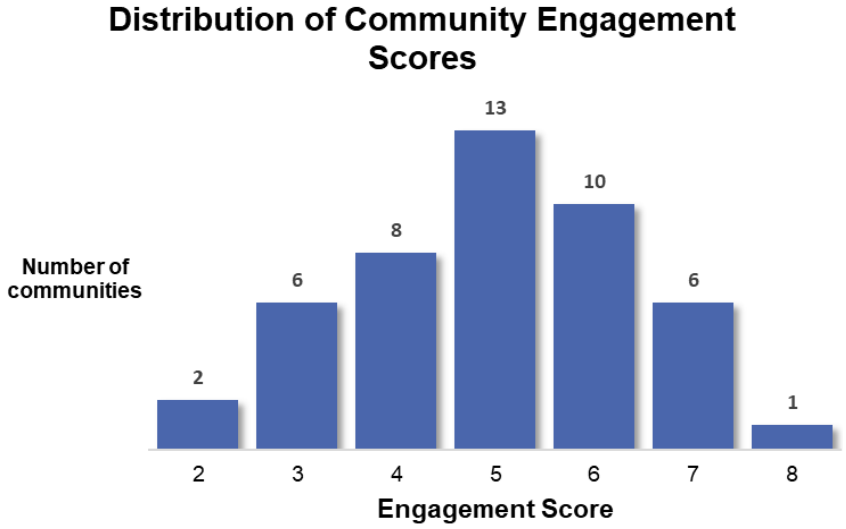
Seventeen respondents (36.9%) reported that their organization had previously partnered with a local public health entity to apply for funding. Once again, a number of respondents provided free text responses that revealed they were thinking about a healthcare entity, rather than a public health partner. Nevertheless, multiple respondents reported their organization had applied for funding either from public health entities or in partnership with their LHD.

Baseline Levels of Cross-Sector Engagement

In order to capture the level of engagement between HRS and local public health entities within communities and understand the range of engagement across our sample, we created an 'engagement score' measure. It is important to note that this engagement score is by no means a standardized metric; it is simply our best estimate of engagement across public health and homeless response sectors. This measure is considerably limited considering we relied on binary indicators, respondents sometimes referenced partners in healthcare (rather than public health) in free-text responses, and our data does not capture all possible forms of cross-sector engagement. Our hope is that this information can be used to help guide future learning and inform the development of a more rigorous approach to quantifying cross-sector engagement.

To create this composite score, we allocated one point for each of the following: 1) one or more representatives from public health serve as CoC board members, 2) one or more work groups or other committees exist that includes representatives from HRS and public health, 3) there was cross-sector collaboration on one or more activities in response to COVID-19, 4) the respondent's organization has set a policy related to public health, 5) the respondent's LHD has set a policy related to homelessness, 6) the LHD provides one or more support services that was asked about, 7) the respondent's organization has a working relationship with another entity in their community that delivers public health services, and 8) the respondent's organization has partnered with a public health entity to apply for funding. Points were summed for each community.

With a possible range from 0 to 8, the average community engagement score among our sample was 4.98 (SD = 1.44). As shown below, engagement levels are normally distributed. Roughly a third of the sample reported lower (Score 2-4; 36.4%), average (Score of 5; 29.5%), or higher (Score 6-8; 38.6%) levels of engagement with local public health entities.



Discussion and Future Directions

In the face of the COVID-19 pandemic, local homeless response and public health systems demonstrated remarkable will and capacity to partner to ensure people experiencing homelessness — and their broader communities — are safe. These partnerships emphasize the crucial role that public health can play in creating and sustaining systems designed to end homelessness at a population level.

In the future, Community Solutions will nurture collaborative initiatives between public health and homelessness response systems across a diverse set of BFZ communities. Public health will be invited to join local homelessness response teams in the BFZ network, where they will be engaged in building a collaborative, data driven system to measurably reduce and end homelessness at the population level. As we strive to understand the most strategic role for public health in driving reductions in homelessness and identify effective approaches for engaging public health agencies, our survey findings serve as a significant part of our discovery work.

Responses provide us with a baseline understanding of the nature and extent of cross-sector engagement between local public health and homelessness response systems across nearly half of the BFZ communities in the U.S. The results also point to numerous avenues for further learning and can inform strategy. To start, we will engage with a cohort of BFZ community leads through follow-up interviews that dig deeper into their unique partnerships and experiences working with local public health and illuminate bright spots within BFZ communities for widespread learning and guidance. Other potential future directions include the following:

1. **Engaging with public health agencies in select communities and comparing perspectives.** As our data only speak to the HRS side of cross-sector engagement, follow-up interviews with local public health representatives can shed light on both unique and shared perspectives of cross-sector engagement among public health agencies as compared to HRS leads.
2. **Investigating the impact of community characteristics on partnership-building across public health and HRS.** Free-text survey responses indicate that governance arrangements can impact relationships between local public health and HRS. There are likely countless other community-level features that are consequential for cross-sector collaboration, but our sample size limits our ability to draw inferences on their influence.
3. **Integrating survey and follow-up findings into our roadmap** for local homelessness response systems and public health departments to forge effective partnerships that drive sustained, systematic responses to homelessness.
4. **Develop methods to address widespread confusion regarding the definition of public health among HRS and the general public.** Our findings illustrate that providing brief, written definitions was not always effective in differentiating public health from other health-focused sectors. Community Solutions' Communications Team can continue to distribute engaging, straightforward materials to educate the public and BFZ partners.

Appendix A: Full Survey

Please refer to these definitions throughout the survey.

While there are many definitions of public health, we want to make sure we're on the same page for the purpose of this survey. **Public health** can be understood as the art and science of prolonging life at a community and population level through large-scale solutions, preventative measures and data-informed policies.

Each community has their own public health system comprised of individuals and public and private entities that are engaged in activities that affect the public's health. Among these, Local Health Departments are considered the backbone of a public health system due to their role delivering public health services. **Public health services** and initiatives include efforts to promote community-level safety and health, including emergency preparedness, vaccination and immunization, injury and disease prevention, and public education (e.g., smoking cessation or seat belt campaigns).

Local health departments are administrative or service units of local or state government that are concerned with health and carrying some responsibility for the community-level health of a jurisdiction smaller than the state. You can find your local health department using this directory.

Please select the community organization you represent.

What is your title within your organization?

_____

What is the name of the organization that you represent?

_____

Are any members of your CoC board representatives or leaders from public health?

( ) No

( ) Yes, one member fits this description

( ) Yes, multiple members fit this description

( ) Unsure

If participants indicate one or more members of CoC board are from public health →
What is the professional role(s) of the CoC board member(s) who represent the public health system in your community?

If participants indicate one or more members of CoC board are from public health →
How would you rate their level of engagement on the board?

( ) Not at all engaged
( ) Somewhat engaged
( ) Average
( ) Very engaged
( ) Extremely engaged

Are you aware of any work groups, task forces, or other types of committees in your community that include representatives from the homelessness response system and public health system?

( ) No

( ) Yes

If participants are aware of groups including PH & HRS representation →
Please describe the nature of this task force, work group, or committee, including its purpose and members.

_____

_____

_____

_____

If participants are aware of groups including PH & HRS representation →
How often does this group meet?

( ) Less than once a year

( ) Once a year

( ) Twice a year

( ) Every few months

( ) Monthly

( ) Weekly

( ) Other - Please specify: _____

Did your organization collaborate with public health partners to respond to the COVID-19 pandemic?

Collaborative efforts may include vaccination planning and rollout, COVID-19 screening and testing, or other prevention efforts.

( ) Yes

( ) No

If participants collaborated with PH partners in response to COVID-19 →

Please select the activities that your organization did in partnership with public health entities in response to the COVID-19 pandemic.

[ ] Vaccination

[ ] Testing

[ ] Outreach

[ ] Education

[ ] Other - Please describe:

_____

If participants collaborated with PH partners in response to COVID-19 →

Do you feel that engaging with public health partners in response to the COVID-19 pandemic has allowed for continued collaboration across sectors?

( ) Yes - Feel free to describe:

_____

( ) No - Feel free to describe:

_____

How would you describe your organization's relationship with your Local Health Department?

( ) Strong relationship

( ) Some relationship

( ) Very limited relationship

( ) No relationship

( ) Unsure

( ) Other - Please describe:

If you have additional comments regarding the relationship between your organization and Local Health Department, please use this space to provide these.

_____

_____

_____

_____

Has your Local Health Department or Department of Public Health set policies related to homelessness?

( ) Yes - Please describe _____

( ) No

( ) Unsure

Has your organization set policies related to public health?

( ) Yes - Please describe

_____

( ) No

( ) Unsure

Does your Local Health Department provide support services in any of the following areas?

( ) Shelters

( ) Encampments

( ) During the Point-in-Time count

( ) Mental health counseling

( ) Medicaid/Insurance challenges

Does your organization have a working relationship with any other entities in your community that deliver public health services? These could be community-based organizations, faith-based organizations, or other governmental entities.

( ) Yes - Please describe

_____

( ) No

( ) Unsure

Has your organization ever partnered with a public health entity to apply for funding?

( ) No

( ) Yes - Please describe: ____