
Health & Homelessness - Collaboration
Across Systems

## Community Solutions: Built for Zero

We work with communities nationally and internationally to create a future where homelessness is **rare, brief when it occurs, and non-recurring.**

# Healthcare x Homelessness Pilot as a Foundation

- Three year national pilot funded by Providence, Kaiser Permanente and CommonSpirit Health
- Institute of Healthcare Improvement + Community Solutions engaged with 5 pilot communities: *Washington County, Oregon; Sacramento, CA; Bakersfield, CA; Chattanooga, TN and Anchorage, AK*
- Creation of commitment and a dedicated space to design and implement projects for collaboration across health and homelessness systems
- Projects included data sharing, increasing respite care, liaison roles, aligning and dedicating resources, and coordination through cross sector case conferencing
- Spread and scale occurring post pilot

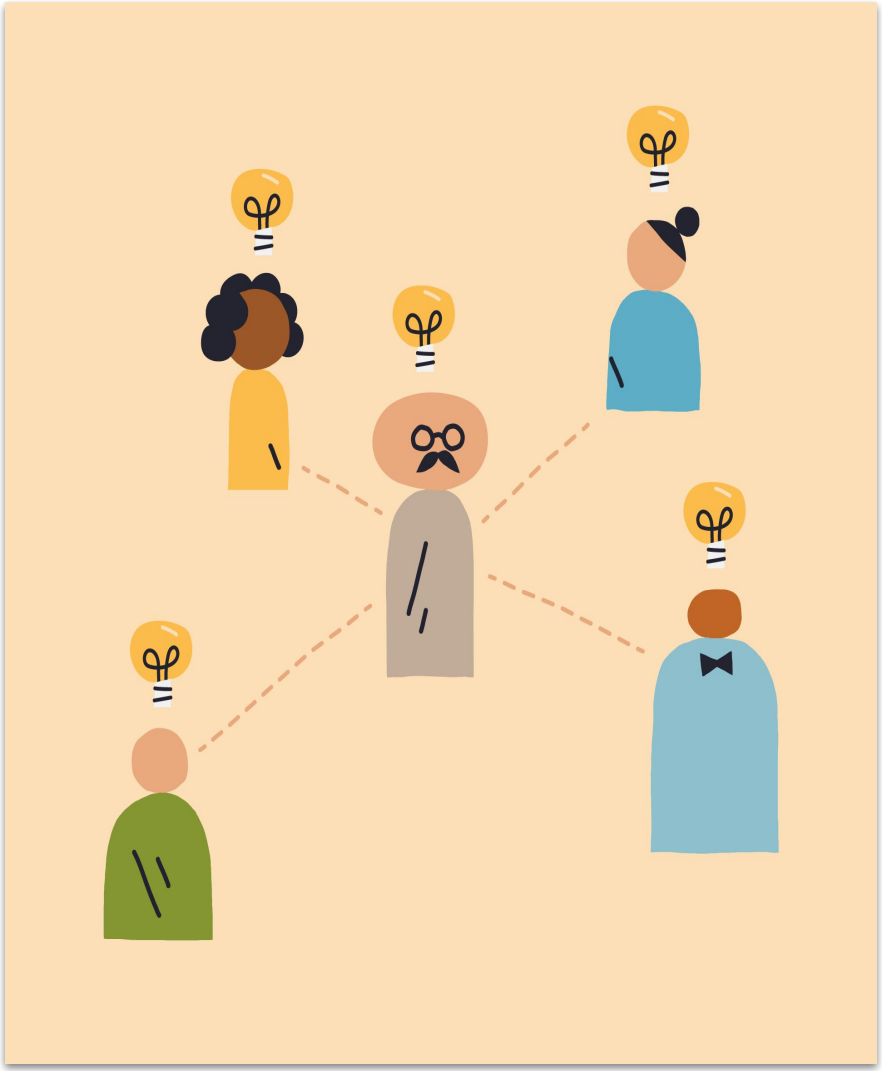
# Health Care and Homelessness Integration

# Creating Staff Positions to Address Gaps Between Sectors

- Health Systems in **Sacramento, CA** created and funded roles to sit between health and homelessness response systems

- The homeless response system in **Hartford, CT** created a dedicated role to partner with local hospitals and receive referrals

- These positions work to connect people to the most appropriate teams like:
  - ED clinicians
  - Inpatient Social Workers
  - Street medicine clinicians
  - Medical Respite
  - Housing Resources



# Disrupting Discharge into Homelessness with Medical Respite

- **Chattanooga,TN and Bakersfield, CA** developed additional medical respite capacity in their communities
    - Coordination between hospital and CoC begins when a patient is admitted to hospital and determined eligible for services
    - Care coordination meetings with homelessness response staff and key respite care providers

# Establishing Cross-Sector Case Conferencing

Case Conferencing:

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

Cross-Sector Case Conferencing:

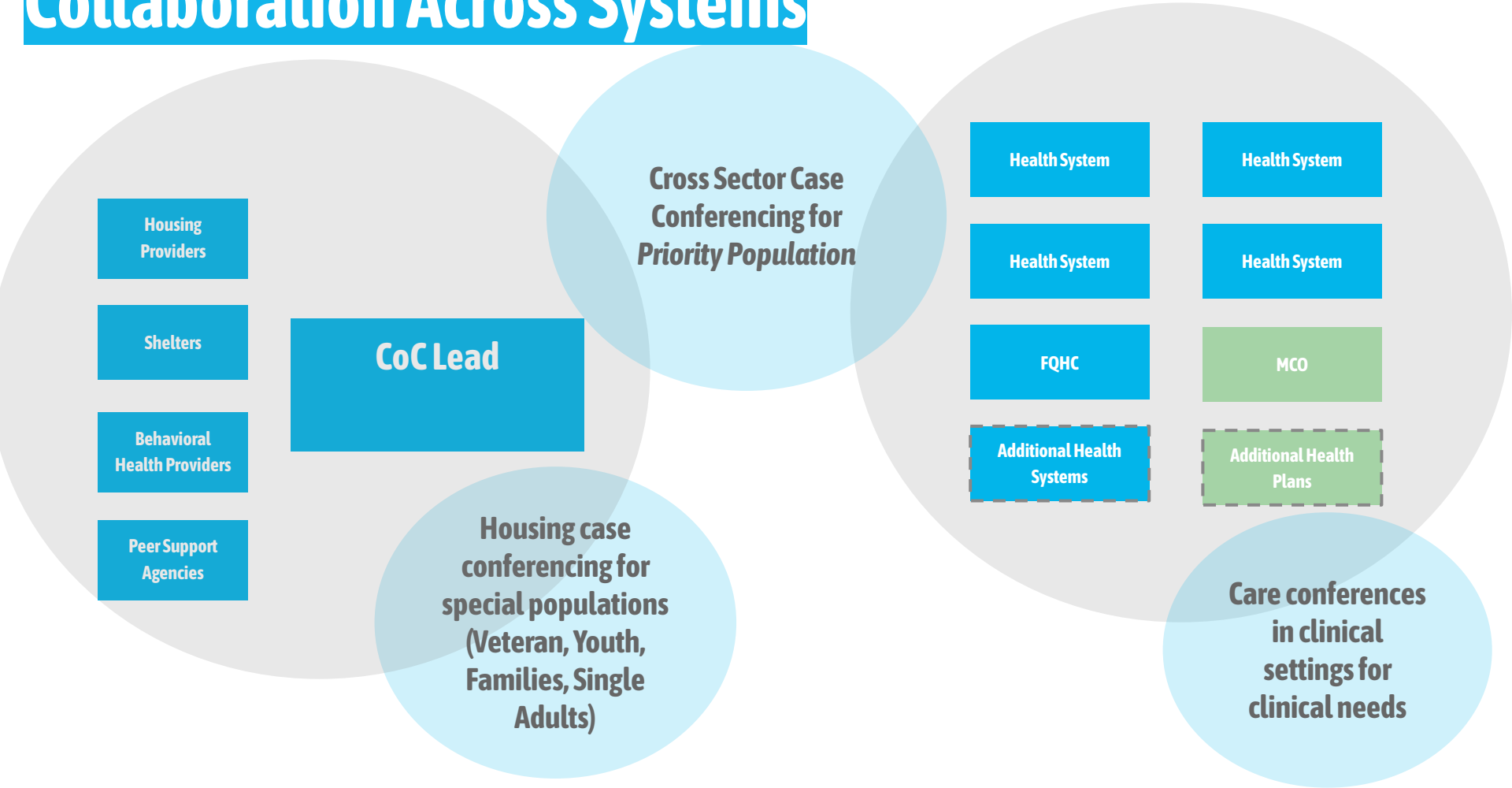
- Homelessness response system, health systems and health plans participate in collaborative problem solving
- Connect clients to services to meet health and housing needs.

# Cross Sector Case Conferencing

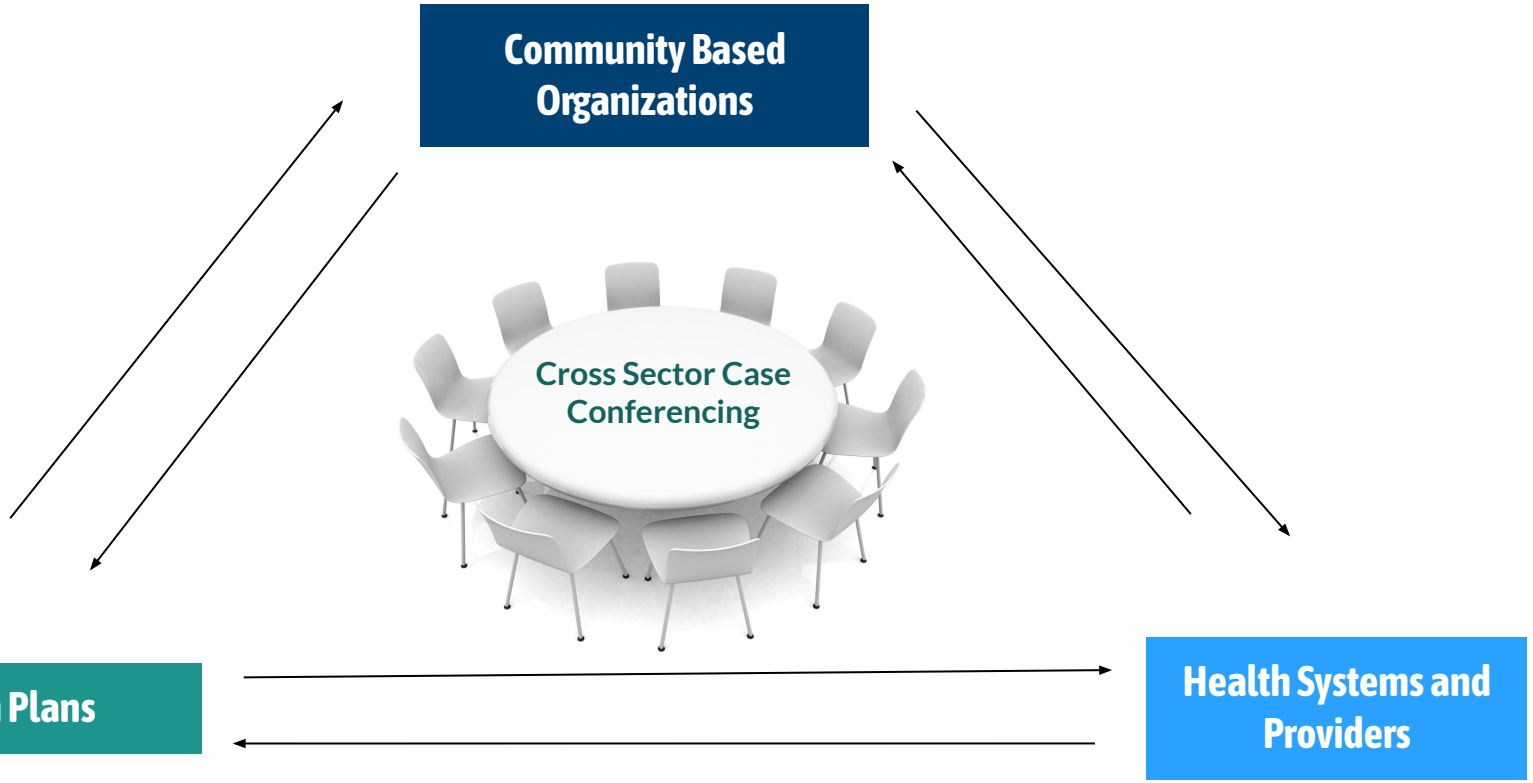
# Cross Sector Case Conferencing

- Formalized process
- Our clients, our resources
- Focus is not just clinical, not just housing, but both
- Systems working collaboratively to meet the needs of individuals
- Person-centered, power sharing

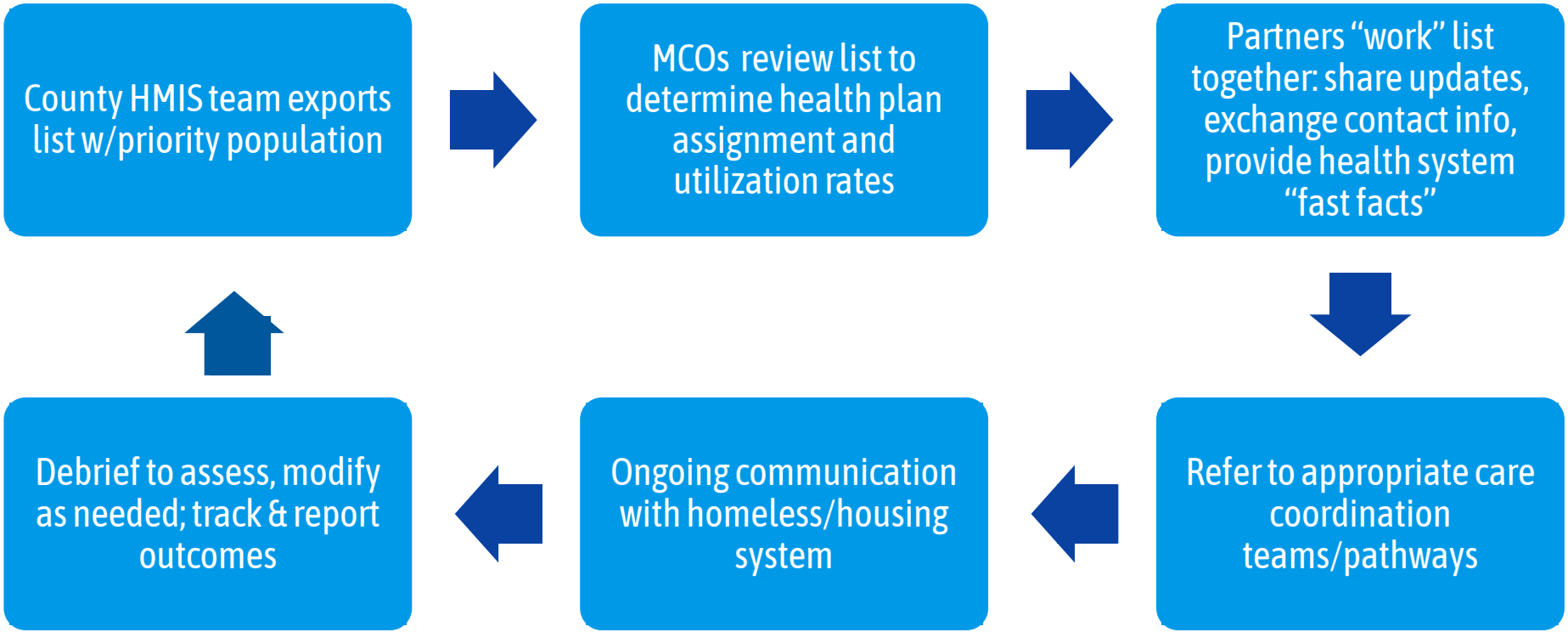
# Collaboration Across Systems



# Cross Sector Case Conferencing Table



# Example Data Flow



# Cross-Sector Case Conferencing

- Cross sector case conferencing helps establish pathways for connecting clients to resources
- Solving at the individual level allows for improvement and change of systems
- There are common client profiles/archetypes that multi-sector teams discuss in case conferencing
- These common profiles reveal typologies of need and teams become more familiar with resource landscape, referral processes and critical partners to work with

# Example: Older Adults Experiencing Homelessness

- Behavioral Health: substance use and/or mental health
- Preference to shelter in the ED
- Complex care diagnosis (COPD, oxygen dependent)
- Cognitive: dementia or traumatic brain injury
- End of life care
- ADA / mobility
- Older adults with activities of daily living limitations

Supported by funding from the California Health Care Foundation

CHCF

# Resources: System of Care for Homeless Older Adult Populations

## Comprehensive Services Needed in the System of Care

| Services | Area Agency on Aging/Guardian | Day Centers | LTSS/CM / Medication Management | Service Enriched PSH/PACE | ASL/ Board and Care | LTC | Hospice Homes | LTC w BH/SUD Focus | LTC w Memory Care Units |
|---|---|---|---|---|---|---|---|---|---|
| **Existing Community Resources** | | | | | | | | | |
| **Key Gaps** | | | | | | | | | |

Other organizations, programs and factors that are needed in delivery:

☐ HMIS* ☐ CES* ☐ ID Documents ☐ Legal Support ☐ Access to Benefits ☐ SOAR*

Asset Map Guide Available here: [Asset Map Guide HC2 Strategies 103125.pdf]

HC² STRATEGIES
HEALTHY CONNECTED COMMUNITIES

# Case Conferencing Overview: Tri County Oregon

## Washington County

- Began case conferencing in Spring 2023
- Using Washington County specific data sharing agreement between county homeless services and health systems
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- Every other week case conferencing –health systems, county homeless services and numerous homeless service providers participating

## Clackamas County

- Began conferencing in March 2024
- Using a release of information model
- Every other week case conferencing –health systems, county homeless services, behavioral health, peer support and multiple homeless services providers participating

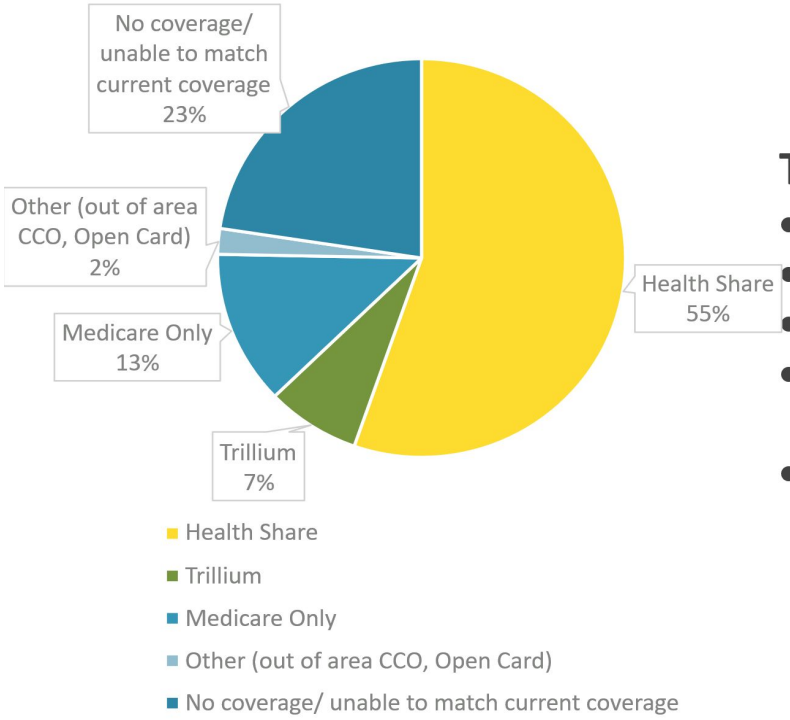
## Multnomah County

- Began conferencing November of 2024
- Pilot phase
- **Data sharing agreement and ROI* hybrid model**
- Every other week case conferencing –health systems, county homeless services, behavioral health, onboarding new homeless services providers and expanding referral criteria

health share

*ROI-Release of information

# Review of Case Conferencing Participants




**Total Number of Participants: 336**

- Health Share: 186
- Trillium:25
- Medicare only: 42
- Other (Open Card, out of area CCO coverage): 7
- No coverage/ unable to match current coverage: 76

*Data as of 10/8/2025*

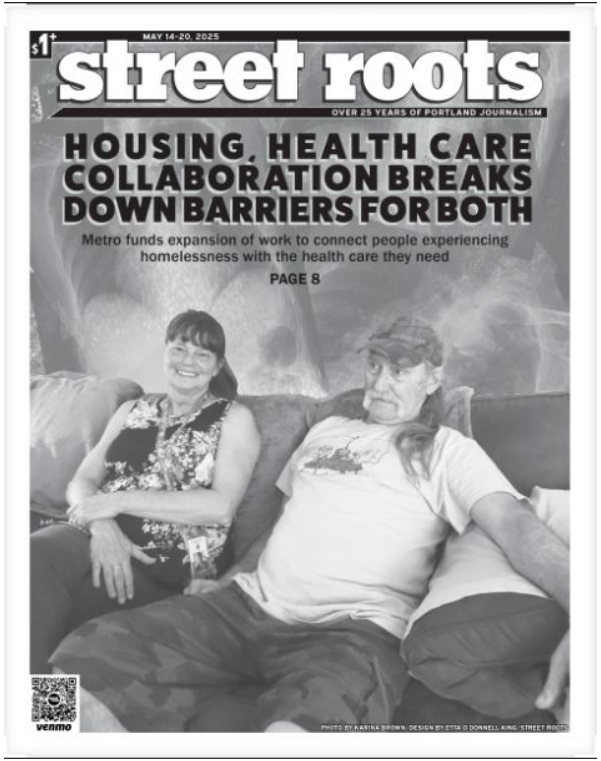
# Early Outcomes

Initial regional data is demonstrating that participants who engage in case conferencing:

- Have less emergency room utilization following their case conferencing session
- Engage with their primary care physician more than they did prior to their case conference

Homeless services providers are experiencing greater support for their members

Healthcare providers are engaging previously hard to reach members in care coordination




health share

# What's Next

- In partnership with communities, developing shared set of metrics to measure efficacy of cross sector case conferencing for both health and housing outcomes
- Health Share conducting data analysis on service utilization within population of people experiencing homelessness in a high risk, behavioral health cohort to develop new resources, services and programs.
- Identifying additional archetypes and building pathways to appropriate resources
- Developing recommendations for meeting resource gaps
- Considering special circumstances for individuals that represent ethical complexity
- And scaling!!

# Communities Getting Started

# Cross Sector Case Conferencing: Getting Started

- Identify and engage key stakeholders (CoC, health plans, health systems)
- Define a focal population
- Sign data sharing agreements and create release of information
- Establish data flow and referral pathways
- Determine data to track for individual client outcomes and evaluating the efficacy of cross sector case conferencing
- Be ready to learn as you test and pivot/improve as you go

# Speaking of Pivots...

- Here are a few the community teams have tackled since launching:
  - Expanding population criteria
    - Removing age limitations
    - Including unsheltered individuals
  - Simplifying referral pathways and ROIs
  - Reducing amount of data that needs to be collected prior to case conferencing meetings
  - Improving the type of information collected and where it is stored

# Thank you