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Improving Care for People Experiencing Homelessness

Organizations have the power to contribute to systematic and sustained improvements.

It has been well documented that homelessness is associated with poorer mental and physical health. Due to limited access to primary care and the compounding effects of health conditions and deteriorating wellness, mental illness, substance use disorders and physical disabilities, individuals experiencing homelessness may not engage with health services until they are in crisis.

The moral imperative—providing equitable access to safe, high-quality healthcare for all—is another compelling reason for health systems to strive for improved care for people experiencing homelessness.

The clear connections between homelessness, poor health and increased use of emergency health services highlight the significant overlap between the populations served by the healthcare system and those served by the homeless response system.

They also point to the pressing need for cross-sector collaboration to drive systematic, sustained reductions in homelessness that can lead to both improved access to housing and better health outcomes at the population level.

The moral imperative—providing equitable access to safe, high-quality healthcare for all—is another compelling reason for health systems to strive for improved care for people experiencing homelessness. More equitable access to not only healthcare is needed but also to the social supports necessary to improve health outcomes.

This work requires providers to build and sustain partnerships with community organizations and people with lived experience of homelessness.

Community Solutions and the Institute for Healthcare Improvement have worked together for years, implementing improvement methods and leading innovation in quality and accountability in clinical and community settings to help effectively and sustainably end homelessness.

Community Solutions' Built for Zero movement works with over

100 communities throughout the nation, employing a quality improvement framework to drive measurable, equitable reductions in homelessness. IHI and Community Solutions also partnered with major health systems—Kaiser Permanente, Providence Health, CommonSpirit Health, UC Davis Health and Sutter Health—in five U.S. communities for a three-year pilot project that brought together leaders from both local homeless response systems and health systems.

This pilot project experience revealed what really mattered in engaging the local community and gleaned five lessons for healthcare leaders to consider as they work toward better experience and outcomes for people experiencing homelessness.

Use existing data to identify opportunities to improve care for people experiencing homelessness. Consider social determinants of health screening data, case management data on homelessness, ZIP code data, or simply start by looking at the number of patients accessing your health system with no address or an address of a local shelter.

Once equipped with this data, look at the outcomes of the patients identified and determine three things: if they are returning frequently with unmet needs, what the data looks like through an equity lens, and how many people are experiencing homelessness who interact with your services and inequities in their outcomes.

Engage with the local Continuum of Care Program to gain understanding of homelessness in the community. Engaging with the regional or local planning body that coordinates housing and services funding for homeless families and individuals, such as the U.S. Department of Housing and Urban Development Continuum of Care Program, can help health systems learn more about the state of homelessness in the community.

In particular, a Continuum of Care Program can provide information on the most recent count of sheltered and unsheltered people experiencing homelessness on a single night, as well as a real-time, by-name comprehensive list of every person in the community experiencing homelessness.

Redesign your healthcare organization's response system. Closely examine your organization's response system to screen for social determinants of health and ensure that this screening is universal and reliable.

Questions to consider include: What happens when a patient screens positive for being unhoused? Does the health system have dedicated staff assigned to help meet the needs of this population?

If these resources are not in place, identify other organizations in the community with which to partner, such as housing service providers, to meet the needs of patients identified as experiencing homelessness.

The clear connections between homelessness, poor health and increased use of emergency health services highlight the significant overlap between the populations served by the healthcare system and those served by the homeless response system.

Explore the power of partnership. Forging meaningful collaborations between healthcare institutions and community-based organizations will help build a comprehensive ecosystem of care, enabling coordinated access to housing supports, mental health supports, substance use treatment and other essential social services.

Working in partnership can help build care pathways that promote a more holistic system of care and foster a better understanding of the health outcomes of people experiencing homelessness at the population level. These partnerships can also identify and start to fill gaps at the community level in support of a more equitable system of care.

Collaborate for impact. One of the biggest takeaways from the pilot

project is that organizations can leverage their influence in the community to make a meaningful impact by harnessing the collective expertise and resources of their own systems, community-based organizations and individuals with lived experience of homelessness.

This kind of authentic collaboration paves the way toward a more compassionate, equitable and impactful ecosystem of care.

Communities participating in the pilot project explored some innovations around collaborating for impact, including the following:

- Expand medical respite and recuperative care to offer a safe environment for healing after hospitalization, as well as to create time and space to connect people with permanent housing services and supports. Emerging evidence shows that this approach decreases hospital length of stay and improves health outcomes for people experiencing homelessness.
- Create new homelessness liaison roles that bring the expertise of the homeless response system to the bedside, facilitating both expedited discharges to the appropriate care setting and collaboration across care settings.
- Establish regular cross-sector case conferencing between providers and homeless response systems that centers the patient, includes a cross-sector team representing each

person or agency intersecting with the patient, and focuses on collaboratively finding solutions and developing a shared plan of care. Designed well, case conferencing serves to not only improve care and outcomes for the individual but also improve quality of care generally and create systemwide improvements.

- Engage people with lived experience of homelessness in improvement work. Communities in the pilot project have, for example, integrated people with lived experience into advisory councils for designing better systems, as well as in the direct delivery of services.

With homelessness intricately linked to poorer health outcomes and increased healthcare use, the moral imperative for cross-sector collaboration between health systems and homeless response organizations has never been more pressing. By leveraging data, forging meaningful partnerships and embracing innovative approaches, healthcare systems have the power to drive systematic and sustained improvements in care for people experiencing homelessness. ▲

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