

Healthcare x Homelessness Theory of Change

Healthcare's participation in Permanent supportive housing

Overview of this strategy

Permanent supportive housing (PSH) is "an intervention that combines affordable housing assistance with voluntary support services to address the needs of chronically homeless people. The services are designed to build independent living and tenancy skills and connect people with community-based health care, treatment and employment services." (National Alliance to End Homelessness, endhomelessness.org). [HUD](https://www.hud.gov) specifies that permanent supportive housing is provided to assist households with at least one member (adult or child) with a disability in achieving housing stability.

Permanent supportive housing and income assistance, such as housing subsidies with case management, are effective in reducing homelessness and achieving housing stability (Raven, Niedzwiecki and Kushel, 2020).

Health systems can and do help equitably grow capacity & capability within community-wide housing processes. Expanding health system partners' understanding of the breadth of homelessness services available in the community is a first step in health care staff being able to support patients experiencing homelessness. Cross-training direct care staff in each system is helpful, with the homelessness response system offering orientation to staff on how to support clients to access healthcare resources, while health systems orient their staff to the range of homelessness services, including existing CoC standard assessments, prioritization, and referral processes for the coordinated entry system. A quick resource such as a fast facts sheet for provider reference can help to support the uptake of preferred referral processes between systems.

Health systems can take proactive steps to connect people to permanent supportive housing, including building direct links to housing placement support in respite care programs and connecting people living in homelessness who were previously unknown to the homelessness response system to housing placement services. Health systems can also fund housing solutions in many ways: in Sacramento, health systems collaborated to fund full time positions at the Continuum of Care, effectively leveraging health system budgets towards housing placement, while in Anchorage, the health system funded the new construction of a 50-unit PSH building.

One idea not fully explored in the pilot is how health systems might align existing complex care management supports for PSH or otherwise investing or advocating for additional PSH resources. Communities interested in this area will need to navigate what can be, at times, a fragmented health and social service reimbursement system. Promising developments are happening to integrate payment for these services through Medicaid 1115 waivers.

Impact of this strategy

Providing or linking people to permanent supportive housing is likely to boost outcomes in these areas:

- **Degree of system coordination** - As health systems collaborate with the HRS, the systems develop efficiencies and build capacity for coordination in other areas.
- **Individual health outcomes** - PSH ends homelessness for individuals and offers the foundation of stability that allows people to engage in preventive and community-based health care.
- **Using resources effectively** - PSH may be a cost-reducing intervention when considering savings from other parts of the safety net system, including costs from emergency departments, inpatient hospital stays, psychiatric centers, detoxification programs, and jails (National Alliance to End Homelessness, 2017).

Resources and tools for implementing this strategy

- National Health Care for the Homelessness Council [homelessness and health resources](#)
- National Healthcare for the Homeless published a [policy brief](#) summarizing how health centers could use medicaid to pay for these services.
- For communities in California, the [Medi-Cal Community Supports policy guide](#) offers information about how Medicaid can housing deposits, housing tenancy and sustaining services.

Practical advice from the field

"What is the role of healthcare in permanent supportive housing? That is a basic, difficult question." - Healthcare X Homelessness participant, Healthcare system representative.

Pilot teams tested various ways for health care to contribute to PSH.

Towards housing provision. Providence Alaska used detailed data from the local Continuum of Care to make the case to invest in a 51 bed PSH building. Washington County leveraged state funds for behavioral health for capital acquisition of a PSH site and engaged in exploratory conversations and commitments for additional PSH acquisitions and on-site services with BH providers. Regarding connecting patients to PSH, all three major hospitals in Anchorage fund medical respite care, where staff refer patients directly to PSH. In Sacramento, 4 health systems are establishing a Funders Collaborative to explore ways to finance PSH and exploring ways to use CalAim benefits to support PSH.

Providing the supportive services that help tenants to sustain their housing is another way for health care to leverage their resources and expertise. Washington County explored retroactively billing for PSH services through Medicaid and dedicated health system staff to support cross-sector case conferencing.

Sustaining healthcare's participation in PSH over the next 3-10 years is likely to be challenging in many regions and pilot teams have identified conditions that enable the teams to initiate health care's active role in PSH. Some of the enabling conditions cited by pilot teams were:

- The ability to share data to identify mutual clients: in the homelessness response system, a quality BNL; in healthcare, hospital utilization data, specifically length of stay when inpatient care is prolonged by a lack of safe discharge placement
- Existing partnerships between health care and the homelessness response sector, with an explicit focus on building buy-in for healthcare's participation in ending homelessness
- Ongoing education for healthcare staff about the needs of people experiencing homelessness, ways for health care to identify housing needs, and the existing partnerships established to help connect people to the homelessness response system

Community Voices: To what extent would you recommend healthcare's participation in PSH to another community?

"I would say I 'highly recommend' collaborating with healthcare around PSH and also learning for our housing system how to bill Medicaid for PSH services. We know that a lot of the services we provide through PSH are billable services, we just don't have the infrastructure and the collaboration to do that yet. We also know that if we are able to bill Medicaid and work collaboratively with health systems for PSH services that we could potentially double the volume of PSH that we are providing for our community."

- Healthcare X Homelessness participant, Homeless system representative.

Tactics & change ideas

- Connect hospital data on people experiencing housing instability/homelessness with coordinated entry system access points or the community by-name-list and share report with housing experts
- Understand how existing CoC standard assessments, prioritization, and referral processes for the coordinated entry system affects health system patients
- Use case conferencing as a mechanism to problem solve and coordinate between players in the system

- Solve for issues within locus of control and escalate larger system-wide issues to health system leadership and community partners for multi-stakeholder consideration
- Consider starting with a specific, complex subpopulation (ie, veterans; older adults; complex behavioral health; cancer) to rally partners around solving for a specific challenge—as well as to begin reducing potential trauma the subpopulation faces from facing a fragmented system
- Map care delivery process(es) to identify bottlenecks, workarounds, and failure points where the existing housing processes is not serving the individuals or community well
- Include people with lived experience in the co-creation of process map(s) and to identify pain points/bottlenecks
- Disaggregate client data by race and other demographic categories to understand which points in housing process contribute to inequitable outcomes
- Review patient utilization data by race/ethnicity, gender, age to see where there may be opportunities to address specific barriers to subpopulations such as immigration status, language, gender
- Recognize that creating new housing or funding subsidies requires a longer-term commitment upstream from the traditional role of health systems.

Bright spots & examples from the field

- Healthcare provide funding or in-kind staff for the CoC
- Provide supportive services for complex or recuperative care even in transitional services like shelters (such as a complex care shelter, or a respite care facility)
- Invest in the near-term and long term development of new affordable housing units
- Provide or finance permanent supportive housing services
- Form coalitions and commitments with other anchor institutions in your community including universities, large corporations, and other health care institutions to encourage them or invest in affordable housing or join a common policy platform
- Partner with businesses to create social impact funds
- Partner with the homelessness response system to build survey items related to housing instability into the Community Health Needs Assessment

Reference:

National Alliance to End Homelessness. 2017. Ending Chronic Homelessness Saves Taxpayers Money.

<https://endhomelessness.org/resource/ending-chronic-homelessness-saves-taxpayers-money-2/>

Permanent supportive housing. National Alliance to End Homelessness. (2023, April).

<https://endhomelessness.org/ending-homelessness/solutions/permanent-supportive-housing/>

Raven MC, Niedzwiecki MJ, Kushel M. A randomized trial of permanent supportive housing for chronically homeless persons with high use of publicly funded services. *Health Serv Res.* 2020; 55: 797–806. <https://doi.org/10.1111/1475-6773.13553>

