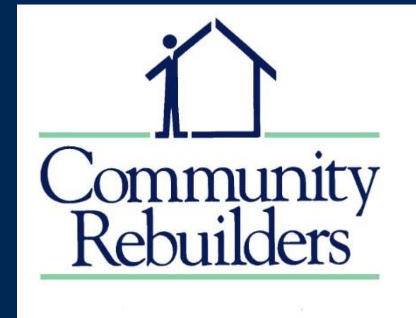

Coordinated Living: Cross-Sector Collaborative Solutions for Health and Housing for a Brighter Tomorrow

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Background

This presentation will share the results of a 3-year project that focused on improving the health outcomes and quality of life for people facing housing instability. This was done by supporting access to permanent housing, removing barriers, access to virtual health care, and education to manage chronic disease. In addition, this presentation will share how a cross-sector collaboration was an effective approach to address the negative impact of systemic issues on people's health.

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Presentation Objectives:

1. Describe how the interaction of individual lifestyle factors, community networks, and general socioeconomic, cultural, and environmental conditions impact public health in Michigan communities

- Reflect and discuss 2 case studies centered on how experiencing being unhoused, surviving significant trauma(s) and socio-economic suffering impact people's health and ability to manage chronic health conditions.

2. Identify the challenges and opportunities related to forming vibrant cross-sector partnerships to develop and guide genuine community-based public health approaches

- The audience will recognize at least 2 benefits & 2 challenges of developing a cross-sector partnership to address systemic social economic issues such as lack of housing & internet/smart devices access, while trying to manage chronic health disease conditions.

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Collaboration Inception

- Aim to create a synergy between Corewell Health StartNow Program, Corewell Health Community Medicine Clinic, Community Rebuilders, and Priority Health to serve the unhoused population
- Seed funding provided through Corewell Health Healthier Communities grant funds
- Project ideation began in 2020 and was implemented in late 2021

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Building Services Delivery - Housing/Chronic Disease Management Project

Only PH

Community Clinic / CHW Identify 30 eligible patients to refer

Definition of Homeless HUD def

Eligible: Patents w/ DM, CHF, COPD w/ Blue R Able to move to Self-management

Documentation from CC

How this definition might identification of eligible patients
1. Chronic Homeless to have a priority (additional services)

How we will take into consideration NS

2/18/22 we have enrolled 17 patients. We have a list of 13 more eligible patients

Dx for Core Health

CC/CHW connect with Patients. Provide information Verify patient's interest & eligibility

Client accepts

Referral to Core Health

Coordination

Staff's availability to go to Com Clinic Room's Availability Com Clinic's CHW – availability

No Show
No Phone

Scheduled Phoned Calls between Com Clinic & Core Health Adm

Liaison Visit: Goal: engagement & building trust.

1st RN Visit: Goals: engagement & education

Total 30 referrals
CHWs: 7/8 referrals each
RN: 15 Referral each

Review charts:
If they have recent screening ask if there is any changes (SDOH, PHQ, GAD)
Core Health's screen: Quality of Life, GSE)

How we can develop engagement / with No show

Biweekly clinical coordination T @ 7:30am

Referral to Community Rebuilders (using Grace Network)

Community Rebuilders' Goals: Access to Housing Economic Security

Average 60 days to access to housing since referral

Temporal housing / phone

Housing Planning

We need to get baseline data

Epic
Signify

Case Consultation

Every Other Week/ Monthly Consultation

Coordinating Care & Access

Engagement

Problem Solving

Improve the quality of life of 30 people

Case #1: Mr. A

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BEFORE enrolling in this Pilot:
Mr. A – 55-year-old. Black man. Immigrant. DM
April-Nov 2021: **8** ED Visits. A1C: **10.9%**
Drinking: Felt shame.
Nov 2021: No Phone- Uncontrolled DM & HTN
Nov 2021: Living in a shelter for 2 years. Issue accessing meds and glucometer. Lonely.

From Enrollment to housing:
Nov 2021: Working in a factory 2nd shift. Issues sleeping in the shelter, chronically homeless
Dec: No Phone-using CMC. Issues with food at shelter. Community Rebuilders provided temporary accommodations
Jan 2022: Phone & Internet access
March 2022: He had 3 meals, meds, and supplies everyday. Section 8
August: Coordination to access to CIM (Alcohol Use)
Sept 2022: Signed the lease. Managing DM. Planning Meals
April 2023: A1C: 5.9%. Going to counseling. Connected w/ PCP

Collaboration:

- **CHWs from CMC, Core Health**: Being the "translator" of cultural barriers to navigate systems. Access to food, Transportation. Listening with empathy. Support access to counseling. Expediate Appts. Application for SNAP
- **Community Rebuilders**: Expediting the process. From the date of enrollment to get emergency place. Got section 8. Listen to patient (fear), transitioning to housing and getting to sign lease. After being 2 years in a shelter. Help to address barrier: having eviction record. Filling Applications. Help Access to furniture
- Core Health: Listening & address challenges managing DM: Having snacks at work. Open communication with Com Reb. Clarify process/ address concerns: Confusion with Lease. And needed blinds for windows. Clarification about charges from landlord.
- Core Health, CMC, Com Reb: **Working in a grant** MHE: Access to phone/Internet.

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Discussion of Case #1

- What assumptions do you have around housing and chronic disease?
- What role did trauma play in this case?
- What impact did long-term shelter use have on this client?
- How did a health and housing cross-sector partnership increase the client-led success?

Case #2: Mr. B

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BEFORE enrolling in this Pilot:
Mr. B – 51-year-old African-American. COPD & Aphasia. Estranged from his family. Trauma history.
April-Oct 2021: Overwhelmed after 2nd stroke. He self-reported to APS - ADF
Nov 2021: Difficult with communication. Missing appts to speech rehab due to being unhoused.
Fear of Shelters

From Enrollment to housing:
Jan 2022 Enrolled in Core Health. Next day Com Reb was paying for a hotel room for him. Low confidence due to speech impairment: He writes to communicate
Jan 2022: He received iPad
July 2022: He secured housing
Nov 2022: He has secure housing, transportation, income (SSI), and got a cat, in the journey to quit smoking.
Jan 2023 he had a car accident (intoxicated): felt shame.
Jan 2023: Writing a book about his experiences after the stroke.

Collaboration:

- **CHWs from CMC:** Support to get his driver license, clothes for job interview. Communicate with empathy. Support to apply for SNAP, and SSI, and to have MyChart in his iPad. **Core Health RN's** access to inhaler, meds, smoke cessation and counseling; and access to orthopedic shoes and cane. **Core Health CHW**: Support to attend group and classes for people with aphasia.
- **Community Rebuilders**: Expediate the process. Paying for a room after 1 day in the program. Securing housing after 7 months in the program, having an incarceration record. CHW from CMC & Core Health helped with communication, with Community Rebuilders.
- **Core Health, CMC, Com Reb**: **Working in a grant** MHE: Access to phone/Internet.

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Discussion of Case #2

- How did a data use agreement enable the client to receive the best services?

- What role did trauma play in this case?

- How did this partnership and smart devices help to serve a client with different needs and abilities?

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Objective 2: Opportunities and Challenges to a Cross-Sector Partnership

Opportunities:

- Increased care coordination
- More points of contact with clients
- Could better identify individuals with the greatest need
- Jointly applied for additional grant for phone and internet services
- More easily calculate ROI in a similar project

Challenges:

- Data sharing
- Different definitions of housing instability-required creativity with funding

Potential challenge:

- Sectors not sticking to their own expertise

Thank you.

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Appendix:

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Community Rebuilders

Outcomes

HRSN Outcomes

58.3%

Improved their SDoH assessment scores

35.3%

Improved their Quality of Life assessment scores

38.1%

Improved their Self-efficacy assessment scores

Clinical Outcomes

68.4%

Improved their HbA1c level

16.7%

Improved their heart failure zone

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Housing Stats