Strategic Partnerships Between Homeless Service Providers and the Healthcare Sector
Agenda for Today’s Session

1. Presentation (50 minutes)

2. Q&A (10 minutes)

3. Activity (30 minutes)
Themes for Today’s Session

1. Partnerships between Health Care and Homeless Service Agencies are Can Be Fruitful, and May Be Increasingly Available

2. There Are Many Ways These Partnerships Can Work and Be Effective

3. These Partnerships Require Careful Nurturing to Be Successful
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OUR HOUSE

UAMS | University of Arkansas for Medical Sciences
**Focus on Social Determinants of Health**


<table>
<thead>
<tr>
<th>Economic Stability</th>
<th>Neighborhood and Physical Environment</th>
<th>Education</th>
<th>Food</th>
<th>Community and Social Context</th>
<th>Health Care System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment</td>
<td>Housing</td>
<td>Literacy</td>
<td>Hunger</td>
<td>Social integration</td>
<td>Health coverage</td>
</tr>
<tr>
<td>Income</td>
<td>Transportation</td>
<td>Language</td>
<td>Access to healthy options</td>
<td>Support systems</td>
<td>Provider availability</td>
</tr>
<tr>
<td>Expenses</td>
<td>Safety</td>
<td>Early childhood education</td>
<td></td>
<td>Community engagement</td>
<td>Provider linguistic and cultural competency</td>
</tr>
<tr>
<td>Debt</td>
<td>Parks</td>
<td>Vocational training</td>
<td></td>
<td>Discrimination</td>
<td>Quality of care</td>
</tr>
<tr>
<td>Medical bills</td>
<td>Playgrounds</td>
<td>Higher education</td>
<td></td>
<td>Stress</td>
<td></td>
</tr>
<tr>
<td>Support</td>
<td>Walkability</td>
<td>Zip code / geography</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Health Outcomes**

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations
Health Coverage Expansion with ACA Increases Access to Care

More People Covered; especially in Medicaid Expansion States

Access also impacted by:
- Geographic Availability
- Provider Availability
- Acceptable personal relationships with health providers
- Relationships between health and social services providers

8.5%
2018 uninsured rate

Health Insurance Coverage
Uninsured rate up between 2017 and 2018.

www.census.gov/programs-surveys/cps

United States Census Bureau
U.S. Department of Commerce
census.gov

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Digital Health Care Growth

The future is now…
And in the future

- Smartphones/Social Media
- Telehealth
- Secure Communications with Patients
- Secure Communications Between Providers
- Artificial Intelligence/Big Data
Value Based Care

Fee for Service → Alternative Care Models → Accountable Care Organizations → Accountable Health Communities
Accountable Health Communities, 2017-2022

https://innovation.cms.gov/initiatives/ahcm/

Screening/Referral

Navigation

Alignment

Source: Centers for Medicare & Medicaid Services
# Accountable Health Communities

## Health-Related Social Needs Screening

<table>
<thead>
<tr>
<th>Core Needs</th>
<th>*Supplemental Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing Instability</td>
<td>Family &amp; Social Supports</td>
</tr>
<tr>
<td>Utility Needs</td>
<td>Education</td>
</tr>
<tr>
<td>Food Insecurity</td>
<td>Employment &amp; Income</td>
</tr>
<tr>
<td>Interpersonal Violence</td>
<td>Health Behaviors</td>
</tr>
<tr>
<td>Transportation</td>
<td></td>
</tr>
</tbody>
</table>

[https://www.pdffiller.com/jsfiller-desk15/?projectId=379189493&expId=6215&expBranch=5#cue802918cbe515e3292aa02677675d](https://www.pdffiller.com/jsfiller-desk15/?projectId=379189493&expId=6215&expBranch=5#cue802918cbe515e3292aa02677675d)
Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation’s Health

Five Activities (5 A’s)

- Individual
  - Adjustment
  - Assistance

- Community
  - Awareness
  - Alignment
  - Advocacy

Population Health

Non-traditional, cross-sector partnerships to achieve positive health outcomes in the communities they serve.

<table>
<thead>
<tr>
<th>Arkansas Issues</th>
<th>US</th>
<th>AR</th>
<th>Pulaski Co.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children with at least 1 ACE</td>
<td>45%</td>
<td>56%</td>
<td>---*</td>
</tr>
<tr>
<td>Poor Mental Health Days (past. 30)</td>
<td>3.1</td>
<td>5.2</td>
<td>4.6</td>
</tr>
<tr>
<td>Adult Tobacco Use</td>
<td>12%</td>
<td>24%</td>
<td>19%</td>
</tr>
<tr>
<td>Binge Drinking</td>
<td>13%</td>
<td>16%</td>
<td>16%</td>
</tr>
<tr>
<td>HIV Prevalence</td>
<td>---</td>
<td>215</td>
<td>534</td>
</tr>
<tr>
<td>STI rate</td>
<td>152</td>
<td>562</td>
<td>855</td>
</tr>
</tbody>
</table>

*Note: The exact value for Pulaski Co. is not provided for the HIV Prevalence rate.*
Themes for Today’s Session

1. Partnerships between Health Care and Homeless Service Agencies are Can Be Fruitful, and May Be Increasingly Available

2. There Are Many Ways These Partnerships Can Work and Be Effective

3. These Partnerships Require Careful Nurturing to Be Successful
How to Find These Opportunities

Be intentional.

Lay a foundation.

Collect and use data.

Be persistent.

When an opportunity arises, jump on it.
Home Together – Overarching Goals

Project Supported by Funding from DHHS SAMHSA CMHS TIEH –SMO80742

Increase the capacity of service providers to engage with one another and with homeless/housing insecure pregnant women and mothers parenting children ages 0-5 who are also experiencing SMI/COD and their families in Little Rock.

Improve access to and family acceptance of coordinated, evidence-based, family-focused, trauma-informed, strengths-base, respectful, culturally responsive, understandable, and integrated primary and behavioral health care, social support services, and peer supports that provide a two-generation approach to improve client-family health and well-being and increase sustainable, permanent housing and long-term successful community living by pregnant women and mothers with children to age five who are experiencing SMI/COD and homelessness or housing insecurity.
Home Together – Basic Details

Five year project

90 families served annually

Eligibility criteria: homeless, pregnant or child under 5 in the home, serious mental illness (SMI)

Up to 2 years of engagement

Holistic services, including mental health treatment

Data Driven Quality Improvement
Invite you to attend the Home Together Partner Training Series to meet partners and learn best practices for homeless mothers and their children.

Dates and Topics:
- August 29 | Introduction to Home Together
- September 19 | Using a Trauma-Informed Approach
- October 24 | The Two-Generation Model of Change
- November 21 | Using Motivational Interviewing to Inspire

All sessions will be held from 12 - 1:30 at the Our House Children's Center.

Lunch will be provided.

Register online at ourhouseshelter.org/cafsi
Other Our House Health Partnerships

Weekly on-site children’s health clinic, staffed by a doctor and a nurse

Full-time children’s MH therapist position

Benefits counseling

Weekly on-site adult health clinic, staffed by a nurse and a telehealth doctor

Benefits counseling

Grew out of partner training series & ACH partnership
Other Our House Health Partnerships

https://ghpc.gsu.edu/project/aligning-systems-for-health/

- Partnership with Robert Wood Johnson Foundation and Georgia Health Policy Center
- Synthesizes existing research and disseminates findings
- Builds relationships with those already working in the field
- Supports original research and evaluation by awarding and administering a $3 million grant portfolio
### Home Together - Project Data

Selected Demographics/Characteristics of mothers (N=110)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race – Underrepresented Racial Minority</td>
<td>85.4%</td>
</tr>
<tr>
<td>Age - &lt;35 years</td>
<td>82.7%</td>
</tr>
<tr>
<td>(18-25 years – 30.9%; 26-34 years – 51.8%)</td>
<td></td>
</tr>
<tr>
<td>Adverse Childhood Experience (ACE) Scores (n-64) ≥ 4</td>
<td>66.1%</td>
</tr>
<tr>
<td>(average 5.15)</td>
<td></td>
</tr>
<tr>
<td>Ever Experienced Trauma</td>
<td>83.6%</td>
</tr>
<tr>
<td>Health Literacy Risk</td>
<td>58.3%</td>
</tr>
<tr>
<td>(High Risk – 18.5%; Moderate Risk – 39.8%)</td>
<td></td>
</tr>
</tbody>
</table>
# Home Together - Project Data

## Housing Status

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Intake (n=48)</th>
<th>6 Months f/u (paired)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Own/Rent</td>
<td>59.2%</td>
<td>77.1%</td>
</tr>
<tr>
<td>Someone Else’s House</td>
<td>22.4%</td>
<td>16.7%</td>
</tr>
<tr>
<td>Homeless (Street/Outdoors, Shelter)</td>
<td>18.4%</td>
<td>6.3%</td>
</tr>
</tbody>
</table>
## Home Together - Project Data

### Mental Health Symptoms

<table>
<thead>
<tr>
<th>Indicator (past 30 days)</th>
<th>Intake (n=49)</th>
<th>6 Months f/u (paired)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experienced nervousness</td>
<td>83.7%</td>
<td>81.2%</td>
</tr>
<tr>
<td>Experienced hopelessness</td>
<td>77.6%</td>
<td>59.2%</td>
</tr>
<tr>
<td>Experienced restlessness</td>
<td>91.8%</td>
<td>77.6%</td>
</tr>
<tr>
<td>Experienced being Depressed</td>
<td>75.5%</td>
<td>62.5%</td>
</tr>
<tr>
<td>Experienced feeling like everything takes too much effort</td>
<td>89.8%</td>
<td>83.7%</td>
</tr>
<tr>
<td>Feeling Worthless</td>
<td>61.2%</td>
<td>44.9%</td>
</tr>
</tbody>
</table>
# Home Together - Project Data

## Access to Health Care

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Intake (n=49)</th>
<th>6 months f/u (paired)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lacks Health Insurance</td>
<td>18.8%</td>
<td>11.8%</td>
</tr>
<tr>
<td>Does Not Have Primary Care Physician</td>
<td>43.8%</td>
<td>32.4%</td>
</tr>
</tbody>
</table>
## Home Together - Project Data

### Alcohol and Tobacco Use

<table>
<thead>
<tr>
<th>Indicator (past 30 days)</th>
<th>Intake (n=49)</th>
<th>6 months f/u (paired)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Use</td>
<td>38.8%</td>
<td>27.1%</td>
</tr>
<tr>
<td>Tobacco Use</td>
<td>44.9%</td>
<td>34.7%</td>
</tr>
</tbody>
</table>

- Majority of Users reported using only once or twice
- Of those that drank, percent drinking 4+ Drinks: 33.3% (Intake) and 33.3% (6 months f/u)
# Home Together - Project Data

**Perceptions of Care (N=49)**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff believe that I can grow, change and recover</td>
<td>91.8%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>I felt free to complain.</td>
<td>87.8%</td>
<td>4.1%</td>
<td>6.1%</td>
</tr>
<tr>
<td>Staff encouraged me to take responsibility for how I live my life.</td>
<td>89.8%</td>
<td>6.1%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Staff were sensitive to my cultural background (race, religion, language, etc.)</td>
<td>89.8%</td>
<td>2.0%</td>
<td>2.0%</td>
</tr>
<tr>
<td>I, not staff, decided my treatment goals.</td>
<td>81.6%</td>
<td>6.1%</td>
<td>4.1%</td>
</tr>
<tr>
<td>I would recommend this agency to a friend or family member.</td>
<td>95.9%</td>
<td>2.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>
Themes for Today’s Session

1. Partnerships between Health Care and Homeless Service Agencies are Can Be Fruitful, and May Be Increasingly Available

2. There Are Many Ways These Partnerships Can Work and Be Effective

3. These Partnerships Require Careful Nurturing to Be Successful
Keys to Successful Partnerships

Thinking and talking about the following seven key factors from day one:

1. Philosophy
2. Culture
3. Capacity
4. Benefits
5. Challenges
6. Roles
7. Data
Keys to Successful Partnerships

1. **Philosophy**
2. Culture
3. Capacity
4. Benefits
5. Challenges
6. Roles
7. Data

- How trauma-informed?
- How poverty-informed?
- How “judgemental”?
- Client-driven vs. provider-driven
- For-profit vs. non-profit
- Harm reduction vs. abstinence
Keys to Successful Partnerships

1. Philosophy
2. **Culture**
3. Capacity
4. Benefits
5. Challenges
6. Roles
7. Data

History of successful partnerships vs. donut-eating/coblaboration

Other helpful characteristics:
- Patience
- Perseverance
- Humility (incl. cultural humility)
- Trust
- Relationship-focus
- Transparency
- Quality-improvement
Keys to Successful Partnerships

1. Philosophy
2. Culture
3. **Capacity**
4. Benefits
5. Challenges
6. Roles
7. Data

Think “differential” -- how far apart are the organizations’ financial/administrative/staff capacities

Being a leader vs. being a follower vs. being both
Keys to Successful Partnerships

1. Philosophy
2. Culture
3. Capacity
4. Benefits
5. Challenges
6. Roles
7. Data

Benefits tend to be mutual:

- Lower health care costs
- Better access to useful data
- Better training for personnel
- Better housing, employment, financial, and other outcomes
- More funding for new or expanded services
Keys to Successful Partnerships

1. Philosophy
2. Culture
3. Capacity
4. Benefits
5. **Challenges**
6. Roles
7. Data

Address proactively, even speculatively

Some are external (policies, system capacities)

Some are internal (capacity, HIPAA, client voice, timing)
Keys to Successful Partnerships

1. Philosophy
2. Culture
3. Capacity
4. Benefits
5. Challenges
6. Roles
7. Data

Clear communication + flexibility

Often requires more dedicated staff resources than we expect
Keys to Successful Partnerships

1. Philosophy
2. Culture
3. Capacity
4. Benefits
5. Challenges
6. Roles
7. Data

What data are wanted/needed?

How prepared/willing are all parties to collect and share data?

How will the data be used?
Questions?
Activity

Find a brainstorming partner and complete worksheet together. (10 minutes)

Pair up with another group to introduce your concept and share reactions. (10 minutes)

Reassemble and report out to the full group. (10 minutes)
Strategic Partnerships Between Homeless Service Providers and the Healthcare Sector
Additional Resources

NCCARE360

North Carolina statewide coordinated care network – invests in non-medical drivers of health; public-private partnership between NC Department of Health and Foundation for Health Leadership & Innovation 2019 - 2020; resource directory and call center; shared technology enables health and human service providers to send and receive secure, electronic referrals and communications real time to share client information and track outcomes; community engagement team

https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/nccare360

American Journal of Preventive Medicine Supplement – December 2019

Identifying and Intervening on Social Needs in Clinical Settings: Evidence and Evidence Gaps
Edited by NE Adler and LM Gottlieb