



HUD Policy Brief: Understanding the Impact and Potential for Health Centers



Rural Homelessness

Introduction

Health centers are increasingly addressing the social determinants of health for their patient population through partnerships and linkages to local housing and service resources. Such partnerships are particularly crucial in rural areas, where communities with limited capacity and resources often struggle to meet the needs of people experiencing homelessness, as well as people living in substandard housing, both of which contribute sharply to poor health.

In August 2018, the Department of Housing and Urban Development (HUD) launched 'All Routes Home: Ending Homelessness in Rural America', a strategy for building the capacity of rural communities to address the needs of persons experiencing homelessness. HUD and other federal partners have also recently released a few key resources that complement this new strategic effort, including the [Balance of State Toolkit](#)¹ and [How to Govern Geographically Diverse CoCs: Leading by Providing a Regional Voice](#), a brief on regional leadership structures.² These resources and more can be found at HUD's [Rural Homelessness landing page](#).³ By developing a better understanding of the 'All Routes Home' strategy and these recently published resources, health centers can identify ways to support local efforts to end homelessness in rural areas and address the social determinants of health for their most vulnerable patients.

The message outlining 'All Routes Home: Ending Homelessness in Rural America' can be found here: <https://www.hudexchange.info/news/snaps-in-focus-ending-homelessness-in-rural-america/>

Rural Homelessness and Housing Instability

Many of the challenges rural communities face in ending homelessness are closely aligned with the challenges rural health centers face in effectively engaging, serving and improving health outcomes for their patients. Some of the unique challenges to ending rural homelessness highlighted by 'All Routes Home' and other recent publications include:

- **Limited capacity and resources.** The homeless, human services, and health systems in rural communities typically have less funding, shorter staffing, and fewer partners to work with than communities in denser areas with more concentrated resources.
- **Large geographies.** Rural systems often have to cover large geographic territories with no options for public transportation. This makes it hard for providers to ensure adequate access to resources/supports in all areas they cover. In addition, for agencies serving clients in their homes or in multiple locations, covering a large geography results in long travel times for staff and high travel costs for the organization.
- **Inadequate housing stock.** People living in rural areas are more likely than their urban counterparts to reside in substandard or severely inadequate housing (e.g. lacking consistent plumbing, heating, or electricity). The rural housing stock tends to be older and tenants often face high utility costs due to substandard conditions like lack of insulation.

¹ Available at: <https://www.hudexchange.info/resource/5735/balance-of-state-continuum-of-care-toolkit/>

² HUD. How to Govern Geographically Diverse CoCs: Leading by Providing a Regional Voice. December, 2018. <https://www.hudexchange.info/resource/5786/how-to-govern-geographically-diverse-cocs-leading-by-providing-a-regional-voice/>

³ <https://www.hudexchange.info/homelessness-assistance/rural/#strategies-for-addressing-rural-homelessness>

HUD's Strategy to Address Rural Homelessness

Through the 'All Routes Home' initiative, HUD is focusing on a few key areas of capacity building in rural communities around their efforts to address homelessness including 1) Continuum of Care (CoC) Program changes; 2) Technical Assistance (TA); and 3) A focus on Collaboration. Through these efforts, HUD is concentrating on a few key areas of improvement to help rural communities, including governance, data collection, and creating a continuum of housing options for people experiencing homelessness.

Health Center Connections

Having an understanding of the context of rural housing instability and homelessness, along with how HUD and local communities are working to address it, provides another tool in the Social Determinants of Health toolbox for health centers. Some specific steps health centers serving rural areas can take to better connect their consumers experiencing homelessness or housing instability to housing and services include:

For more on how health centers can work with housing partners, see *Health and Housing Partnerships: Strategic Guidance for Health Centers and Supportive Housing Providers*, available at: <https://www.csh.org/resources/health-and-housing-partnerships-strategic-guidance-for-health-centers-and-supportive-housing-providers/>

- **Partner with local housing/homelessness providers to expand access to services.** Rural communities tend to have fewer housing/homelessness related resources and services available than suburban and rural areas, making partnerships with other service providers, including health centers, particularly important to ensure that the needs of households experiencing housing crises are met. Health centers should look to work closely with housing and services providers in the community by building strong referral relationships, integrating services when possible, and partnering to identify and fill service gaps for shared clients. There are many possible partnership models to expand access, including the use of mobile units, integrated outreach/services teams, and using telehealth to expand access to specialists. For more ideas and information about how health and housing partners in rural communities can work together to integrate and expand access to services, see the Rural Health Information Hub's [Rural Services Integration Toolkit](#).¹

- **Screen for homelessness and housing instability** to identify individuals experiencing housing crises and connect them to resources and providers. Resources to help health centers understand how to screen for social determinants of health, including housing status and stability, include:
 - [The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences \(PRAPARE\) Implementation and Action Toolkit](#)⁴
 - [Strategies for Using PRAPARE and Other Tools to Address Homelessness: Quick Guide and Recommendations](#).⁵
 - [Health Outcomes & Data Measures: A Quick Guide for Health Center & Housing Partnerships](#)⁶
 - [How 6 Organizations Developed Tools and Processes for Social Determinants of Health Screening in Primary Care: An Overview](#)⁷

⁴ National Association of Community Health Centers, Inc., Association of Asian Pacific Community Health Organizations, Oregon Primary Care Association. Available at: <http://www.nachc.org/research-and-data/prapare/toolkit/>

⁵ CSH, National Health Care for the Homeless Council. "Strategies for Using PRAPARE and Other Tools to Address Homelessness: Quick Guide and Recommendations." Available at: <https://www.nhchc.org/2018/11/new-quick-guide-examines-strategies-for-using-prapare-and-other-tools-to-address-homelessness/>

⁶ Available at: <https://www.csh.org/resources/health-outcomes-data-measures-a-quick-guide-for-health-center-housing-partnerships/>

⁷ LaForge K, Gold R, Cottrell E, et al. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5705433/>

- **Participate in coordinated entry.** A few ways health centers can get involved are:
 - **Accepting referrals through coordinated entry.** In coordinated entry systems that make referrals for services, as well as housing, to people experiencing a housing crisis, health centers can work with the CoC to enter relevant information into system, including eligibility criteria, details about the services and contact information. This will enable the system to make appropriate referrals based on a presenting household's needs and circumstances.
 - **Serving as access points.** This may involve either hosting coordinated entry staff to complete assessments and help clients access coordinated entry on a full-time or part-time basis or training health center staff to complete assessments and enter client information to the coordinated entry system. If these options are not appropriate, health centers can provide clients information on how and where to access the coordinated entry system.
 - **Documenting disability and length of homelessness.** In order to qualify for HUD-funded supportive housing, providers must document that an individual has a disability and typically that they are experiencing chronic homelessness, which has specific requirements around episodes and length of homelessness. The need for such documentation can delay the process of getting someone into housing, even when they have been matched to a slot through the coordinated entry process. With client permission and appropriate data-sharing agreements, health centers can provide critical information needed to expedite the connection to housing of the people who need it the most.

For more, information on how health centers can participate in coordinated entry, see the guide *Health Centers and Coordinated Entry: How and Why to Engage with Local Homeless Systems*, available at: <https://www.csh.org/resources/health-centers-and-coordinated-entry-how-and-why-to-engage-with-local-homeless-systems/>

ABOUT CSH

CSH is the national champion for supportive housing, demonstrating its potential to improve the lives of very vulnerable individuals and families by helping communities create over 335,000 real homes for people who desperately need them. CSH funding, expertise and advocacy have provided \$1 billion in direct loans and grants for supportive housing across the country. Building on nearly 30 years of success developing multi and cross-sector partnerships, CSH engages broader systems to fully invest in solutions that drive equity, help people thrive, and harness data to generate concrete and sustainable results. By aligning affordable housing with services and other sectors, CSH helps communities move away from crisis, optimize their public resources, and ensure a better future for everyone. Visit us at csh.org.

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ⁱ Available at: <https://www.ruralhealthinfo.org/toolkits/services-integration>