Healthcare and Housing Integration: a Community Collaborative Approach to Reducing Homelessness

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Background
The Department of Housing and Urban Development has recently changed how social services are funded, with the objective of verifying that services offered to homeless individuals are actually matching the needs of people experiencing homelessness. This shift in federal funding has made it necessary for service providers to identify the gaps and overlaps in services and form collaborations to maximize program effectiveness and efficiency. The Erie United Methodist Alliance (EUMA) is a court-yardscale homeless social service provider out of Erie, Pennsylvania. It is currently spearheading a community collaboration effort to address the inefficiencies in the county’s services for homeless individuals.

EUMA has created a web of resources including city and county leadership, public and private healthcare providers, mental health services, homeless service providers, economic development organizations, faith groups, police, and others to address the needs of the chronically homeless. Supportive Housing Services, the central component of this collaboration, focuses on both the housing and healthcare needs of clients.

Supportive Housing services, which combine rapid re-housing with wrap-around services, has proven to provide housing stability, support community integration, improve health outcomes and reduce public costs. Rapid rehousing programs aim to move homeless individuals into permanent housing immediately, which ultimately reduces the length of time that they are homeless. Although rapid rehousing is a critical component to solving homelessness, the rest of the support services that are client-centered such as mental health services, drug, and alcohol counseling/harm reduction and healthcare navigation are crucial to preventing homeless individuals from returning to a state of homelessness.

Supportive Housing Services

- Outreach, Engagement, Housing Search, Application Assistance, and Move-In Assistance
- Landlord Relationship Management, Tenancy Right and Responsibilities Education, Eviction Prevention, Crisis Intervention and Subsidy Program Adherence
- Case Managers/Health Advocates help tenant to navigate the Healthcare System (clinical primary health providers and behavioral health services)
- Counseling, Peer Supports, Independent Living Skill Training, Employment Training, End of Life Planning and Crisis Supports

Chronically homeless individuals have been identified as the most at-risk for returning to homelessness, therefore they have become the main focus for social service providers. Chronically homeless individuals are defined as: unaccompanied homeless individuals who have either been continuously homeless for a year or more and have experienced at least four episodes of homelessness in the past three years where the combined length of time homeless in those occasions is at least 12 months. This population’s healthcare costs constitute a disproportionately large percent of Medicaid expenditures because they do not receive the coordinated and integrated continuum of care necessary for improved health outcomes. Chronically homeless individuals often turn to expensive and frequently preventable institutionalization when their health needs are not being met, thus EUMA has chosen to focus most of their efforts on this small yet costly subpopulation.

Objectives

1. Participants will examine why integration of housing and healthcare services through a community-wide collaboration is essential to addressing the health and safety needs of both the homeless population and the greater community.
2. Participants will leave with four steps that are fundamental to healthcare and housing integration that should be considered for implementation upon returning to their community.
3. Participants will understand the realities of the successes and barriers that a community will face when implementing wraparound housing and health service.

Description

1. Identify potential collaborative partners
   - Create a Health/Housing Service Provider Committee
2. Perform a community assessment
   - Develop a coordinated data entity method to assess program outcomes, frequently
   - Identify gaps, overlaps and barriers of pre-existing housing and health services
   - Identify the most vulnerable and most costly subpopulations of homeless individuals
3. Design a community plan that focuses on Supportive Housing
   - Identify services with best outcomes to eliminate gaps/overlaps in care
   - Identify new services/principles to address previously unmet needs of (chronically) homeless individuals
4. Enact plan and continue to improve based on community need
   - Complete a new community assessment every year

Results

In Erie County, fourteen individuals meet the criteria for chronic homelessness; however, these individuals continue to utilize the emergency room and other services more than other homeless individuals. Research has found that in twelve months when people were homeless, they used on average $48,217 worth of government services, in the twelve months as tenants of supportive housing, the cohort used on average, including the cost of supportive housing, $91,117 in government services. Not only does supportive housing save almost $13,000 per person, but it potentially improves the health and quality of life of a client. Across the country there were 550,000 (unaccompanied) Single Young and Young Adults up to the age of 24 in the U.S., experiencing a homelessness episode of longer than one week. This staggering statistic, along with the increase of the homeless youth population in Erie County, has highlighted the need to develop programming specifically for these youth.

Community Assessment

Collaborations with the following agencies have made the following programs and principles possible:

- Federally Qualified Health Center - Outreach Programs (Healthcare for the Homeless Partnerships Program)
- Medical volunteers (DO Students, Nursing Students, Nurse Practitioners, Physicians), Hospitals, Social Service Providers, Housing Providers and Jails/Prisons
  - Nurse Faculty Practice Model Clinic: planning is underway to decrease wait times, and increase services for homeless individual
  - Mobile Medical Unit: offers medical care to individuals staying at emergency shelters
  - Discharge Planning: in hospitals and prisons to prevent homeless individuals from returning to the streets
  - Harm-Reduction: focuses on the prevention of harm, rather than on the prevention of drug use itself
  - Trauma-Informed Care: treatment framework involves understanding, recognizing, and responding to the effects of all types of trauma

Lessons Learned

Throughout the process of ending homelessness in Erie County, Pennsylvania, the Erie United Methodist Alliance has identified multiple barriers that have hindered progress:

- Resistance to community collaboration and integration of social, health and housing services
- Inadequate data sharing and collecting

It is imperative that communities committed to ending homelessness recognize that the integration of housing and health care services can only be made possible through collaboration. Furthermore, adopting supportive housing services will enable communities to make homelessness rare, brief and non-recurring.

References