CSH

Report

Health Center Role in Housing Innovations:

Coordinated Entry

Access to safe, quality, affordable housing—and the supports necessary to maintain that housing—constitute one of the most basic and powerful social determinants of health and why housing itself is healthcare.

Much has changed in the homeless system since the Homeless Emergency Assistance and Rapid Transition to Housing (Act HEARTH) passed in 2009 and the creation of Coordinated Entry (CE)[1]. Notably, the homeless response system, CE processes and Continuums of Care (CoC) have grown to include a variety of partners, including health centers, and are working toward a reliance on real-time data and improving equity within its work in order to reduce the number of people experiencing homelessness or housing instability.

Building upon the original CSH Coordinated Entry publication[2], this paper will examine the current state of CE and the importance of health center involvement in the homeless response system. CE is a process that assesses, prioritizes and refers people experiencing homelessness with community housing resources. The challenges and responses to the COVID-19 pandemic re-emphasize the value of strong collaborations between health and housing sectors to prioritize resources and improve health outcomes. This publication will outline suggested steps for initiating or improving such collaborations and highlight examples of health centers that have successfully integrated CE into their outreach and efforts to address social determinants of health.

Introduction

The COVID-19 pandemic has highlighted the urgency of providing housing as a healthcare intervention. The pandemic pushed shelters and other congregate living arrangements to reduce their populations and ensure that people were able to live safely in isolation. Additionally, the pandemic generated multiple new federal funding sources creating more opportunities for affordable housing across the country.

The CARES Act used the ***Emergency Solutions Grants*** (ESG) Program to grant $4 billion to communities to "prevent, prepare for, and respond to coronavirus," among individuals and families experiencing homelessness.[3] ***The American Rescue Plan*** (ARP) provided $5 billion to provide housing, rental assistance, and supportive services for individuals and households experiencing homelessness or at risk of homelessness.[4] The ***Emergency Housing Voucher*** (EHV) program through the ***American Rescue Plan Act*** (ARPA) provided 70,000 additional housing vouchers to Public Housing Authorities (PHAs) to house people at-risk of or experiencing homelessness.[5]

The threat posed by the pandemic as well as the increase of housing resources has highlighted the urgent need for health centers and the homelessness response system to collaborate in order to meet the health and housing needs of those experiencing homelessness. Health centers have partnered with housing and homelessness systems to help connect people experiencing homelessness with housing, but increased collaboration between these systems is necessary.

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What Is Coordinated Entry (CE) and a Continuum of Care (CoC)?

Coordinated Entry is a process where housing resources funded by The Department of Housing and Urban Development (HUD) and administered by the local ***Continuum of Care (CoC)*** are distributed based on a locally defined set of priorities and a common assessment tool. Continuums of Care (CoC) are a collective of homeless service and housing providers and other community services designed "to promote community-wide planning and strategic use of resources to address homelessness."[6] Essentially, social service providers including housing, shelter, healthcare, justice and other stakeholders come together to organize a system-wide response to homelessness and apply for funding from HUD to implement this response. A CoC will look different in every community, with some structured as a statewide body while others are localized in a city or a county. Health Centers can find more information about the CoC in their area ***here***. Each CoC determines how and who to prioritize based on local needs and goals. For instance, one community may prioritize homeless veterans and another may prioritize by length of time spent homeless. Generally, households are assessed for housing need using the same tool and placed on a centralized list for the housing options that match their needs.

All CoCs are required to have Coordinated Entry and all organizations that receive homelessness assistance funding from HUD are required to use it. However, the status and progress towards a fully implemented CE will vary by CoC.[7]

Why Should Health Centers Partner with a Continuum of Care?

Both health centers and CoCs share the same goal of supporting people in the community who have the most complex needs. In addition, housing is widely accepted as an important social determinant of health (SDOH).

> It is well established that people who experience chronic homelessness "face substantially higher morbidity in terms of both physical and mental health and of increased mortality."[8]

These individuals are also more likely to experience poor health in comparison to their stably housed peers."[9] Indeed, particularly for patients managing complex chronic conditions such as diabetes, substance use disorder or mental health, stable housing is the essential ingredient for successful health management.

Given that HUD has modified its guidance in response to the pandemic to allow CoC to prioritize those most at-risk for developing severe COVID-19 symptoms, now is the optimal time for Health Centers to launch or strengthen their partnerships with their local Continuum of Care.

How Health Centers Can Partner with Continuums of Care

Health centers can partner with a CoC in a myriad of ways, including joining the CoC as a community "Referral Partner" to being a full "Access Point" for Coordinated Entry or even as an actual housing or services provider.

A ***Referral Partner*** is a member of the CoC that serves individuals or families experiencing homelessness or at imminent risk of experiencing homelessness and can facilitate a referral to a proper Access Point in the CE system. An ***Access Point*** is a partner within the CoC that is responsible for receiving referrals and conducting the initial triage, assessment and entry onto the prioritization list usually via the Homeless Management Information System (HMIS).[10] In some localities, all partners are able to serve as an Access Point, while others have a limited number due to capacity for assessment and entry to the list.

For most, the first step will be to reach out to the lead contact of their local CoC and inquire about the process to formally join as a member.

HUD maintains a searchable, active list of the lead contact for each CoC at *https://www.hudexchange.info/grantees/contacts/*.

Having a seat at the table provides the opportunity to lend perspective and expertise around healthcare and patient needs when strategizing how best to serve the homeless population in the community. While the CoC benefits from the health center perspective, they also provide important information for health centers on funding opportunities from the Federal, state and local governments as well as the community's response to homelessness. Below are some strategies that health centers can use to partner with the CE. This list is not exhaustive and health centers should consider the different options, as well as their own capacities and resources to determine which strategies may be right for them.

1 Becoming an Access Point for Coordinated Entry.

As many health centers serve clients who are experiencing homelessness, they can be helpful Access Points for entering people into the Coordinated Entry system.

KEY CONSIDERATIONS

- ☑ **Screening Tools.** Is the health center screening for Social Determinants of Health using the Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (***PRAPARE***) or similar tool?
- ☑ **Patient Demographics.** Do patients experience higher rates of housing instability?
- ☑ **Community Statistics.** Does the community have high rates of homelessness?
- ☑ **Staff Capacity**. Who is currently managing the electronic health records? Who could complete assessments for CE? Staff presently overseeing social determinant of health needs for patients or presently conducting outreach services can be a good fit for this role.

2 Create or Expand a Mobile Outreach Team to Provide Health Care to People Experiencing Homelessness.

Mobile outreach teams can help bring healthcare to people living on the streets, in shelters, and in encampments. Outreach teams can also process the intake of people into the CE (***See Wai'anae Coast Comprehensive Health Center Example***) helping people experiencing homelessness to receive both health care and the opportunity to receive housing if possible.

KEY CONSIDERATIONS

- ☑ **Partnerships.** Can the health center partner with existing outreach teams to connect with people experiencing homelessness?
- ☑ **Outreach Staff Capacity.** What is the existing outreach staff capacity (if applicable)? What adjustments or additions would be needed to include housing assessment or referral activities to existing outreach efforts?
- ☑ **Strengthening Existing Partnerships.** Are there existing partnerships with shelters or encampments that can be strengthened?

3 Providing Housing and Case Management Services.

Housing projects and programs run by health centers can be particularly helpful for the most medically complex and vulnerable patients experiencing housing instability, (***See Duffy Health Center Example***). Integrated care teams can ensure that housing needs are met alongside a patient's clinical care needs.

KEY CONSIDERATIONS

- ☑ **Staff Capacity**. In order to provide housing, health centers need to have dedicated staff for the program that is knowledgeable of the housing system.
- ☑ **Housing Model**. The program will need to decide if they will rent, lease, or build housing for the program.
- ☑ **Funding Streams**. Health Centers will likely need to receive funding from HUD or other Federal or state resources. This will require staff that can ensure the program is complying with reporting and document requirements, which can often be burdensome and time consuming.

Racial Equity and Social Determinants of Health

U.S. Department of Health and Human Services' Office of Disease Prevention and Health Promotion's ***Healthy People 2030 framework*** defines social determinants of health as "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."[11].

The five domains of the social determinants of health are:

1. Economic stability
2. Education access and quality
3. Health care access and quality
4. Neighborhood and built environment
5. Social and community context

The history of housing discrimination and policies of racial discrimination that were carried out by both the federal government and the private housing market for decades, have made housing a key factor that intersects with all of the domains of the social determinants of health.

Housing discrimination has disproportionately affected Black and Indigenous People of Color. Black/African American people make up 13.4% of the U.S. population, but 39.8% of all persons experiencing homelessness in 2019[12].

In the wake of COVID-19, health and housing inequities were shown in even a brighter light and HUD has provided a myriad of tools and resources to support homeless systems to become more equitable. A sample of these resources can be found in Table 1 below.

Therefore, all health and housing partnerships must recognize racism as a driving factor of inequities in both housing and health. Centering racial equity in these partnerships will improve both the housing and healthcare outcomes for people being served by these systems. Health centers, as a part of the homeless system, can work to ensure that those who are homeless or housing unstable can equitably access CE, housing, health and social services. Additionally, health centers can ensure that planning for those programs and services are led by people with lived expertise who utilize those programs and services.

CSH has developed a series of resources for health centers on creating equitable structures through health and housing partnerships. A list of these resources can be found in Table 2 below.

The recent upheaval driven by the pandemic has reiterated the need to address the dire housing needs and rising instability in many communities. It highlights the need for strengthened cross-sector partnerships to ensure better coordination and communication. Health centers are a critical partner in any systemic or community-wide approach to addressing housing instability and homelessness. Becoming a strong partner to the local Continuum of Care and Coordinated Entry process will not only benefit the long-term health outcomes of existing patients but also will ultimately benefit whole communities by emphasizing that housing is indeed healthcare. Across the United States, health centers are furthering cross-sector collaboration and demonstrating best practices for engaging the local homeless response system. Provided below are two such examples of high-quality health and housing partnerships and lessons to be learned from their respective methods.

Table 1.

Info	**HUD Homeless Assistance Programs and Racial Equity:** *https://www.hudexchange.info/homelessness-assistance/racial-equity/#coordinated-entry-equity-demonstration*
Info	**HUD Disaster Response Housing-Equity:** *https://disaster-response-rehousing.info/equity/*
Tool	**HUD CoC Analysis Tool: Race and Ethnicity:** *https://www.hudexchange.info/resource/5787/coc-analysis-tool-race-and-ethnicity/*

Table 2.

CSH Paper	***Addressing Health Equity through Health and Housing Partnerships:*** *https://www.csh.org/wp-content/uploads/2019/05/CSH-Addressing_Health_Equity_Through_Partnerships-Final.pdf*
CSH Paper	***Centering Equity in Health and Housing Partnerships in Times of Crisis and Beyond:*** *https://www.csh.org/wp-content/uploads/2020/08/CSH_Centering-Equity-in-Health-and-Housing-Partnerships-in-Times-of-Crisis.pdf*
CSH Paper	***Focusing on Structural Racism to Address Social Determinants of Health:*** *https://www.csh.org/wp-content/uploads/2022/02/Health-Equity-Addressing-Structural-Racism-Paper-2022.pdf*

HEALTH CENTER SPOTLIGHT

Wai'anae Coast Comprehensive Health Center

Island of Oahu, Hawaii

Wai'anae Coast Comprehensive Health Center (WCCHC) **is a Federally Qualified Health Center (FQHC) on the Island of Oahu in Hawaii. WCCHC has been a member of their CoC since the CoC was created. They are a Coordinated Entry Access Point and have a homeless outreach team of four people, which is funded by the WCCHC. The team performs the VI-SPDAT, which is a vulnerability assessment tool, and HMIS assessments, which collect local data on homelessness, to place individuals and families on the list for housing. WCCHC has strong relationships with nearby encampments, including the Pu'uhonua o Wai'anae encampment where they provide mobile health services.**

Approaching Work with Racial Equity

+ The homeless outreach team is primarily comprised of Native Hawaiians, while the ***majority of people experiencing homelessness in their community are also Native Hawaiian***.
+ Many of their staff also have lived experience of homelessness.
+ The health center provides trainings on cultural humility.

ADVICE FOR PARTNERING

- ☑ **Become a member of your CoC.** All health centers are encouraged to become members of their Continuum of Care, even if there is no capacity yet to become an Access Point for CE. It is typically a simple process to apply for membership.
- ☑ **Attend CoC meetings.** FQHCs tend to be focused on the day-to-day needs of their patients. CoC meetings provide a bigger picture, particularly regarding funding from the Federal, State, and local governments.

Learn more about Wai'anae Coast Comprehensive Health Center at *https://www.wcchc.com/*.

Image courtesy of Wai'anae Coast Comprehensive Health Center.

HEALTH CENTER SPOTLIGHT

Duffy Health Center

Cape Cod, Massachusetts

Duffy Health Center **is located on Cape Cod in Massachusetts and is a Healthcare for the Homeless health center. They are partnered with their CoC to provide healthcare to the homeless community. They also have 11 units of Permanent Supportive Housing (PSH) that they operate using HUD funding. The Duffy Health Center is not an Access Point, and does not process applications themselves, but rather refers to the Housing Assistance Corporation (HAC), which process the VI-SPDAT and HMIS applications.**

Changes During the COVID-19 Pandemic

- Because of the COVID-19 pandemic, the shelters had to de-populate, and Duffy Health Center helped move 140 people into local hotels.
- The pandemic greatly decreased the amount of available rental housing on Cape Cod. The area saw an increase in homelessness among their aging population.
- Duffy Health Center was able to capitalize on both ***Emergency Solutions Grant (ESG)***[13] and ***Community Development Block Grant (CDBG)***[14] money from the Federal government during the pandemic to help house people. Using these funds increased the amount of paperwork, however, and the Center was not able to increase their staff.
- Duffy Health Center encourages other health centers to join a CoC Committee to meet more partners and take advantage of the opportunity to influence decision-making.

ADVICE FOR HEALTH CENTERS INTERESTED IN PROVIDING HOUSING

- ☑ The housing system has its own complexities. If health centers want to provide and operate housing, they need to **understand the housing system**.
- ☑ If a health center is operating housing, they need to **separate the role of landlord/property manager and case manager**.
- ☑ Health centers will need to **understand HUD funding and the different definitions of homelessness that *HUD* uses vs. *HRSA***. It is helpful to have a dedicated staff person who understands the regulations, eligibility and can complete the required reporting and documentation like rent calculations and documentation of homelessness and disability.

Learn more about Duffy Health Center at *https://www.duffyhealthcenter.org/*.

Image courtesy of Duffy Health Center.

Conclusion

Providers cannot achieve the health outcomes they are increasingly being required to achieve without the ability to impact other systems and their respective social determinants. Access to safe, quality, affordable housing—and the supports necessary to maintain that housing—constitute one of the most basic and powerful social determinants of health and why housing itself is healthcare.

There are a number of next steps to consider from this guidance for health centers aiming to engage and impact the housing and homelessness response system in their community:

1. **Consider** becoming a member of your Continuum of Care and an access point for Coordinated Entry.
2. **Scan** for pre-existing cross-sector collaborations so as not to duplicate efforts internally.
3. **Identify** your local Housing Advocacy Coalition and connect with them to support existing campaigns.
4. **Consider** your role in a health and housing partnership to create new housing.
5. **Organization not yet ready to take these steps?** Become an internal champion for housing and social determinants of health.

Endnotes

1 "The McKinney-Vento Homeless Assistance Act, as Amended by S. 896 Homeless Emergency Assistance and Rapid Transition to Housing (Hearth) Act of 2009." HUD Exchange. U.S. Department of Housing and Urban Development. Accessed April 4, 2022. *https://www.hudexchange.info/resource/1715/mckinney-vento-homeless-assistance-act-amended-by-hearth-act-of-2009/*

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6 "Introductory Guide to the Continuum of Care (COC) Program." HUD Exchange. U.S. Department of Housing and Urban Development, July 14, 2012. *https://files.hudexchange.info/resources/documents/CoCProgramIntroductoryGuide.pdf*

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8 Taylor, Lauren. "Housing and Health: An Overview of the Literature: Health Affairs Brief." Health Affairs, June 7, 2018. *https://www.healthaffairs.org/do/10.1377/hpb20180313.396577/*

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10 Coordinated Entry Core Elements; *https://files.hudexchange.info/resources/documents/Coordinated-Entry-Core-Elements.pdf*

11 "Social Determinants of Health." Social Determinants of Health - Healthy People 2030. U.S. Department of Health and Human Services. Accessed April 4, 2022. *https://health.gov/healthypeople/objectives-and-data/social-determinants-health*

12 "U.S. Census Bureau Quickfacts: United States." U.S. Census Bureau, July 1, 2021. *https://www.census.gov/quickfacts/fact/table/US/PST045221*

13 *https://www.hudexchange.info/programs/esg/*

14 *https://www.hudexchange.info/programs/cdbg/*

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