Integrating Care for People Experiencing Homelessness

Overcoming Challenges, Optimizing Best Practices, Highlighting Special Subjects

By Arturo Baiocchi, Susanna Curry, Ethan Evans, California State University, Sacramento

A growing number of people are experiencing homelessness in Sacramento County, a common challenge across California and the United States. Those who are chronically homeless can have complex physical and/or mental health conditions which inhibit coordination of care among traditionally siloed service sectors (i.e., housing, medical care, behavioral health care, social services support, etc.). Like many communities, Sacramento spends millions of dollars annually on community supports and health care for people experiencing homelessness. To promote more effective service integration and improve outcomes, local leaders need first to sketch and assess the complex web of services operating in their communities, evaluating detrimental gaps as well as existing program assets. In this brief, we highlight a method for such assessment and describe our results.

We interviewed 35 stakeholders across 24 organizations and public agencies in Sacramento, as well as conducted two focus groups, and surveyed 15 individuals confidentially between July 2019 and September 2019. Stakeholders included individuals from local health systems, community clinics, social service providers, people with lived experience, and local government. We asked about current programs, user experience, a hypothetical integrated care campus concept, potential barriers, and alternatives. A central question we asked all stakeholders was: "Tell me a bit about your experience with the coordination of healthcare and social services for people who experience homelessness and who indicate need for mental health and substance abuse treatment, as well as social/life skill support. What seems to be lacking?"

A key take-way from our conversations with stakeholders is that what is often spoken of and characterized as a "system" of care is in fact, not a singular system but instead resembles a complex, and at times disjointed, constellation of providers and programs across different networks of services (e.g., housing, substance-use, healthcare, social services, etc.) . More specifically, stakeholders spoke to three central issues related to the landscape of services addressing homelessness in Sacramento.

Challenges that need to be overcome

Stakeholders elaborated on a number of challenges inhibiting services in Sacramento. Common challenges identified include insufficient service capacity; limited coordination, lack of communication and organization; inconsistent or non-existent service pathways, multiple providers

performing similar services; and misalignments of various local, state, and federal regulatory and funding regimes.

Approaches, programs, and infrastructure that need to be retained and optimized

Despite the multitude of challenges, stakeholders nonetheless emphasized that existing program models and infrastructure that should be *retained and optimized*. These programs or approaches included: The Flexible Supportive Re-Housing Program; the low barrier triage shelter approach; Pathways to Health and Home (Whole Person Care funded through Medi-Cal); and the Interim Care Program. Effective infrastructure elements included the Sacramento Continuum of Care, the Coordinated Entry System, data-sharing agreements between care providers (such as between a hospital system and a homeless services agency), and a collective impact model of shared governance.

Special subjects that warrant highlighting

Stakeholders described important contextual considerations in the Sacramento region that warrant particular attention when developing or expanding new models that serve homeless persons in crisis. First, the prevalence of methamphetamine use in Sacramento County (and throughout the State) hinders service efforts in part because they complicate the ability of providers to make appropriate diagnoses. Methamphetamine use is also challenging because treatment options are limited, especially for patients who have co-occurring mental and physical health needs. Second, service partners across systems were said to have varying levels of understanding working with chronically homelessness people. Their complex medical and social service needs require targeted expertise. Third, trauma, or what some described as "moral injury," was discussed by several interviewees as a central aspect of the client experience and a barrier to successful integration into society. Accordingly, service providers should be trained in trauma-informed care and must be attuned to the complex experiences that clients have faced both before and while homeless.

Recommendations

Stakeholders in Sacramento suggested that service capacity of homeless shelters, supported housing, social services, and especially behavioral health and substance abuse treatment should be expanded. Further, stakeholders indicated a concurrent need to further develop coordination capacity as well as partnerships through which information can be freely shared. To accomplish this, most stakeholders indicated interest in pursuing an initiative to improve the integration and colocation of services. We think the following recommendations for Sacramento also are generalizable to many communities:

- Develop a **county-wide and service integrated communication system**, such as an electronic Social-Health Information Exchange, that eliminates communication siloes across housing, clinical care, social services, and the criminal justice system. Such a communication system would improve efficiency and access to services for people experiencing homelessness.

Systems developed by Alameda and San Diego counties are good learning resources for other communities.

- Additional residential **treatment programs for people with methamphetamine use disorder** are urgently needed. Programs should offer evidence-based treatment including contingency management.

- Individuals with SMI and/or SUD being diverted or released from jail require an immediate **warm hand-off** to coordinated care and housing services. This will improve quality of life and reduce unnecessary costs.

- A cross-disciplinary council of finance experts could **collaborate to develop innovative funding options** for integrated and/or co-located social services, housing, and medical treatment. Funding sources for integrated care models vary, and include government sources (city, county, state, federal), health systems, and corporate and philanthropic contributors. An integrated delivery system will require a substantial investment of resources and a team of finance and service delivery experts can leverage creative funding approaches.