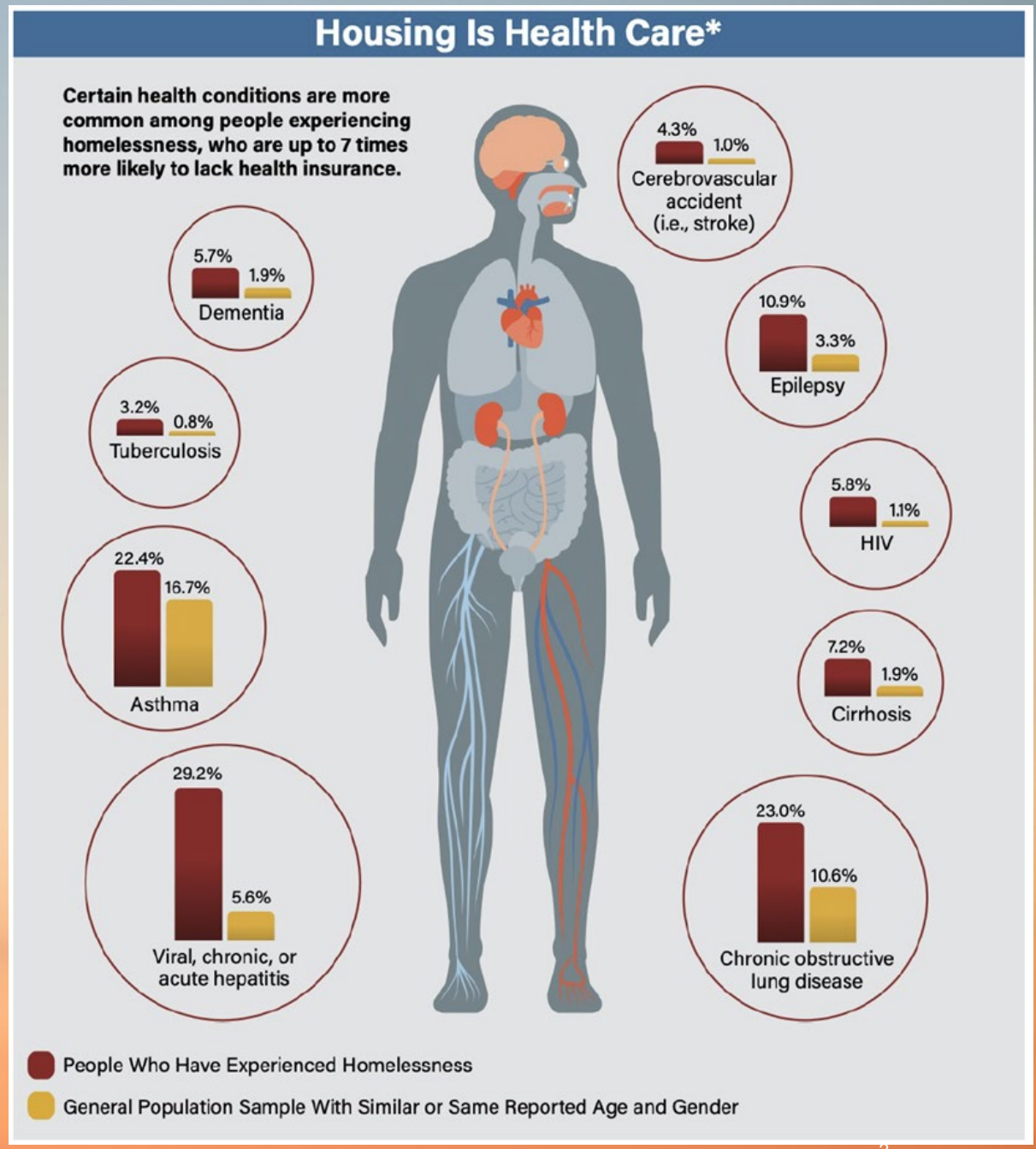
ANCHORAGE COALITION TO
END HOMELESSNESS

HOUSING REFERRAL SESSION 2

Serving People who are **Highly Vulnerable**

Presented by Dakota Orm, Healthcare Integration Director

How do healthcare and homelessness intersect?



Social Drivers of Health

Where a person lives, works, and plays.

Determines quality of life, outcomes and risks.

Examples: access to grocery stores, racism, education, and *housing*.

What does homelessness do to a person's health?

Worsens health outcomes.

Worsens pre-existing conditions.

Shortens life-span.

Creates difficulties in accessing medical care.

Overuse of Emergency Department

Less personalized attention.

Homelessness is a public health crisis. People experiencing homelessness often have serious and complex health challenges.

Ensuring access to quality health care must be part of our community's response to homelessness.

Housing *is* health care.

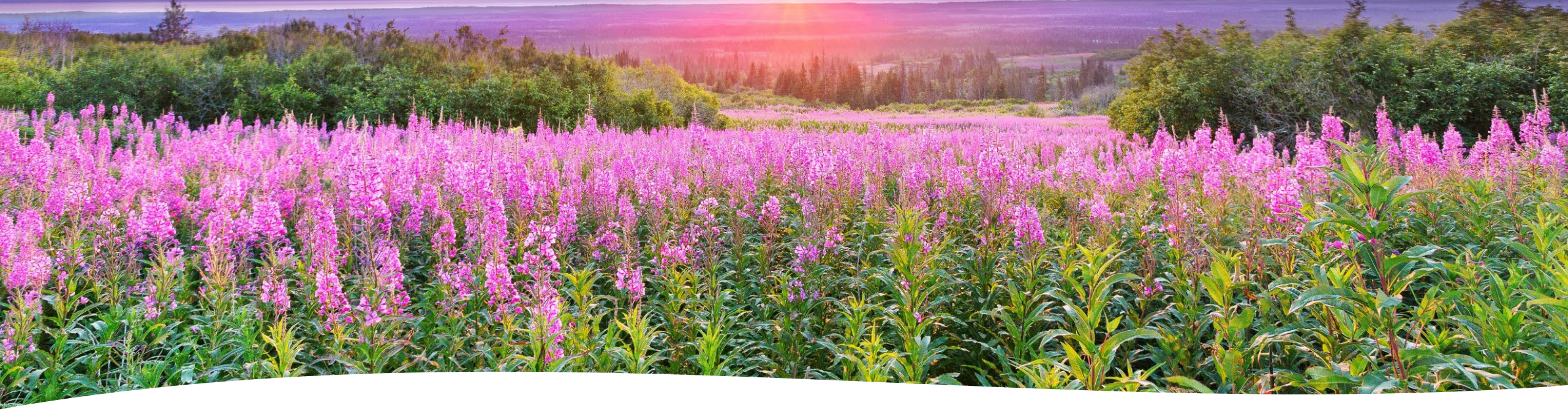
Improving the Intersection

PRE-PILOT

- **Medical Respite.**
- **Caring Clinic at largest shelter.**
- **Creating trust with healthcare partners.**

PILOT IN ACTION

- **Building racially equitable systems with new partnerships.**
- **Measuring for success.**
- **Transferrable learning.**
- **Commitment to integrating healthcare at every level of intervention.**



What makes a person **highly vulnerable**?

Must have:

Two or more co-occurring disabilities.

Difficulties with Activities of Daily Living.

Considered:

Unsheltered.

55+ (prioritized by oldest to youngest).

Chronicity.

Direct Connection to Housing: Highly Vulnerable Adult Case Conferencing

- Serves the most vulnerable, medically fragile individuals.
- Funding through home- and community-based Medicaid waivers.
- Wraparound services before and after they are housed.
- New partnerships with experts at the table.
- Use of data for results.
- Person-centered housing outcomes.
- Ranging housing options in and out of the Coordinated Entry system.

Coordinated Entry Specialist: Hospital Liaison

New Grant Opportunity

- Create a seamless transition for PEH discharging from the hospital and API.
- Healthcare-enhanced Coordinated Entry process for those with complex medical needs.
- Creating baseline data for the Highly Vulnerable Adult Population.
- Cross-sector, bi-directional case conferencing.
- Person-centered outcomes.
- Reductions in length of stay.

Healthcare integration **will better serve Highly Vulnerable Adults.**

- Current homelessness response system may not have the kind of housing they need.
- Service providers can collaborate with Medicaid through shared data.
- New housing resources will come into play.
- Clients can exit Coordinated Entry into medically supported permanent housing.

What's Coming Next?

Collaborating and coordinating about what is possible with stakeholders

- Continuums of Care, Division of Public Health & hospital partners, Institute for Community Alliance (ICA), Community Solutions

Policies & Procedures: Creation of the Process

- Community and client contributions and feedback

Data and Prioritization Improvements

- Verifications of Disability

THANK YOU!

Questions & Ideas?

Slides and additional resources are available at aceh.org/conference

Contact Dakota Orm at dorm@aceh.org