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www.ourhouseshelter.org/beyondhousing

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)

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Housing

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Workforce Training

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Early Childhood Education

Out-of-School Time Program

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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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Focus on Social Determinants of Health

https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

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

Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

KFF
HENRY J KAISER FAMILY FOUNDATION

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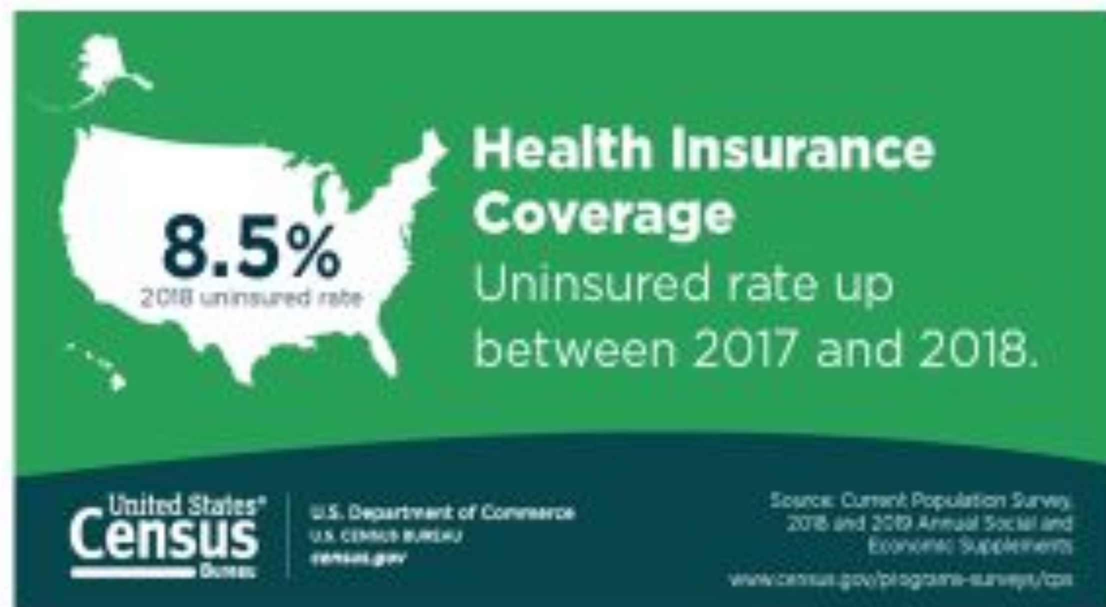
Health Coverage Expansion with ACA Increases Access to Care



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

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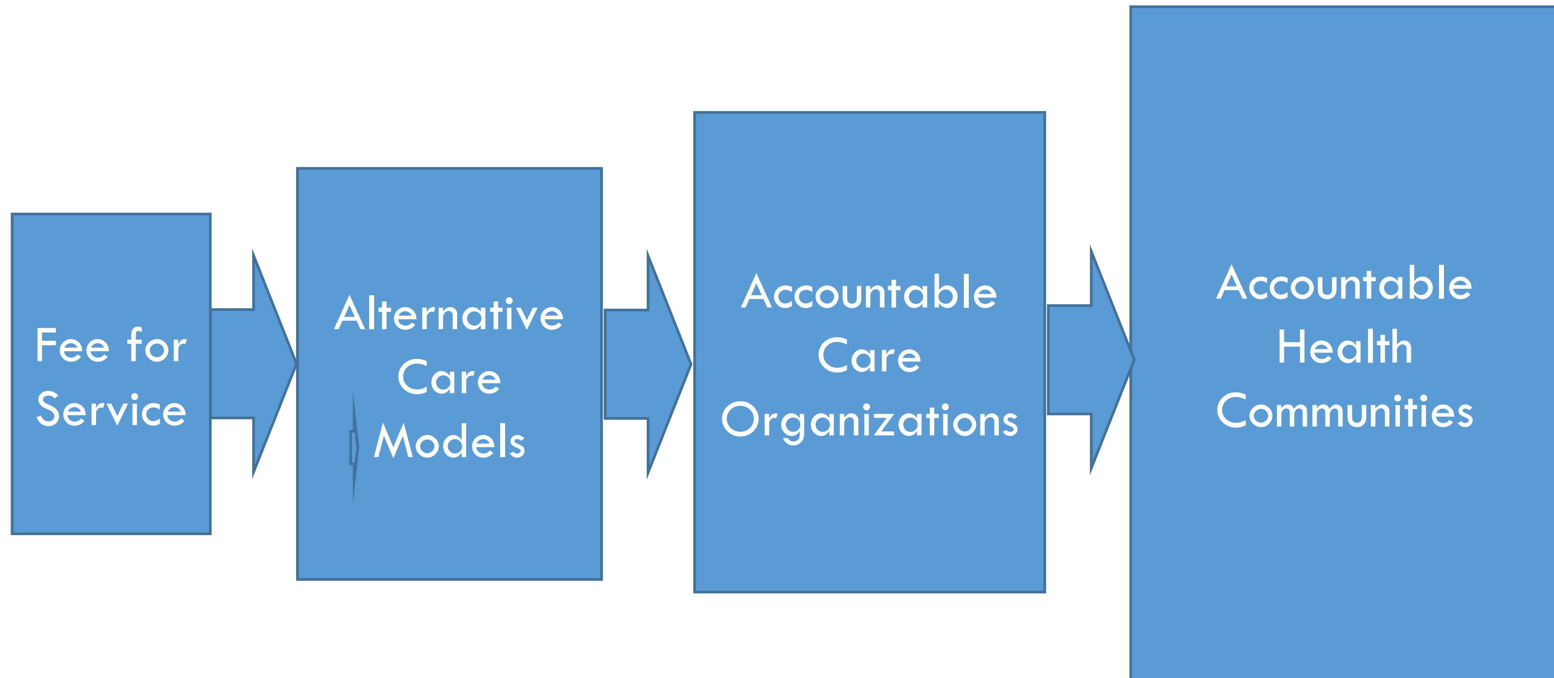
Digital Health Care Growth

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



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Accountable Health Communities, 2017-2022

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

Screening/Referral

Navigation

Alignment

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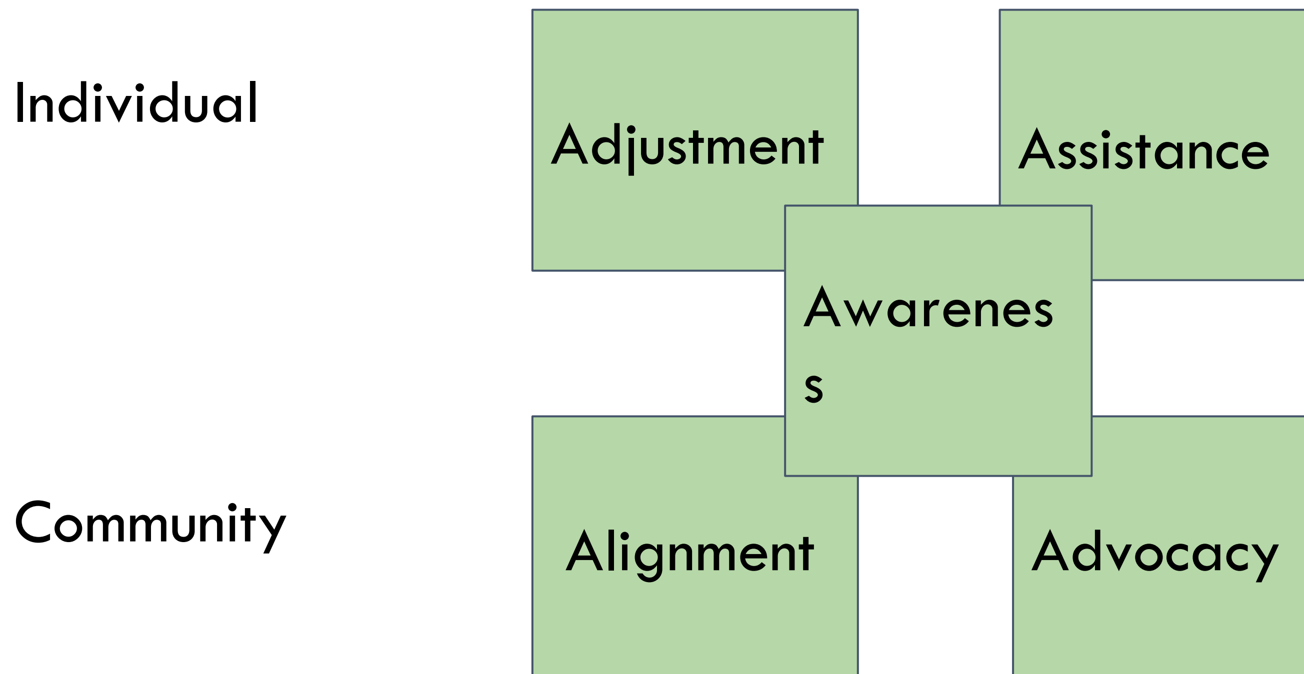
Accountable Health Communities Health-Related Social Needs Screening

Core Needs	*Supplemental Needs
Housing Instability	Family & Social Supports
Utility Needs	Education
Food Insecurity	Employment & Income
Interpersonal Violence	Health Behaviors
Transportation	

https://www.pdffiller.com/jsfiller-desk15/?projectId=379189493&expId=6215&expBranch=3#c1de802918cbef15e3292aa02677675d

Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health

Five Activities (5 A's)



https://nam.edu/event/integrating-social-care-into-the-delivery-of-health-care-moving-upstream-to-improve-the-nations-health-report-release-webinar

Population Health

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

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

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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

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Home Together – Partner Training

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

ALIGNING SYSTEMS FOR HEALTH
Health Care + Public Health + Social Services

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)

Measure	***Percent***
Race – Underrepresented Racial Minority	85.4%
Age - <35 years (18-25 years – 30.9%; 26-34 years – 51.8%)	82.7%
Adverse Childhood Experience (ACE) Scores *(n-64)* $\geq$ 4 (average 5.15)	66.1%
Ever Experienced Trauma	83.6%
Health Literacy Risk (High Risk – 18.5%; Moderate Risk – 39.8%)	58.3%

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Home Together - Project Data

Housing Status

Indicator	*Intake (n=48)*	*6 Months f/u (paired)*
Own/Rent	59.2%	77.1%
Someone Else's House	22.4%	16.7%
Homeless (Street/Outdoors, Shelter)	18.4%	6.3%

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Home Together - Project Data

Mental Health Symptoms

Indicator (past 30 days)	*Intake (n=49)*	*6 Months f/u (paired)*
Experienced nervousness	83.7%	81.2%
Experienced hopelessness	77.6%	59.2%
Experienced restlessness	91.8%	77.6%
Experienced being Depressed	75.5%	62.5%
Experienced feeling like everything takes too much effort	89.8%	83.7%
Feeling Worthless	61.2%	44.9%

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Home Together - Project Data

Access to Health Care

Indicator	*Intake (n=49)*	*6 months f/u (paired)*
Lacks Health Insurance	18.8%	11.8%
Does Not Have Primary Care Physician	43.8%	32.4%

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Home Together - Project Data

Alcohol and Tobacco Use

Indicator (past 30 days)	*Intake (n=49)*	*6 months f/u (paired)*
Alcohol Use	**38.8%**	**27.1%**
Majority of Users reported using only once or twice		
Of those that drank, percent drinking 4+ Drinks	**33.3%**	**33.3%**
Tobacco Use	**44.9%**	**34.7%**

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Home Together - Project Data

Perceptions of Care (N=49)

	Agree	*Undecided*	*Disagree*
Staff believe that I can grow, change and recover	**91.8%**	**0.0%**	**0.0%**
I felt free to complain.	**87.8%**	**4.1%**	**6.1%**
Staff encouraged me to take responsibility for how I live my life.	**89.8%**	**6.1%**	**2.0%**
Staff were sensitive to my cultural background (race, religion, language, etc.).	**89.8%**	**2.0%**	**2.0%**
I, not staff, decided my treatment goals.	**81.6%**	**6.1%**	**4.1%**
I would recommend this agency to a friend or	**95.9%**	**2.0%**	**0.0%**

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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
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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
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History of successful partnerships vs.
donut-eating/coblabboration

Other helpful characteristics:

Patience
Perseverance
Humility (incl. cultural humility)
Trust
Relationship-focus
Transparency
Quality-improvement

Keys to Successful Partnerships

1. Philosophy
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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

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Keys to Successful Partnerships

1. Philosophy
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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. <u>Roles</u>
7. Data

Clear communication + flexibility

Often requires more dedicated staff resources than we expect

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Keys to Successful Partnerships

1. Philosophy
2. Culture
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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)

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slides available at:
www.ourhouseshelter.org/beyondhousing

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 andLM Gottlieb

https://www.sciencedirect.com/science/article/pii/S0749379719304374?via%3Dihub